**EXHIBIT B**
**SCOPE OF WORK AND FEE SCHEDULE**

## 1. PROJECT DESCRIPTION

The Boulder County General Fund supports Mental Health Partners (MHP) in filling funding gaps for agreed upon priority focus areas, as described in Section 2. These funds may supplement services covered by Medicaid, Medicare, and private insurance, but may not supplant any existing services and/or funds.

The Boulder County General Funds are directed towards main purposes:

**A.** Fund priority treatment and support services in three focus areas, as listed in Section 2, for individuals without insurance, whose payer source does not cover the entire cost, or for whom coverage is terminated for short periods of time. Funds may also be used to provide value-added services that enhance services for Boulder County clients.

**B.** Collect performance and outcome data to determine the ongoing effectiveness of services listed in Section 2 and plan for the implementation of new services for Boulder County.

## 2. Priority Focus Areas – Treatment and Support Services

Boulder County residents who are members of the following three Focus Areas may receive services under this Contract:

### A. Focus Area 1: Access to Care – Priority Services

i. Engagement, empanelment, and level of care assignment in Behavioral Health Home or Integrated Health Home depending on client need.
ii. Access to, activation for, and provision of brief and outpatient treatment for mental health and substance use disorders.
iii. Assignment to Centers of Excellence for specialized treatment
iv. Ongoing care management and assistance navigating to needs related to social determinants of health, other health needs, referrals.
v. Primary Prevention Programs are those directed at individuals who have not been determined to require treatment for mental health and/or substance abuse. Such programs are aimed at educating and counseling individuals on such concerns and providing for activities to reduce the risk of these disorders.
vi. A comprehensive primary prevention program shall include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for mental health and/or substance abuse.
vii. MHP may use a variety of strategies for a primary prevention program, as appropriate for each target group, including but not limited to the following:
    a. Information Dissemination
    b. Mental Health First Aid and/or other training models
    c. Attendance at Community Forums where these topics are discussed.

**B. Focus Area 2: Early Intervention – Priority services for mental health and substance use disorders.**

i. Access for Housing and Human Services (HHS) and non-HHS referred Boulder County residents ages:
   a. 0 – 5
   b. Identified Elementary Schools and special needs.
   c. Identified Middle and High Schools and special needs.
ii. Substance Abuse Interventions Program (SAIP), via the Behavioral Health Homes
iii. Mental Health First Aid training
iv. Mental Health Disaster Response, via the Community Health Worker Outreach Team
v. Home based services for treatment.
vi. Home based, peer supported, and office-based services for older adults.
vii. Services for adult recovery maintenance (such as, peer specialist support, Chinook model, AA, NA), via coordination by the Behavioral Health Homes, Housing, IHH, and PACE
viii. Harm reduction activities to prevent self/other harm and overdose/loss of maintenance risks, via coordination by the Behavioral Health Homes, Housing, IHH, and PACE

**C. Focus Area 3: High Acuity/ Collaborative/Coordination Opportunities**

i. Other IMPACT/Core/Truancy referral programs
ii. Collaborative programming with criminal justice, juvenile justice, and corrections in all jurisdictions
iii. Immediate access to crisis services in 2 county locations
iv. Housing services available in 2 county locations
v. Employment services available in 2 county locations
vi. Treatment, stabilization, and recovery services for substance use disorder, via coordination by the Behavioral Health Homes, Housing, IHH, and PACE
vii. High maintenance services to prevent relapse (DBT outpatient, Vivitrol, Suboxone), via coordination by the Behavioral Health Homes, Housing, IHH, and PACE

## 3. PERFORMANCE RESPONSIBILITES

Contractor, in accordance with the terms and conditions in the this Contract, shall, in a timely and satisfactory manner, provide the following services:

A. Provide culturally appropriate marketing materials of Contractors services to other local agencies and Family Resource Centers who serve low-income and at-risk individuals in order to increase participant access to healthcare services and education.
B. As needed, work collaboratively with BCDHHS Community Support Division staff to develop, and distribute culturally appropriate marketing materials that work to destigmatize access and enrollment in public assistance benefits.
C. As needed, contractor will support participants in connecting with self-reliance benefits

utilizing the Colorado PEAK online application and/or creating a Boulder County Connect (BCC) Account and encourage online system use for accessing case information, completing required actions on their cases, and uploading documents.

D. Contractor agrees to provide space for BCDHHS staff for enrollment in public benefits programs, the Low-Income Energy Assistance Program (LEAP), and for Family and Children Services (FCS) community-based family meetings (team decision-making meetings), when and if applicable.

## 4. TARGET POPULATION

The target population includes low-income individuals and families who are Boulder County residents. Contractor shall ensure that priority for services be provided to individuals and families within geographic service area who are at high risk or have unmet needs.

## 5. REFERRALS FOR SERVICE

A. Contractor agrees to accept and prioritize referrals as able from other service providers and government agencies operating in Boulder County who serve similar populations.
B. Contractor agrees to work collaboratively with BCDHHS and other community partners to ensure participants are enrolled in all self-sufficiency benefits for which they are eligible and wish to receive.
C. Contractor shall make referrals to appropriate service providers in effort to move participants from crisis to stability, establishing a network of care supporting the participant.
D. Contractor shall refer all participants to their local Family Resource Center (OUR Center, Emergency Family Assistance Association (EFAA), or Sister Carmen Community Center) for additional stabilizing services, depending on their geographic location.

## 6. MEETINGS AND COMMUNICATIONS

A. BCDHHS and Contractor may meet semi-annually to evaluate Contract usage and program effectiveness that may include:
    i. recommendations for modifications in the scope of services for this Contract,
    ii. technical assistance necessary to enable the performance of this Contract by Contractor, or
    iii. the specification of necessary additional services to enable Contractor's performance of the services provided under this Contract.
B. A fiscal review may be conducted during the term. Prior to this review, BCDHHS may request a copy of Contractor's published annual report for the prior year.
C. BCDHHS will communicate with Contractor regarding applicable trainings and meetings as available.

## 7. DELIVERABLES AND REPORTING REQUIREMENTS

A. MHP shall submit the following quarterly data and reports, including any applicable reports already generated for the services under the priority areas as necessary. Data and reports shall be submitted no later than the 20th of the month following the end of the quarter. Reports shall be submitted via email to: hhsimpactreporting@bouldercounty.gov and Estiberson Parra Cordero (eparracordero@bouldercounty.gov).

**Behavioral Health Homes (BHH)**:

- *Activity 1:* Provide initial clinical assessment to 2,000 Boulder County resident clients at enrollment, and assessment updates every six months. These can be provided via telehealth when necessary and available. Assessment definitions and targets may be adjusted to reflect implementation of new rules from the Colorado Behavioral Health Administration, including the shift to a new regulatory intake structure (i.e., screening, initial assessment, comprehensive assessment). These adjustments will be identified in quarterly reporting.
    - *Outputs:* At least 85% of clients will receive an assessment appointment within 7 days of registration, and at least 50% of continuing clients will receive updated assessments within 6 months (+/-30 days)
    - *Timelines:* Clinical assessments are provided within 7 days after initial registration; re-assessment occurs every 6 months for clients enrolled in care, with a +/- 30 day window to provide an appropriate timeframe to complete the reassessment interview
    - *Partners:* Key partners include any referring organizations, such as Boulder County HHS, homeless shelters, family assistance organizations, schools, and criminal justice system
    - *Outcomes:* At least 85% of clients will remain engaged in services 45 days after assessment.
    - *Measurement Tools:* Assessment services are documented in the MHP electronic health record; reassessment rates are identified by completion of the follow-up National Outcome Measure set tool (NOMS), completion of updated assessment module in the EHR, and/or completion of the updated care plan EHR module.
    - *Indicators:* Actual number of Boulder County resident clients who received a clinical assessment, actual number of clients receiving the assessment within 7 days of their registration, actual number of clients receiving timely 6-month reassessments, and actual number of clients remaining engaged 45 days post-assessment
- *Activity 2:* Provide 9,000 targeted case management services to clients who have an identified need for coordination of care, support addressing social determinants of health, or accessing benefits.
    - *Outputs:* 9,000 targeted case management services will be provided to clients.
    - *Timelines:* Targeted case management services are provided as-needed based on each client's individualized care plan and treatment progress, sometimes as often as daily or as infrequent as a single case management service during enrollment; we expect to see outcome change by 6- or 12-month reassessments
    - *Partners:* Key partners include other community organizations and local agencies providing social determinants of health supports, such as County agencies, homeless shelters, family assistance centers (OUR Center, EFAA, Sister

Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool; we expect to see reduction in clients reporting high psychological distress (less than 30% at reassessment), and improvements in ratings of daily functioning (above 35% at reassessment) and social connectedness (above 60% at reassessment). At least 90% of surveyed clients will indicate positive experience of care on client satisfaction surveys, as measured by the SAMHSA National Outcome Measure set or similar standardized client satisfaction tool, including a measure of Net Promoter Score when possible.
- *Measurement Tools:* The SAMHSA National Outcome Measure set, CCAR, and/or other identified standardized measurement tools
- *Indicators:* Key indicators include (1) Psychological Distress, (2) Daily Functioning, (3) Social Connectedness, and (4) Client Perception of Care

**Integrated Health Home (IHH)**:
- *Activity 1:* Provide 2,000 Targeted Case Management services to Boulder County resident clients, including providing support for referral and follow-through for physical health specialty care and/or dental care, assistance navigating and accessing public benefits (e.g., Medicaid, TANF), and support and coaching to improve daily functioning (e.g., transportation access, education/employment support, housing support)
    - *Outputs:* 2,000 targeted case management services will be provided to clients
    - *Timelines:* Targeted case management services are provided as-needed based on each client's individualized care plan and treatment progress, sometimes as often as daily or as infrequent as a single case management service during enrollment; we expect to see outcome change by 6- or 12-month reassessments
    - *Partners:* Key partners include Clinical Family Health and Dental Aid, as well as other community organizations and local agencies providing social determinants of health supports, such as County agencies, homeless shelters, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
    - *Outcomes:* Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool. We expect to see reduction in clients reporting high psychological distress (less than 30% at reassessment), and improvements in ratings of daily functioning (above 35% at reassessment) and social connectedness (above 60% at reassessment). At least 90% of surveyed clients will indicate positive experience of care on client satisfaction surveys, as measured by the SAMHSA National Outcome Measure set or similar standardized client satisfaction tool, including a measure of Net Promoter Score when possible.
    - *Measurement Tools:* The SAMHSA National Outcome Measure set, CCAR, and/or other identified standardized measurement tools
    - *Indicators:* Key indicators include (1) Psychological Distress, (2) Daily Functioning, (3) Social Connectedness, and (4) Client Perception of Care.

- *Activity 2:* Provide 1,050 psychiatric services to clients, including new psychiatric prescriptions, adjustments to existing prescriptions, consultations with primary care and other IHH partners, and other medication management services.
    - *Outputs:* 1,050 psychiatric medication services will be provided to clients
    - *Timelines:* Psychiatric medication services are provided as-needed based on each client's individualized care plan and treatment progress, sometimes as often as daily (e.g., medication administration support and coaching) or on a monthly or bi-monthly basis
    - *Partners:* Key partners include Clinical Family Health and Dental Aid, as well as Genoa Pharmacy or other local pharmacies
    - *Outcomes:* Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool; we expect to see reduction in clients reporting high psychological distress (less than 30% at reassessment), and improvements in ratings of daily functioning (above 35% at reassessment) and social connectedness (above 60% at reassessment). At least 90% of surveyed clients will indicate positive experience of care on client satisfaction surveys, as measured by the SAMHSA National Outcome Measure set or similar standardized client satisfaction tool, including a measure of Net Promoter Score when possible.
    - *Measurement Tools:* The SAMHSA National Outcome Measure set, CCAR, and/or other identified standardized measurement tools
    - *Indicators:* Key indicators include (1) Psychological Distress, (2) Daily Functioning, (3) Social Connectedness, and (4) Client Perception of Care.

**Housing**:

- *Activity:* Provide Housing Case Management and other supports, including voucher navigation, health and wellness coaching, targeted case management, outreach, brief support, Vi-SPDATS completion, referral and follow-up support, and assistance accessing public benefits (e.g., Medicaid TANF); Voucher management only will be provided to an additional 330 clients
- *Outputs:* Housing support services will be provided to 645 clients and voucher management only provided to 330 clients
- *Timelines:* Housing services are provided as-needed based on each client's individualized care plan and treatment progress, sometimes as often as daily. We expect to see outcome change by 6- or 12-month reassessments.
- *Partners:* Key partners include shelters, housing authorities, Homeless Solutions Boulder County, as well as other community organizations and local agencies providing social determinants of health supports, such as County agencies, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool; we expect to see reduction in clients reporting high psychological distress (less than 30% at reassessment), and improvements in ratings of daily functioning (above 35% at reassessment) and social connectedness (above 60% at reassessment). At least 90% of surveyed clients will indicate positive experience of care on client satisfaction surveys, as measured by the SAMHSA National Outcome Measure set or

similar standardized client satisfaction tool, including a measure of Net Promoter Score when possible.
- *Measurement Tools:* The SAMHSA National Outcome Measure set, CCAR, and/or other identified standardized measurement tools
- *Indicators:* Key indicators include (1) Psychological Distress, (2) Daily Functioning, (3) Social Connectedness, and (4) Client Perception of Care.

**Crisis Intervention Services (CIS)**:
- *Activity:* Provide immediate crisis services to Boulder County resident clients, regardless of status, ability to pay, or background; services may include crisis assessment, brief counseling, crisis stabilization support, respite, and referral
- *Outputs:* Provide 6,000 services each year to 1500 unduplicated individuals
- *Timelines:* Crisis services are intended to be provided immediately, with clients engaging in crisis services for no more than 23 hours (with referral to Crisis Stabilization Centers or other resources for those needing a higher level of intervention); mobile crisis services may respond within 1-2 hours (urban and rural settings)
- *Partners:* Key partners include law enforcement, local healthcare providers, the statewide Colorado Crisis Services, and other community organizations and local agencies providing healthcare and social determinants of health supports, such as County agencies, homeless shelters, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Follow-up outreach and connection is conducted post-CIS service, to determine whether clients' needs are being met, referrals can be successfully accessed, and clients are building resilience
- *Measurement Tools:* CIS services and number of visits are documented within the electronic health record, including post-CIS follow-up services.
- *Indicators:* Actual number of clients receiving follow-up services

**PACE**:
- *Activity:* Provide services to 40 clients, including individual therapy, psychiatric medication services, psychoeducation and other group services, care coordination, supportive counseling, and targeted case management
- *Outputs:* At least 85% of clients will receive an assessment appointment within 7 days of registration, and at least 50% of continuing clients will receive updated assessments within 6 months (+/-30 days)
- *Timelines:* PACE services are provided as-needed based on each client's individualized care plan and treatment progress, often weekly or multiple times per week; we expect to see outcome change by 6- or 12-month reassessments
- *Partners:* Key partners include law enforcement, probation, other criminal justice system partners, and other community organizations and local agencies providing healthcare and social determinants of health supports, such as County agencies, homeless shelters, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool. We expect to see reduction in clients reporting high psychological distress (less than 30% at reassessment), and improvements in ratings of daily functioning

(above 35% at reassessment) and social connectedness (above 60% at reassessment). At least 90% of surveyed clients will indicate positive experience of care on client satisfaction surveys, as measured by the SAMHSA National Outcome Measure set or similar standardized client satisfaction tool, including a measure of Net Promoter Score when possible.
- *Measurement Tools:* The SAMHSA National Outcome Measure set, CCAR, and/or other identified standardized measurement tools
- *Indicators:* Key indicators include (1) Psychological Distress, (2) Daily Functioning, (3) Social Connectedness, and (4) Client Perception of Care.

