**RFS 24-77045**

**Attachment D**

**Technical Proposal Response Template**

**Instructions:**

Respondents shall use this template Attachment D as part of their Technical Proposals. Respondents must also complete E, F, and G as part of their Technical Proposals. Please note, Attachment J is referenced in Attachment D. Attachment J is not a response template - a Respondent’s acceptance or feedback of this attachment is provided in Attachment D.

In their Technical Proposals, Respondents shall explain how they propose to perform the work, specifically answering the question prompts in the template below.

Respondents should insert their text in the provided boxes which appear below the question/prompts. Respondents may reference attachments or exhibits not included in the boxes provided for the responses, so long as those materials are clearly referenced in the boxes in the template. The boxes may be expanded to fit a response.

Respondents are strongly encouraged to submit inventive proposals for addressing the Program’s goals that go beyond the minimum requirements set forth in this RFS.

**Section 1. General Information**

* + - 1. In 2,000 words or less, describe why your organization should be selected as part of the Demonstration.

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| **Section 1. General Information**  **2.4.1.1**  **In 2,000 words or less describe why your organization should be selected as part of the Demonstration.**  Beginning in April 2020, Hamilton Center, Inc. (HCI) received and successfully achieved all programmatic goals associated with the SAMHSA CCBHC grant award extending from 05/01/2020 – 04/30/2022 (#1H79SM083212-01 – Vigo County). HCI’s record of success with CCBHC services builds on a 51-year track record of supporting excellence and placing the needs of consumers first. Our team is fully invested in providing high quality access to the complete crisis continuum for all Hoosiers residing in an 8-county geographic region, including Clay, Greene, Parke, Sullivan, Vermillion, Vigo, Owen and Putnam.  Even before receiving SAMHSA funding, HCI has implemented key components of the nine required CCBHC services and will be ready for full implementation of all new requirements before July 1, 2024. Our award-winning history as a Community Mental Health Center (CMHC) confirms the capacity for HCI to serve as an excellent demonstration program partner. The depth of our community partnerships across all 8 counties is strong, evidenced by the over 30 enclosed letters of support. We will collaborate to strategically identify DCOs possessing a similar focus, especially regarding the identification and training of certified peers.  During the first year of CCBHC implementation, programmatic goals included exceeding all success metrics related to 24/7/365 mobile crisis, mental health screenings, primary care screenings, adolescents & adults served, community representation (governance), assertive community treatment (ACT) services, organizational collaboration, and organization wide trainings.  This process included approval by SAMHSA as a CCBHC meeting all required attestation criteria (9 core service areas). SAMHSA approved HCI’s attestation in April 2021 and again in January 2023. Our team is on track to meet all new CCBHC attestation requirements prior to the July 1, 2024, deadline as published by SAMHSA in March 2023.  The first years of CCBHC implementation (FY21 – FY23) resulted in significant improvements for consumers, such as:   1. Significantly Increased Access to Crisis Services. The average number of crisis walk-ins per month more than doubled, increasing from an average of 90 to 240 per month. 2. Significantly Increased Primary Care & Mental Health Screenings. Our team performed 379 unduplicated mental health screenings. 3. Significant Decrease in Hospitalizations. The number of hospitalizations for ACT team consumers decreased from 122 prior to receiving the grant to 65 after receipt of grant (a 53% decrease). 4. Increased Access for Diverse Consumer Population (Age, Race, & Ethnicity). A total of 187 mobile crisis runs were completed impacting a diverse consumer population including the following ages.  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Age Ranges:** | | | | | | | | | **<18** | **18 to 20** | **21 to 30** | **31 to 40** | **41 to 50** | **51 to 60** | **61 to 70** | **71+** | | 8 | 9 | 35 | 52 | 34 | 31 | 12 | 4 | | 4.3% | 4.9% | 18.9% | 28.1% | 18.4% | 16.8% | 6.5% | 2.2% |  1. The percentage of *African American* walk-ins served by HCI in crisis improved by 148% when comparing the previous 2 fiscal years to the most current 2 fiscal years. The average of African Americans crisis services increased from 13% to 31%. 2. The percentage of *consumers making less than $8,000* increased 31% during the grant period. The annual average number of unduplicated consumers seen making less than $8,000 increased from 192 to 252. The percentage of *consumers identified as homeless* increased by 87% during the grant period. The average annual number of unduplicated consumers increased from 12 to 22. 