**School Based and Prevention Intervention**:
- *Activity:* Provide services to students, families, and school staff partners, including trauma-informed services, solution-focused brief therapy or other counseling supports, crisis supports, and psychoeducation and other prevention services
- *Outputs:* 850 students, families, and school staff partners will receive supportive prevention and intervention services
- *Timelines:* Services are provided based on each school's need and behavioral health prevention intervention model, with trained clinicians available on a daily and weekly basis
- *Partners:* Key partners include Boulder Valley School District and staff at each partner school, and other community organizations and local agencies providing healthcare and social determinants of health supports, such as County agencies, child welfare, homeless shelters, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Community partners, including school administrators and teachers, are reporting satisfaction with the programs and services
- *Measurement Tools:* Custom Community Partner Satisfaction Survey
- *Indicators:* Response rate to the survey and indications of satisfaction with services

**Community Infant Program (CIP)**:
- *Activity:* Receive referrals for 340 pregnant women or families with young children, and provide services including trauma-informed care, public health nursing supports, evidence-based therapy, solution-focused brief therapy, or other counseling supports, crisis support, and psychoeducation and other prevention services
- *Outputs:* 340 referrals to be received, with engaging clients receiving services based on individualized care plans
- *Timelines:* CIP services are provided as-needed based on each client's individualized care plan and treatment progress, often weekly or multiple times per week
- *Partners:* Key partners include DHHS, Public Health, pediatric and primary care providers, and other community organizations and local agencies providing healthcare and social determinants of health supports, such as County agencies, child welfare, homeless shelters, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Of the client referrals that begin services with CIP, approximately 70% will demonstrated progress across domains such as social supports, family conflict, basic needs, and emotional availability
- *Measurement Tools:* Edinburgh Postnatal Depression Scale (EPDS) and the Scale of Parenting and Life Functioning (SPLF)

- *Indicators:* Actual number of clients showing minimal, moderate, or significant progress on the identified domains

**Justice-Equity-Diversity-Inclusion (JEDI)**:

- *Activity:* Continue work identified in the 2023 Equity Audit Report, including Solution Labs and other projects specifically recommended in the report.
- *Outputs:* Specify quarterly Key Performance Indicators (KPIs) for each project identified for CY2024, as recommended in the Equity Audit Report. Progress on KPIs will be reported each quarter.
- *Timelines:* Projects will be confirmed during CY2024 Q1, with quarterly Key Performance Indicators (KPIs) confirmed and reported out each quarter.
- *Partners:* Key partners include Groundswell Change, Sunshower and Relias (training partners), and all MHP staff
- *Outcomes:* Projects identified in the Equity Audit Report will make progress throughout CY2024, in an effort to ultimately increase the Scorecard level for each area of the Report (i.e., based on Groundswell Change's scorecard values: 1-Operating, 2-Coordinating, 3-Innovating, 4-Transforming).
- *Measurement Tools:* pre/post training surveys, Groundswell Change "SIDEIM Levels" scorecard methodology, as described in the Equity Audit Report ("SIDEIM" = Strategic Institutional Diversity, Equity, and Inclusion Management")
- *Indicators:* Scorecard ratings, number of KPIs identified and reported quarterly, survey responses

**Senior Reach:**

- *Activities:* Provide community- and home-based therapeutic services for older adults with moderate and low-level mental health needs
- *Outputs:* Services to be provided to 75 older adults, age 60 and above
- *Timelines:* Services are provided based on each client's needs, often weekly or monthly
- *Partners:* Partners include referring agencies and others serving the target population, such as BCAAA, other County agencies, homeless shelters, family assistance centers (OUR Center, EFAA, Sister Carmen), State Medicaid partners and other health insurance providers, food banks, and many others
- *Outcomes:* Clients will engage in services, report satisfaction on custom surveys, and demonstrate behavioral health outcome improvement when applicable per individual care plan goals (e.g., PHQ9, GAD7)
- *Measurement Tools:* Utilization as tracked within the electronic health record, satisfaction surveys, and symptom-specific outcome tools when available (e.g., PHQ9, GAD7)
- *Indicators:* Number of clients served, participant satisfaction survey response rate, and symptom-specific outcome indicators when available (e.g., PHQ9, GAD7)

**Community Health Workers**:

- *Activity 1:* Provide salient contacts to community members, defined as meaningful and engaging conversations about resources, discussing the health of a family member or loved one, and/or discussing barriers to care; services typically include referral for behavioral healthcare or primary care, assistance accessing public benefits (e.g., Medicaid, TANF), brief counseling interventions, and navigation support for other resources.

- *Outputs:* 2,500 community members will participate in CHW services
- *Timelines:* CHW salient contacts are provided based on community partner need, with CHWs often embedding on-site on a daily or weekly basis
- *Partners:* Key partners include the Louisville Recreation and Senior Center, Nederland Food Pantry, Nederland Farmer's Market, local libraries, OUR Center, El Comite, Sister Carmen, EFAA, Feet Forward, TGTHR, and many others
- *Outcomes:* Participants will receive referrals based on individual need (e.g., behavioral health or primary care services, Medicaid access), and will report satisfaction
- *Measurement Tools:* Custom CHW database that tracks referrals to behavioral health and primary care services, Medicaid applications and re-applications, and other referrals.
- *Indicators:* Number of salient contacts and referrals, and portion of participants reporting satisfaction

- *Activity 2:* Facilitate or participate in special events, including wellness groups, library activities, farmers markets and other community fairs or events.
  - *Outputs:* Facilitate or participate in 80 special events with approximately 14,000-15,000 attendees
  - *Timelines:* CHWs facilitate approximately 3-4 special events each month, in alignment with community partner need; some events are facilitated on a weekly or monthly basis (e.g., library wellness activities)
  - *Partners:* Key partners include the Louisville Recreation and Senior Center, Nederland Food Pantry, Nederland Farmer's Market, local libraries, OUR Center, El Comite, Sister Carmen, EFAA, Feet Forward, TGTHR, and many others
  - *Outcomes:* Participants will report satisfaction, including learning new skills for health and wellbeing
  - *Measurement Tools:* Community partner survey, pre/post event surveys when available
  - *Indicators:* Number of events and attendees, as well as portion of participants reporting satisfaction

B. Contractor shall notify BCDHHS within 30 days of vacancies for positions funded under this Contract. Notification shall be sent in writing to Rory Thomes at rthomes@bouldercounty.gov.

C. Contractor shall submit an annual qualitative report at the conclusion of each Contract term. Annual reports shall be submitted no later than the 20th of the month following the end of the Contract term. Reports shall be submitted to Estiberson Parra Cordero eparracordero@bouldercounty.gov and hhsimpactreporting@bouldercounty.gov.

## 8. CONTRACTOR RECORDS AND INSPECTION

A. MHP shall maintain a file of all documents, records, communications, notes, and other materials relating to the services provided under this Contract (the "Records").

B. MHP shall permit the County to audit, inspect, examine, excerpt, copy and transcribe Records for payer purposes during the state-defined Record Retention Period. MHP

shall make Records available during normal business hours at an MHP office or place of business, or at other mutually agreed upon times or locations, upon no fewer than two business days' notice.

C. Training and credentialing records of staff shall be made available upon request.

## 9. ROLE OF MHP OVERSIGHT OF FUNDS

A. MHP will oversee the expenditure of Boulder County General Funds in providing effective population-specific prevention, mental health and/or substance use disorder treatment and related services in the priority focus areas identified in this Contract. MHP shall ensure that clients who have no other means of paying for treatment (i.e., insurance, income, etc.) receive services funded under this Contract. People who participate in specialized services must be eligible for those services as defined by federal, state, and local program specifications.

B. MHP shall determine eligibility for indigent and other payer clients' status.

C. MHP shall determine and report on % of clients served who are residents of Boulder County by program area. MHP shall only invoice BCDHHS for the % of shortfall that is less than or equal to the % of Boulder County residents served by that program area, in order to ensure that Boulder County funds are not subsidizing services for residents who reside outside of Boulder County.

D. MHP may braid or leverage Contract funds with other funding sources in order to enhance services and/or expand capacity to serve indigent clients.

## 10. PLACEMENT OF CLIENTS SEEKING SERVICES INTO THE APPROPRIATE LEVELS OF CARE

A. MHP shall assure use of a standardized placement protocol based upon the most recent edition of "The ASAM Criteria," published by the American Society of Addiction Medicine (ASAM) or the LOCUS/CalLOCUS to assess accurately each client for the most appropriate level of care. Other assessments may be used that are population-specific to determine level of care.

## PAYMENT AND FISCAL REPORTING REQUIREMENTS

### 1. BUDGET

A. The total dollar amount for this Contract shall not exceed $3,862,088. The projected allocation of funds across service delivery areas is outlined in the table below.

**Boulder County Department of Housing and Human Services 2023 RFA: Program Budget Form**

**Contract Term: 01/01/2024 to 12/31/2024**
**Agency Name: Mental Health Center of Boulder County, Inc., dba Mental Health Partners**
**Program Name: General Operating**

| | | |
|---|---|---|
| **2023 Award Amount** | | 3,862,088 |
| ***Once you have matched the award amount below, this should be "0" :*** | $ | 0 |
| **Feel free to add or change expense rows categories to this form** | | |

| **DESCRIPTION** | **Budget of Line Item** |
|---|---|
| Crisis Intervention Services (CIS) | 575,000 |
| Justice-Equity-Diversity-Inclusivity (JEDI) | 260,000 |
| Housing and Supportive Services | 515,000 |
| Integrated Health Home and Integrated Services | 75,000 |
| School-Based and Early Intervention & Prevention Services | 132,088 |
| Behavioral Health Home (BHH) Services: Boulder Adult BHH, Boulder Child & Family BHH, Longmont Adult BHH, Longmont Child & Family BHH | 1,700,000 |
| Community Infant Program (CIP) | 130,000 |
| Jail and PACE Services | 100,000 |
| Community Health Worker Outreach Team (CHW) | 275,000 |
| Senior Reach | 100,000 |
| **TOTAL Program Budget** | **3,862,088** |

B. Contractor has the discretion to transfer up to ten percent (10%) of the approved budget between the major direct cost budget categories without the approval of BCDHHS. Any budget transfer greater than ten percent (10%) requires prior written approval from an authorized BCDHHS representative.

C. For all allocations, the amount of funding that is used can only be an “up-to” percentage based on the percent of clients served who are Boulder County Residents.

D. Contractor has the discretion to transfer up to 10% of the total Contract amount between service delivery areas without prior approval from Boulder County Department of Housing and Human Services (BCDHHS). Contractor shall inform BCDHHS of any changes made in the month that the budgetary change is completed, as a part of the monthly fiscal reporting requirements in Section 2. A. below.

E. Any budget transfer greater than 10% of the total Contract amount requires prior written approval from BCDHHS. Contractor shall request the transfer in writing along with a rationale for the requested change. Requests should be submitted to Susan Caskey at scaskey@bouldercounty.gov and Rory Thomes at rthomes@bouldercounty.gov.

## 2. PAYMENT AND REPORTING REQUIREMENTS

### A. Monthly Invoicing and Fiscal Reporting

i. BCDHHS shall provide Contractor with a monthly invoice template.
ii. Contractor shall complete and submit monthly invoices and supporting documentation that supports the amount invoiced on/or before the twentieth (20th) calendar day following the reporting period, regardless of the level of activity or amount of expenditure(s) in the preceding report period.
    a. **Any invoices submitted 90 days after due date may not be accepted by BCDHHS.**
iii. Monthly invoiced expenses shall be for actual expenditures incurred by the Contractor.
iv. BCDHHS shall not pay for vacant positions funded through this Contract.
v. Monthly invoiced expenses may not be reimbursable by any other funding source.
vi. Monthly invoices shall only include expenditures for the prior billing period. Any adjustments to a previously billed period need to be billed as an amendment to a previous invoice.
vii. The invoice shall contain the name and title of the person authorized, or his or her designee, to submit claims for payment.
viii. All invoices, supporting documentation, and applicable reports shall be submitted electronically to BCDHHS via email to:
    hhsaccountingoffice@bouldercounty.gov and
    rthomes@bouldercounty.gov

### B. Supporting Documentation

i. Monthly invoices shall be supported by a general ledger and/or sub-ledger detail generated from the Contractor's accounting system to include payee, description, date, and amount.
    a. For participant services, participant name and purpose must be included (for those participants who have signed an authorization to release information).

b. For personnel requests, an excerpt of the payroll register from the paying system is appropriate. The payroll register should include staff name(s) or initials, period paid, salary and itemized employer-paid taxes and benefits.

ii. Supporting documentation submitted with monthly invoices must meet or exceed the amount being invoiced.

iii. Contractor shall keep on site for BCDHHS review, for the Contract term plus three years, the following supporting documentation for each invoice:

a. Non-personnel reimbursements must be supported by general ledger or sub-ledger detail generated from Contractor's accounting system.

1) The ledger detail should include payee, description, date, and amount.
2) For participant services, participant name and purpose must be maintained on file (for those participants who have signed an authorization to release information).
3) The documentation should include all receipts and/or other original support. Receipts are required for purchases from a single vendor more than $100.
4) Travel expenditures should include travel expense reports.
5) Mileage will be reimbursed at a rate equal to or less than the IRS standard mileage rate.

b. For personnel requests, an excerpt of the payroll register from the paying system is appropriate. The payroll register should include staff name(s) or initials, period paid, salary and itemized employer-paid taxes and benefits.

1. Staff working less than 100% on Contracted work may be required via a written amendment to maintain an accurate daily record of hours worked and correct charge codes. These records shall be made available to BCDHHS during financial review visits or upon request.

iv. If Contractor does not produce sufficient documentation as described above at financial review visits, BCDHHS has the right to recapture any unsupported payments.

## C. Payments

1. Payments will be made to Contractor based on the actual calculated cumulative funding gaps identified in each service delivery allocation area, up to the total amount identified in the service delivery area budget in Section 1.B above. Each funding gap shall be paid proportional to the percent of Boulder County residents served by each unique program. For example, if 80% of a program's clients are Boulder County residents, then 80% of the funding gap may be covered by this Contract. Contractor shall not invoice BCDHHS for services delivered to any non-Boulder County residents.

2. Monthly invoices and supporting documentation must be submitted in a timely manner and in accordance with the terms of the Contract in order to receive payment.
3. BCDHHS will reimburse Contractor within 30 days of receipt and approval of a fully-supported and payable invoice. BCDHHS will follow-up with Contractor within 15 days of receipt should there be any questioned or unsupported costs.

### D. Internal Controls

i. Contractor shall maintain written internal control policies and procedures around financial and accounting practices, including procurement policies and procedures.
ii. Confidentiality of Client Information and Records: Contractor shall maintain best practices for safeguarding confidential information, including signed certification from Contractor's directors, officers, and employees.
iii. Conflict of Interest: Contractor shall maintain best practices regarding conflicts of interest, including signed certification from Contractor's directors, officers, and employees.
iv. Written policies and procedures shall be made available to BCDHHS during financial review visits or upon request. During the Contract term, BCDHHS will request to review Contractor's procurement policy.