3. The percentage of *youth and adolescents* served increased by 72%. The average annual number of consumers increased from 29 to 42. Within this average there was a 45% increase in the proportion of males served and a 110% in the proportion of females served. Over the last 4 years, approximately 1 youth consumer identified themselves as non-binary. 4. The percentage of *adults 65 years of age and older* served increased by 57% when comparing the past (two years) versus present (two years). The average annual number of consumers increased from 7 to 11.   As part of SAMHSA CCBHC implementation, HCI applied for and was selected by the National Council for Mental Wellbeing to take part in the General Health Integration Learning Collaborative and the CCBHC National Mentor program. Our team collaborated with Tri-County Mental Health Services (now Beacon Mental Health) out of Kansas City, MO monthly to share and integrate lessons learned from a nationally recognized CCBHC.  Following this one-year mentorship, HCI was selected by the National Council to serve as a mentor for a total of four new CCBHC from the states of Michigan, Oregon, Illinois, and Texas. This provided our team the opportunity to share our implementation success and lessons learned each month. As part of the General Health Integration Learning Collaborative, HCI was one of only 20 agencies selected nationally from 13 states. This cohort of agencies submitted monthly CCBHC data focused on self-assessment using a research-based integration tool spanning 8 domains (screenings, evidence-based care, patient self-management, training, systematic quality improvement, community linkages, and sustainability). This cohort also participated in monthly features focused on the best practices and lessons learned with CCBHC implementation from many of the nation’s leading CCBHC states, including best practices related to certified peers.  Our team was the first CMHC and CCBHC in Indiana to attain both the One Star and Two Star Designation from Star Behavioral Health Providers. HCI has achieved the level of Three Star designation. This designation shows that our team has put in the policies, procedures, staff training, community relations, and data tracking to support excellence in serving veterans.  In September 2022, HCI was awarded a second SAMHSA grant to continue implementation for the next four years, extending from 09/30/2022 – 09/29/2026. HCI is honored to be part of the 9 CCBHCs in Indiana currently funded by SAMHSA. Within this new grant, SAMHSA introduced a new sampling method consisting of a random sample of unduplicated consumers receiving CCBHC services.  HCI successfully achieved all programmatic goals providing services to over 2,900 consumers (surpassing the annual goal of 2,680), and successfully sampled 10% of this population reported as part of the NOMS (National Outcome Measures) baseline data. The method of sampling was reviewed and approved by SAMHSA, along with the ten percent sampling rate.  HCI surpassed all programmatic goals related to primary care screenings (434 unduplicated), mobile crisis runs (39 unduplicated), crisis walk-ins (172 unduplicated), along with all IPP data indicators related to board composition (i.e., greater than 51%), collaborating organizations (more than 20), individuals receiving mental health related referrals (608).  HCI was also selected by DMHA to receive Crisis Stabilization (Vigo County) funding including the addition of a new mobile crisis hub in Sullivan County. The HCI team is currently ramping up these implementation plans and participates in the monthly office hours planning related to these services. Additionally, HCI received communication that more funding for mobile crisis in Sullivan County will be available via the CCRP SAMHSA grant cohort 2.  Our team has been a fully engaged participant in Indiana Council activities related to CCBHC planning, including participation in the bi-weekly data analytics committee meeting and CCBHC mobile crisis group. We will continue to maintain the standard of full participation and engagement from our leadership team for all CCBHC planning activities. HCI’s President / CEO also was recently elected to the Indiana Council Board of Directors and is fully engaged in contributing to the vision of CCBHC for the state.  HCI looks forward to continuing as a strong CCBHC partner with the State of Indiana and is committed to full participation in all planning and activities that support transformation to a new behavioral health system for all Hoosiers. |

* + - 1. How many sites or locations is your organization applying for to be a part of the Demonstration Program? Where is each site located? What geographic area(s) does each site serve? As applicable, please propose the service area your site(s) would serve.