## 3. Schedule of Attachments

The following attachments to this Exhibit are hereby attached and incorporated by this reference:

A. Exhibit B-1, Sample Income Statement
B. Exhibit B-2, Sample Monthly Invoice Template Cover Sheet
C. Exhibit B-3, Sample Monthly Invoice Program Detail with % Boulder County Residents as Multiplier
D. Exhibit B-4, Detailed Service Description by Allocation Area
E. Exhibit B-5, Program Level Report

## EXHIBIT B-1
## SAMPLE INCOME STATEMENT

MENTAL HEALTH PARTNERS
BOULDER COUNTY FINANCIAL REVIEW FOR THE TIME PERIOD JAN 1, 2015 - DEC 31, 2

| | Total Jan 2015 Actual | Total Feb 2015 Actual | Total Mar 2015 Actual | Total Apr 2015 Actual | Total May 2015 Actual | Total Jun 2015 Actual | Total Jul 2015 Actual | Total Aug 2015 Actual | Total Sep 2015 Actual | Total Oct 2015 Actual | Total Nov 2015 Actual |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Revenue** | | | | | | | | | | | |
| Net Client Svc Revenue | | | | | | | | | | | |
| Client Fees | 8 911 | 8 910 | 35 821 | 70 221 | 65 646 | 55 595 | 50 110 | 90 867 | | | |
| Insurance, Third Party | 32 236 | 34 132 | 36 442 | 53 555 | 41 694 | 40 835 | 58 991 | 25 018 | | | |
| Medicaid Capitation | 1 993 633 | 1 703 390 | 2 186 678 | 1 966 689 | 2 031 615 | 2 230 219 | 2 179 713 | 2 114 327 | | | |
| Medicaid - Rehab | 48 542 | 54 189 | 45 620 | 37 055 | 41 148 | 38 016 | 39 891 | 31 029 | | | |
| Medicare | 31 350 | 22 940 | 23 300 | 20 794 | 23 939 | 35 273 | 25 829 | 13 924 | | | |
| Medicaid - Injectables | 45 266 | 39 736 | 66 974 | 54 454 | 56 406 | 51 265 | 42 839 | 33 437 | | | |
| Pharmacy | 261 688 | 268 707 | 301 028 | 362 850 | 403 598 | 303 348 | 287 978 | 281 882 | | | |
| **Total Client Svc Revenue** | **2 421 626** | **2 132 004** | **2 695 863** | **2 565 618** | **2 664 046** | **2 754 551** | **2 685 351** | **2 590 484** | | | |
| Government | | | | | | | | | | | |
| Federal | 33 495 | 55 375 | 35 105 | 31 061 | 51 205 | 32 657 | 34 972 | 33 638 | | | |
| State | 367 174 | 466 183 | 477 419 | 393 881 | 455 984 | 515 120 | 260 058 | 311 322 | | | |
| Local and County: | | | | | | | | | | | |
| Boulder County GF, Core & 1A | 473 697 | 465 423 | 410 341 | 168 326 | 238 944 | 151 614 | 113 240 | 22 670 | | | |
| less: BC GF Payments | | | | | | | | | | | |
| Broomfield/City & County GF | 25 196 | 25 196 | 25 198 | 29 406 | 26 250 | 26 250 | 26 250 | 26 250 | | | |
| Longmont GF | 8 736 | 8 736 | 11 236 | 9 569 | 9 569 | 9 569 | 9 569 | 29 281 | | | |
| Public Support | 137 108 | 141 451 | 160 318 | 139 258 | 128 239 | 29 167 | 199 084 | 184 415 | | | |
| Bad Debt | 50 582 | 55 061 | 33 185 | 32 941 | 131 598 | 63 041 | 38 804 | 55 304 | | | |
| Other | 116 728 | 196 529 | 43 304 | 263 492 | 152 717 | 179 544 | 274 733 | 162 411 | | | |
| Adjust for Worthy Cause - Alpine Bldg | ( 150 000) | ( 150 000) | ( 200 000) | ( 150 000) | ( 150 000) | ( 100 000) | | | | | |
| **Total Revenues** | **3 484 342** | **3 395 958** | **3 691 969** | **3 483 552** | **3 708 552** | **3 661 513** | **3 564 453** | **3 305 167** | | | |
| **Expenses** | | | | | | | | | | | |
| Salaries | 2 151 822 | 2 097 694 | 2 178 524 | 2,219,565 | 2 110 229 | 2 354 591 | 2 316 480 | 2 139 377 | | | |
| Fringe Benefits | 321 095 | 346 728 | 407 800 | 466,020 | 449 995 | 318 711 | 441 050 | 392 688 | | | |
| Contract Labor | | | 627 899 | 24,146 | 48 502 | 154 388 | 63 195 | 44 377 | | | |
| MedCap Medically Necessary uncovered | 47 369 | 48 470 | 44 938 | 57,446 | 52 854 | 56 887 | 54 885 | 53 488 | | | |
| Cost of Drugs Sold | 259 926 | 202 845 | 276 633 | 391,383 | 245 812 | 322 375 | 218 868 | 301 384 | | | |
| Consultants | 161 335 | 49 014 | ( 416 651) | 72,727 | 230 972 | 177 341 | 39 100 | 32 376 | | | |
| Security | 46 522 | 48 088 | 16 060 | 16,060 | 20 000 | 12 120 | 16 060 | 16 060 | | | |
| Staff Travel | 7 534 | 11 893 | 15 476 | 13,912 | 31 186 | 46 610 | 9 311 | 7 154 | | | |
| Utilities | 22 213 | 17 377 | 18 010 | 18,850 | 15 820 | 22 960 | 50 996 | 6 438 | | | |
| Telephone | 23 098 | 13 418 | 40 957 | 43,930 | 23 943 | 55 661 | 48 463 | 31 540 | | | |
| Medicines / Injectables | 2 134 | 550 | 4 558 | 4,597 | 6 275 | 2 232 | 11 920 | 9 672 | | | |
| Food | 12 085 | 9 590 | 9 338 | 9,191 | 8 189 | 8 366 | 6 929 | 9 620 | | | |
| Insurance | 10 485 | 32 028 | 31 528 | 31,528 | 31 528 | 30 677 | 43 528 | 35 247 | | | |
| Office Supplies | 32 255 | 15 347 | 27 045 | 16,959 | 17 559 | 41 463 | 11 282 | 17 633 | | | |
| Interest | 364 560 | 14 903 | 22 994 | 4,856 | 48 640 | 8 015 | 41 062 | 46 928 | | | |
| Property Taxes | 13 873 | 1 587 | 1 587 | 1,587 | 1 587 | ( 23 929) | 1 659 | 1 659 | | | |
| Building Maintenance | 47 533 | 49 866 | 45 075 | 54,803 | 30 610 | 31 512 | 45 094 | 20 961 | | | |
| Rent / Lease | 40 967 | 50 421 | 45 056 | 40,496 | 42 199 | ( 48 742) | 62 811 | 61 784 | | | |
| Depreciation | 89 145 | 88 667 | 87 979 | 87,843 | 107 158 | 87 204 | 117 791 | 109 651 | | | |
| Depreciation Adjustment Per Contract | ( 44 573) | ( 44 334) | ( 43 990) | ( 43 922) | ( 53 579) | ( 43 602) | ( 58 896) | ( 54 826) | | | |
| Donated Space, Goods & Svcs | 119 464 | 132 864 | 134 844 | 116,674 | 92 885 | 88 515 | 120 831 | 102 385 | | | |
| Other Costs - Each < $50K | 237 160 | 225 627 | 188 708 | 248,985 | 165 451 | 380 148 | 201 865 | 191 021 | | | |
| Total Expenses | 3,966,003 | 3,412,644 | 3,764,369 | 3 897 637 | 3 727 815 | 4 083 503 | 3 864 285 | 3 576 618 | | | |

**EXHIBIT B-2**
**SAMPLE MONTHLY INVOICE TEMPLATE COVER SHEET**

| Service Delivery Area/Team | Jul-Dec 2020 | Jul-2020 | Aug-2020 | Sep-2020 | Oct-2020 | Nov-2020 | Dec-2020 | Total Billed | % Billed |
|---|---|---|---|---|---|---|---|---|---|
| MESA | $ 60,000.00 | | | | | | | | |
| CRISIS | $ 57,000.00 | | | | | | | | |
| EQUITY AND DISPARITY | $ 50,000.00 | | | | | | | | |
| INTENSIVE OUTPATIENT SERVICES | $ 184,720.50 | | | | | | | | $ - |
| HOUSING & SUPPORTIVE SERVICES | $ 208,036.50 | | | | | | | | $ - |
| HEALTH HOME & INTEGRATED SERVICES | $ 90,150.00 | | | | | | | | $ - |
| SCHOOL BASED, EARLY CHILDHOOD, EARLY INTERVENTION & PREVENTION SERVICES | $ 95,342.00 | | | | | | | | $ - |
| BEHAVIORAL HEALTH HOME SERVICES | $ 756,295.50 | | | | | | | | $ - |
| COMMUNITY INFANT PROGRAM | $ 171,755.50 | | | | | | | | $ - |
| JAIL AND PACE SERVICE | $ 101,137.50 | | | | | | | | $ - |
| OLDER ADULT SPECIALIZED SERVICES | $ 37,150.50 | | | | | | | | $ - |
| Total | $ 1,811,588.00 | $ - | $ - | | | $ - | $ - | $ - | $ - |

## EXHIBIT B-3

## SAMPLE MONTHLY INVOICE PROGRAM DETAIL
## WITH % BOULDER COUNTY RESIDENTS AS MULTIPLIER

| 2/20/2020 | BOULDER COUNTY, INC. | |
|---|---|---|
| | Boulder County TO1 | |
| | For the Six Months Ending Tuesday, December 31, 2019 | |
| **SAMPLE DOCUMENTATION BY PROGRAM** | Jan-2020 Actual | Jan-2020 YTD |
| **Revenues and Support** | | |
| Medicaid Capitation | 144,758. | 1,129,718. |
| Net client & third-party revenue | 31,195. | 423,460. |
| State/Federal revenue | 38,616. | 250,015. |
| Local government contracts | (39,106). | 350,110. |
| Public support & Donated Space | 25,603. | 159,875. |
| Other revenue | 10. | 10. |
| **Total Revenues and support** | **201,076.** | **2,313,188.** |
| **Expenses** | | |
| Employee compensation | 180,694. | 1,062,927. |
| Indirect Overhead | 78,951. | 474,920. |
| Employee benefits | 32,604. | 207,808. |
| Staff Recognition & Training | 35. | 56. |
| Purchased Services | 710. | 4,744. |
| Client related | 1,677. | 4,766. |
| Cost of Goods sold | | 1,965. |
| Occupancy | 11,677. | 73,223. |
| Bad debt | | 27,184. |
| Communications | 1,831. | 7,684. |
| Employee expenses | 623. | 4,858. |
| Equipment expense | | 19. |
| License, fees and penalties | | 148. |
| Outside services | 1,266. | 6,022. |
| Postage and shipping | 4. | 197. |
| Supplies | 1,205. | 8,146. |
| Travel and meetings | | 235. |
| Vehicle expense | | 126. |
| Depreciation | 5,108. | 31,591. |
| Depreciation Adjustment Per Contract | (5,108). | (31,591). |
| Donations | 25,603. | 159,875. |
| Total Expenses | 336,881. | 2,044,902. |
| Net Income (Loss) From Operations | (135,805). | 268,286. |

| | |
|---|---|
| **Net Income (Loss) from Operations** | **(135,805).** |
| **TOTAL Number of Clients Served** | **100** |
| **Boulder County Residents Served** | **80** |
| **% of Boulder County** | **0.8** |
| **Requested Payment** | **108,643.91** |
| **Quality Check** | **-80%** |
| **Allocation Balance Remaining** | **-** |

**EXHIBIT B-4**

**DETAILED SERVICE DESCRIPTION BY ALLOCATION AREA**

**MHP General Fund Service Delivery Allocation SOW**

**Justice-Equity-Diversity-Inclusivity (JEDI):** JEDI is intentionally not a discreet program in MHP's structure, but rather is a foundational component throughout every aspect of the organization. MHP is developing and implementing a JEDI evaluation plan with targeted goals, objectives, and metrics to meet throughout 2022 and 2023. In 2022, MHP has finalized a new set of JEDI values to guide the work ahead:

- *Justice and Humility*. Justice is the most important component of our work. MHP employees demonstrate commitment to JEDI when: We speak truth to power and ensure issues of injustice and inequity are at the center of our work; Justice and solidarity are foundational in all we do to ensure we are keeping all people, identities, and experiences in mind and we diligently ask, "Who is missing and who will be impacted by our decisions?"; and We listen first and act second.
- *Vulnerability and Culturally Responsive Education.* MHP employees are committed to the process of vulnerability, and we value the power that vulnerability can bring to our JEDI work. Key components include leaning into discomfort and recognizing that is when change can occur, being vulnerable to what we do not know, and being intentional about the sources of information we seek to guide us.
- *Accountability*. We hold ourselves accountable to the process of our JEDI work and are committed to leaning into our own discomfort to address our own individual biases and prejudices. Key components include challenging structures of power and holding them accountable, understanding how our roles perpetuate and uphold inequities, and taking responsibility for the outcomes of our actions and inactions.
- *Integrity*. MHP celebrates, values, supports, and cultivates the richness of our employees, who are multi-faceted and intersectional beings. Each of us embodies varying cultures, values, traditions, life experiences, and lived/living experiences that have shaped us at our core. We honor and recognize our uniqueness and drastically differing experiences and exposures with various systems depending on our identities (both visible and passing). We understand that our differences have benefited some and allowed for privilege to exist, while oppressing others in ways that cause harm and perpetuate multiple systems of inequities. Our JEDI values help guide us in becoming an anti-racist and anti-biased organization.
- *Equity Lens and Transparency.* MHP leaders adopt an equity lens before making organizational decisions and take into consideration minoritized and under-resourced groups who might be affected. For example, we communicate openly and honestly, we do not withhold information out of malicious intent, and we ask whether all who are impacted by a decision are heard throughout the process.

**Behavioral Health Homes (BHH):** The BHH model consists of regionally-based multidisciplinary teams with clinical, psychiatric, and wellness staff who provide timely access to assessment and ongoing support. Funding from the 2024 Human Services Safety Net program will directly support services for Boulder County residents in the Boulder Adult BHH, Boulder Child and Family BHH, Longmont Adult BHH, and Longmont Child and Family BHH. At intake,

all clients complete comprehensive and person-centered screening, assessment, diagnosis, and risk assessment. The BHH staff conduct patient-centered treatment planning, including risk assessment and crisis planning, with all clients, using validated, evidence-based clinical assessment tools and strengths-based service planning. Risk assessment for all clients includes suicidality using the Zero Suicide framework, the Columbia Suicide Severity Rating Scales (CSSRS), and Collaborative Assessment and Management of Suicidality (CAMS). BHH staff also complete safety and crisis planning, education on psychiatric advanced directives, and primary care coordination (including referral to Salud, Clinica, and MHP's Integrated Health Home when applicable). Ongoing support aims to help clients achieve health and wellness goals and remain engaged in care, including targeted case management, housing supports, employment/education support, health coaching, wellness groups, peer support, resource navigation, and brief counseling. Each BHH team includes psychiatric prescribers and nursing staff who are responsible for medication support and clinical monitoring for adverse effects, including metabolic syndrome. The BHH teams coordinate care with MHP outpatient and specialty programs, as well as other community partners. These specialty programs provide comprehensive, evidence-based outpatient and intensive services, including individual and group therapy, trauma-focused evidence-based practices, intensive outpatient programs, medication assisted treatment (MAT), withdrawal management, and crisis services. The BHH teams measure the impact of the program via data analysis using the SAMHSA National Outcome Measure set (NOMS), which measures a comprehensive range of behavioral health domains, including overall mental health and psychological distress, daily functioning, housing stability, social connectedness, quality of life, and perception of care; a copy of the tool is available at *https://spars.samhsa.gov/*.