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| HCI is proposing a total of 15 physical addresses (see flash drive) spanning the following 8 counties (geographic areas): Clay, Greene, Parke, Sullivan, Vermillion, Vigo, Owen, Putnam. Collectively, the 15 sites would cover each of the geographic regions listed above. The location of each physical address is detailed on the flash drive Folder 2, Section 3 - 2.4.1.2, pages 33 – 34 of the Community Needs Assessment (CNA) and Folder 3, Criteria 2.a.2 (excel file).  An estimated total of 274,569 people live in the 3,318.3 square miles of Hamilton Center’s proposed RFS service area. The population density for this area, estimated at 82.74 persons per square mile, is less than the state average population density of 188.50 per square mile.  HCI’s community needs assessment (CNA) provides a detailed overview of the geographic regions including total population, total land area, population density, gender, age, race/ethnicity, and veteran population. See the flash drive file, Folder 2 – Section 3 – 2.4.1.2. |

**Section 2. Staffing**

2.4.2.1 How many staff are in your total workforce currently? How many vacancies do you presently have? How many vacancies do you project over the next year? What staffing levels or specializations do you have the highest need for?

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| HCI currently employs 612 staff, including 43 vacancies. Over the next year HCI anticipates 75 projected vacancies based on a 3-year average of vacancies for the last 3 fiscal years. We have the highest need for the following staff:   1. Certified Peer Recovery Specialists 2. Registered Nurses / LPNs 3. Therapist 4. Psychiatrists 5. Nurse Practitioners |

2.4.2.2 What support do you need for staffing to meet the CCBHC certification requirements by 7/1/24?

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| Meeting the requirements for certified peers is the most significant area where an increased capacity related to the availability of statewide training is needed to expand the pipeline. HCI’s has a plan for providing telehealth support with certified peers, as needed, and will fully invest in the recruitment and training of peers as the overall statewide pool of potential certified peers increases. HCI has also created a written internal recruitment plan focused on identifying potential certified peers, making them aware of the short supply and increased demand for this role within the CCBHC landscape.  An additional area of support related to Crisis Stabilization is continuing to push forward on the Crisis Stabilization contract agreements. Once these have been officially authorized this will provide the capacity for projecting a specific delivery date and crisis stabilization services. |

2.4.2.3 What goals do you have for your workforce capacity for CCBHC?

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| HCI’s workforce will be able to consistently deliver the 9 required services in a timely, consistent, and culturally response manner.  Our strategic plan for workforce capacity includes attaining an overall turnover rate at or below twenty percent 20% by FY24. This includes building on a five-year analysis baseline breaking down the attrition rate by age group.  HCI is committed to hiring staff, which reflects the cultural and ethnic diversity of the community that we serve.  To address the behavioral health workforce shortage, HCI is committed to continuing internship opportunities that provide the pathway for future behavioral health professionals to enter the field and expand career opportunities available to them through more specialized degree attainment (e.g. Therapists, Registered Nurses, and Nurse Practitioner).  HCI is committed to continuing yearlong training and on-boarding that requires the following annual refreshers and certifications for key provider focused positions, Question Persuade Refer (QPR), Mental Health First Aid, Crisis Prevention Institute, Trauma Informed Care, First Aid, Military Cultural Competency Training, along with Motivational Interviewing. |

**Section 3. Community Needs and Engagement**

2.4.3.1 Please provide a copy of your most recent Community Needs Assessment (CNA). Include all relevant information, including, but not limited to the key steps in a CNA as defined by SAMHSA: goals for the assessment, purpose for the assessment, target populations for the assessment of needs and services, how data was collected, timeline of assessment, geographic area assessed, and the strategic use of the findings.