**Boulder Integrated Health Home (IHH) and Integrated Services:** MHP provides a range of services along the widely recognized Integrated Practice Assessment Tool (IPAT) spectrum,[i] including Boulder Integrated Health Home (IHH) and embedded Behavioral Health Professionals on-site at primary care and pediatric clinics. The Boulder IHH provides integrated medical, dental, and behavioral health services in one location at the Ryan Wellness Center. The program is a collaboration between MHP, Clinica Family Health, and Dental Aid. The IHH serves adults with serious mental illness and/or substance use disorders and chronic co-occurring physical health conditions. Services include well visits/physicals, immunizations, acute care, nutrition services, lab services, preventative care, psychiatric services, care coordination, behavioral health consultation/brief therapy, health coaching, dental exams, oral cleanings, dental sealants, x-rays, and more. Similar to the BHH programs, the IHH demonstrates the value and impact of services via the National Outcome Measure set (NOMS). Importantly, the IHH has demonstrated significant impact on whole health outcomes, including over 50% reduction in blood sugar level risk (HgbA1c), reducing risk significantly from baseline to reassessment.

**Housing**: The Housing team provides Section 8 and Shelter Plus Care Voucher management, housing resource consultation, and supported housing, including partnerships with community providers such as County agencies, shelters, and housing authorities. Services include enhanced support for those experiencing chronic homelessness, serious mental illness, and criminal justice involvement. Partnership across community providers and systems is a core component of the Housing program, especially in efforts to address systemic barriers to sustainable housing and lasting recovery. For example, the Housing program partners closely with the Shelter and County agencies to identify individuals in need of help, build local landlord

relationships, and provide direct assistance with application and leasing fees. The program uses the NOMS, VI-SPDAT, and other tools as needed to measure and track impact.

**Partnership for Active Community Engagement (PACE):** The PACE program is a collaborative outpatient program with the Boulder County Probation Department, Community Justice Services, and the Boulder County Sheriff's Department. PACE staff maintains a close relationship with probation officers and other judicial system partners to ensure care is coordinated and aligned with probation responsibilities. The program primarily aims to demonstrate impact by reducing recidivism and helping clients complete the requirements of their probation.

**Crisis Intervention Program (CIS):** MHP is a partner in the statewide Colorado Crisis Services Network, providing a range of crisis intervention services: 24/7/365 Walk-In Center for drop off by law enforcement or client or family referral, regardless of age, diagnosis, insurance, or address; The Living Room, which is a welcoming communal space for individuals in crisis to receive support and care; Mobile Services, to extend our reach into the community to provide behavioral health crisis support when and where it is most needed; and Respite at Warner House, which is a community-based alternative to hospitalization for those with acute psychiatric needs. CIS services focus on immediate response to urgent needs, de-escalation and safe stabilization, and referral for follow-up care. The CIS program aims to measure impact via tracking possible repeat visits by individual clients, referral or disposition information, and other indicators that the program is meeting each client's needs and connecting them with the resources that will help most for building immediate safety and working toward long-term recovery.

**School-based and Prevention Intervention Programs:** MHP partners with local school districts to provide school-based prevention and intervention services, as well as parent/staff/teacher trainings in youth mental health, suicide prevention and intervention, trauma-informed care, and secondary traumatic stress. These services are part of a partnership between Boulder Valley School District, Boulder County Public Health, and Boulder County Department of Health and Human Services. The P/I program was founded in 1987 to promote resiliency in pre-teens and adolescents by providing school-based, mental health-related prevention and intervention services. All services are free of charge to families. The program's goal is to strengthen students' capacities to succeed academically by supporting their social and emotional well-being. The school programs align strongly with the Boulder Valley School District in the use of evidence-based practices and curriculum, including Sources of Strength, RISE, and Second Step, along with mindfulness and wellness curriculum, Solution-Focused Brief Therapy, Dialectical Behavior Therapy (DBT), and play therapy with younger students. The teams include masters-level or licensed professional mental health counselors and are located at many BVSD middle and high schools, including Boulder High School, Fairview High School, New Vista High School, Arapahoe Ridge High School, Nederland Middle/high School, Monarch High School, Centaurus High School, Southern Hills Middle School, Manhattan Middle School, Angevine Middle School, Casey Middle School, Centennial Middle School, Monarch K-8.

**Community Infant Program (CIP)**: CIP is a prevention-intervention service for vulnerable infants and their parents who are at risk for child abuse and neglect. It was developed in 1984 with the aim to promote the health, safety, and social-emotional development of infants; strengthen the capacity for secure attachment and learning readiness for the child; prevent toxic stress, child abuse, and neglect in at-risk families; and address the mental health needs of

infants and parents. CIP is an integrated service model utilizing infant mental health psychotherapists and nurse home visitors to provide home-based services for families from pregnancy to the pre-school years. CIP provides an outreach program that is preventive in scope, as well as having the therapeutic capacity to work intensively with families who present with mood disturbance, attachment disorders, and other mental health difficulties. The CIP team works with children and caregivers as a dyad in treatment and focuses on strengthening the family relationship to improve outcomes within a broader family system context that includes culture, socioeconomic factors, and stressors related to social determinants of health. The CIP program includes bilingual psychologists, therapists, and public health nurses who work exclusively with pregnant women and families with children 0-3 years old to offer comprehensive, trauma-informed, culturally sensitive, relationship-based support services. The wide range of evidence-based services provided in the office or in-home includes Parent-Infant Therapy, Family Visits, Public Health Nurse Visits, and assistance with depression and anxiety. CIP also has the unique ability to provide women who are pregnant or have young children, including those with substance use concerns, by purchasing items that will help keep the client engaged in care and remove barriers to receiving treatment and attending groups, including supplies for participating in groups as well as supplies like diapers, wipes, car seats, strollers, cribs, books, and interactive learning toys. The CIP program uses the Edinburgh Postnatal Depression Scale (EPDS) and the Scale of Parenting and Life Functioning (SPLF) to measure impact.

**Senior Reach**: Senior Reach is a vital component of MHP's service model for comprehensive older adult safety net services, which includes multiple levels of care specifically targeting the unique needs of older adults. Funding will support the Senior Reach clinicians to provide community- and home-based therapeutic services to support older adults with moderate and low-level mental health needs. Senior Reach clinicians use validated screening and assessment tools, depending on client need. For example, clinicians use the PHQ9 to assess depression risk and symptoms and the GAD7 to assess anxiety risk and symptoms. Other services provided in MHP's older adult spectrum of care include Older Adult Outpatient Specialty Services, which utilize evidence-based and data-informed therapeutic models and psychiatric medication services for high- and moderate-needs clients; and supportive counseling and caregiver support provided by the Senior Peer Volunteer program and individual and group therapy services funded by the Boulder County Area Agency on Aging. Senior Reach clinicians refer to these other services as needed.