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| HCI’s community needs assessment (CNA) is attached (see flash drive - Folder 2 – Section 3 – 2.4.3.1). Within the report each of the areas listed above are addressed. The goals for the assessment were to capture the social and behavioral health demographic profile for the 8 counties HCI proposes to serve (Clay, Greene, Parke, Sullivan, Vermillion, Vigo, Owen, and Putnam).  The purpose of the assessment was to provide a comprehensive picture of community needs, including responses received from consumers spanning all 8 counties regarding received services. Additionally, responses from 20 community partners were received regarding the overall state of behavioral health within the region using SAMHSA’s National Consumer Support Technical Assistance survey. The targeted populations included consumers spanning all 8 counties and the data was collected using national data sources, direct consumer survey data from HCI’s EMR, and direct community partner survey information. The timeline of the assessment spans from 2021 through 2023.  The CNA includes detailed analysis related to the following categories: demographics (age, race/ethnicity, veterans, gender, total population), social and economic factors (insurance, the uninsured, poverty), clinical care (access to providers, access to primary care), health outcomes (mortality – suicide, alcohol consumption, disabilities, languages), consumer survey, and community partnership survey.  The findings from the CNA will be used to inform benchmarks related to the cultural diversity of HCI staff along with goals for reducing vacancies in difficult to staff positions like nurses, therapists, nurse practitioners, and psychiatrists. |

2.4.3.2 Please share any lessons learned from your most recent CNA.

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| HCI’s Community Needs Assessment (CNA) reveals some important strengths based on the responses of consumers that the team will continue to build upon. Consumer survey respondents to the following questions were strongly favorable establishing a high baseline for continued improvement.   1. Staff were sensitive to my cultural background 2. I was able to get all the services I thought I needed 3. Services were available at times that were good for me 4. The location of services was convenient 5. I would recommend this agency to a friend or family member 6. If I had other choices, I would still get services from this agency.   Across each of the statement list above the percentage of consumers that disagreed with these statements averaged less than 1 percent within each category and across all respondents spanning all 8 counties identified as HCI’s CCBHC sites.  This data indicates that HCI can continue to place a high priority on the delivery of personalized treatment plans, the hiring of culturally diverse staff, and innovative community outreach that integrates community wide activities focused on reducing the stigma associated with mental health.  HCI will also place a greater emphasis on receiving more consumer responses during the implementation and scale up of CCBHC.  When examining the community partner responses regarding behavioral health throughout the region (Central and West Indiana), HCI’s community partners identify the following areas as opportunities for improvement for the larger community.   1. There is a critical need for peer support services across the region. 2. There is an important need for more organizations to be culturally responsive. 3. There is an important need related to the ability for consumers to have a choice of providers. 4. The region can continue to make progress regarding the integration of behavioral health services, creating stronger connections between mental health, substance abuse, and primary care. 5. Individuals who identify as consumers can be provided more leadership opportunity roles within coalitions, partnerships, policy-making bodies, and leadership groups. |

2.4.3.3 The State is focused on the integration and connection between providers and their respective community stakeholders, as well as providers’ ability to appropriately assess and positively impact the needs of their communities served. With which organizations do you currently work? With which organizations do you plan to forge partnerships? Please include a description of any existing designated collaborating organizations (DCO), referral, or other care coordination partnerships with other organizations in your community. If you list an organization as a current or potential partner, if possible, please attach letters of support with your proposal submission. If letters of support are not possible, please include contact information from each organization listed as a partner.

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| HCI’s application includes over 60 community partners spanning all 8 selected county regions (see flash drive). Our teams' priorities related to DCOs will center around the recruitment and training of certified peers. The following organizations have been identified as potential DCO partners: Wabash Valley Recovery Center  Union Hospital, Sullivan Hospital |

**Section 4. Financial**

2.4.4.1 The State has selected the daily Prospective Payment System (PPS)-1 Rate as the statewide CCBHC PPS rate. The rate operates on a Medicaid per-encounter basis, determined by a cost report that outlines a clinic’s total annual allowable costs and qualifying patient encounters on a daily basis throughout the year. The costs are divided by the number of qualifying encounters resulting in a single rate which is disbursed to the clinic with each daily encounter, irrespective of the number or intensity of services delivered to a patient. Please confirm that you have reviewed the PPS-1 Rate and understand how your organization will be paid as a CCBHC, if selected to participate in the Demonstration Program.

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| HCI has reviewed the information provided related to how the PPS-1 rate will be calculated using the referenced spreadsheet within Appendix J (CCBHC Cost Report). HCI will attend the planned Cost Report workshops to be delivered by the state as communicated in the official written responses. Several of the written responses related to questions HCI has regarding implementation of the PPS-1 rate referred back to the upcoming Cost Report workshops. |

2.4.4.2 Please review the list of financial documents required for cost reporting and rate setting in Attachment J. For each item on the list, please confirm your organization has the appropriate documentation as of the most recently completed fiscal year period; or indicate what your organization would need in order to provide said documentation:

1. Working Trial Balance or Financial Record of Expenses during the Cost Reporting Period
2. Crosswalk of Working Trial Balance Expenses to the Direct and Indirect Costs for CCBHC Services and Direct Costs for Non-CCBHC Services listed in the Cost Report
3. Supporting Documentation and Explanation for any Trial Balance Reclassifications or Adjustments of Expenses on the CCBHC Cost Report
4. Supporting Documentation and Explanation for Anticipated Costs of CCBHC Services Not Currently Provided
5. Explanation of Methodologies Used to Allocate Resources to Direct or Indirect Costs for CCBHC Operations
6. Documentation Supporting the Reported Daily Visit Count
7. Documentation of Direct Care Practitioner Full-Time Equivalent (FTE) Amounts

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| HC has the appropriate documentation as of the most recently completed fiscal year to provide the financial documents for cost reporting for each of the categories as stated above. |

**Section 5. Quality and Data**

2.4.5.1 Confirm your commitment to meet all reporting requirements, as detailed in Attachment A – Scope of Work and Attachment E – Certification Criteria. Indicate your commitment to reporting on quality metrics detailed in Attachment F and EBPs, assessments, and screening tools detailed in Attachment G. Please confirm you will provide data and information requested by the State, in the format and periodicity required, to meet State and federal reporting requirements.

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| Hamilton Center, Inc. (HCI) is committed to meeting all reporting requirements, as detailed in Attachment A – Scope of Work and Attachment E – Certification Criteria by July 1, 2024.  As outlined in Attachment A – Scope of Work, HCI understands that the State will require that sites selected through this RFS provide data and information to develop its application. HCI attests that this includes but is not limited to:   * Qualitative and quantitative information regarding why the Contractor is the best positioned to be in the Demonstration to further the State’s Application, including the Contractor’s readiness for CCBHC and how the Contractor will meet the needs in its community (driven by its Community Needs Assessment or “CNA”) * Financial information required for CCBHC rate-setting * Qualitative and quantitative information on quality metrics, evidence-based practices, assessments, and screeners * Participation in meetings and/or response to written requests from the State’s technical assistance vendor supporting Demonstration Application development   Furthermore, HCI is committed to data collection and reporting requirements throughout the duration of the Demonstration Program as necessary to fulfill State and federal expectations. HCI is equipped to meet and exceed the minimum reporting requirements of the quality metrics as detailed in Attachment F as well as the evidence-based practices (EBPs) and screening & assessment tool reporting requirements as detailed in Attachment G by July 1, 2024.  Lastly, HCI attests that periodic written reports will be produced in accordance with the requirement to provide data and information requested by the State, in the format and periodicity required, to meet State and federal reporting requirements. |