**Community Health Worker (CHW) Program**: MHP's innovative CHW program strives to meet community needs, bridge system gaps, and connect individuals and families to a broad range of health care and social determinants of health services. Funding will support the CHWs to provide embedded services, facilitate wellness groups and workshops, lead or co-lead presentations and psychoeducation events, and participate in community events. CHWs meet community need in a uniquely effective way, bringing resources to individuals regardless of background or socioeconomic status. The program has no prerequired conditions of eligibility and aims to break down barriers and work toward healthy lives and healthy communities. MHP's CHW staff are specially-trained to work with individuals and families who have or are at risk for mental health and/or substance use challenges, providing services such as community building, psychoeducation, outreach and engagement support, stigma-reduction training, system navigation, and direct assistance with benefits acquisition. CHWs are based regionally throughout Boulder County, including the mountain communities, and the team includes at least

one bilingual CHW. CHWs provide embedded services and facilitate wellness activities and community events with partners such as the Louisville Recreation and Senior Center, Communities that Care in Lafayette and Nederland, Nederland Food Pantry, Nederland Library, OUR Center, Sister Carmen, El Comite, EFAA, Feet Forward, The Inn Between, SafeLot, TGTHR, Motherhouse and The Lodge, Deacon's Closet, Community Food Share, Recovery Café, Queer Asterisk, OASOS, Salud and Clinica, and schools throughout the Boulder Valley School District.

# Exhibit B-5
# Program Level Report

| | |
|---|---|
| Name of Organization: | |
| Name of Program (should match funding award): | |
| Name of Person Completing Report: | |
| Program staff email to use if questions arise: | |

| Quarterly Reporting Metrics | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **TOTAL Number of individuals served by Program** | | | | |
| **TOTAL Number of Individuals served by residency** | | | | |
| Boulder | | | | |
| Lafayette | | | | |
| Louisville | | | | |
| Longmont | | | | |
| Erie | | | | |
| Lyons | | | | |
| Nederland | | | | |
| Superior | | | | |
| Jamestown | | | | |
| Other Cities Inside Boulder County | | | | |
| Homeless Inside Boulder County | | | | |
| Other Cities Outside Boulder County | | | | |
| Homeless Outside Boulder County | | | | |
| Unknown | | | | |
| **TOTAL Number of clients served by Program by age** | | | | |
| 0-12 | | | | |
| 13-17 | | | | |
| 18-35 | | | | |
| 36-54 | | | | |
| 55-65 | | | | |
| 65+ | | | | |
| **TOTAL Number of individuals served by Program - Race** | | | | |
| American Indian/Alaska Native | | | | |
| Asian | | | | |
| Black/African American | | | | |
| Native Hawaiian or other Pacific Islander | | | | |
| Multiracial | | | | |
| White/Caucasian | | | | |
| Unknown or Declined | | | | |
| **TOTAL Number of individuals served by Program - Hispanic, Latino or Spanish origin** | | | | |
| No, Not of Hispanic, Latinx, or Spanish origin | | | | |
| Yes, of Hispanic, Latinx, or Spanish origin | | | | |
| Unknown or Declined | | | | |
| **TOTAL Number of households served by Program - Primary Household Language** | | | | |
| English | | | | |
| Spanish | | | | |
| Other | | | | |
| Unknown | | | | |

| Quarterly Questions for Funders: | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| **1. What % of program funding does this contract provide as a percent of the total program budget:** | | | | |
| **2. Please describe the ways in which this funding helps meet program goals:** | | | | |
| **3. Please briefly describe any gaps or areas of need that you are noticing emerge in the community:** | | | | |
| **4. This contract is funded by tax dollars. If you are able to share a success story of this program that we can share with the public,** | | | | |

| Crisis Intervention Program (CIS) | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Provide immediate crisis services to Boulder County resident clients, regardless of status, ability to pay, or background; services may include crisis assessment, brief counseling, crisis stabilization support, respite, and referral | | | | |
| OUTPUT: Provide 6,000-7,000 services each year | | | | |
| OUTPUT: Provide services to 1,725 unduplicated individuals | | | | |
| OUTCOME: Follow-up outreach and connection is conducted post-CIS service, to determine whether clients' needs are being met, referrals can be successfully accessed, and clients are building resilience (# of clients receiving follow-up outreach post-CIS service). | | | | |

| Justice-Equity-Diversity-Inclusivity (JEDI) | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Administer second annual JEDI Employee Engagement survey to all staff, provide training in Disarming Microaggressions and Unconsious Bias to staff, and complete the Organization Equity Audit with Groundswell Change | | | | |
| OUTPUT 1: At least 75% response rate to JEDI Employee Engagement Survey | | | | |
| OUTPUT 2: At least 90% staff completion of identified training modules | | | | |
| OUTPUT 3: Finalizing Organization Equity Audit including consulting and coaching on the results | | | | |
| OUTCOME 1: Staff will report positive perception of JEDI activities to date | | | | |
| OUTCOME 2: Staff will report satisfaction with the training modules | | | | |
| OUTCOME 3: Key recommendations and action steps will be identified and acted on based on the results of the Equity Audit | | | | |

| Housing | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Provide Housing Case Management and other supports, including voucher navigation, health and wellness coaching, targeted case management, outreach, brief support, Vi-SPDATS completion, referral and follow-up support, and assistance accessing public benefits (e.g., Medicaid TANF); Voucher management only will be provided to an additional 330 clients | | | | |
| OUTPUT: Housing support services will be provided to 645 clients | | | | |
| OUTPUT: Housing voucher management only provided to 330 clients | | | | |
| OUTCOME: Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool | | | | |
| OUTCOME Target: Reduction in clients reporting serious psychological distress, less than 20% at reassessment | | | | |
| OUTCOME TARGET: Improvements in ratings of positive daily functioning, above 35% at reassessment | | | | |
| OUTCOME TARGET: Improvements in ratings of positive social connectedness, above 60% at reassessment | | | | |
| OUTCOME TARGET: At least 90% of surveyed clients will indicate positive experience of care at reassessment | | | | |

| Boulder Integrated Health Home and Integrated Services | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY 1: Provide 2,300 Targeted Case Management services to Boulder County resident clients, including providing support for referral and follow-through for physical health specialty care and/or dental care, assistance navigating and accessing public benefits (e.g., Medicaid, TANF), and support and coaching to improve daily functioning (e.g., transportation access, education/employment support, housing support). | | | | |
| OUTPUT 1: 2,300 targeted case management services will be provided to clients | | | | |
| ACTIVITY 2: Provide 1,050 psychiatric services to clients, including new psychiatric prescriptions, adjustments to existing prescriptions, consultations with primary care and other IHH partners, and other medication management services. | | | | |
| OUTPUT2: 1,050 psychiatric medication services will be provided to clients | | | | |
| OUTCOMES: Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool | | | | |
| OUTCOMES Target: Reduction in clients reporting serious psychological distress, less than 20% at reassessment | | | | |
| OUTCOMES TARGET: Improvements in ratings of positive daily functioning, above 35% at reassessment | | | | |
| OUTCOMES TARGET: Improvements in ratings of positive social connectedness, above 60% at reassessment | | | | |
| OUTCOMES TARGET: At least 90% of surveyed clients will indicate positive experience of care at reassessment | | | | |

| FRS and PI | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Provide services to students, families, and school staff partners, including trauma-informed services, solution-focused brief therapy or other counseling supports, crisis supports, and psychoeducation and other prevention services | | | | |
| OUTPUT: 850 students, families, and school staff partners will receive supportive prevention and intervention services | | | | |
| OUTCOME: Community partners, including school administrators and teachers, are reporting satisfaction with the programs and services | | | | |

| Behavioral Health Homes | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY 1: Provide initial clinical assessment to 2,500 Boulder County resident clients at enrollment, and assessment updates every six months. These can be provided via telehealth when necessary and available. | | | | |
| OUTPUT 1: At least 85% of clients will receive an assessment appointment within 7 days of registration | | | | |
| OUTPUT 1: At least 50% of continuing clients will receive updated assessments within 6 months (+/-30 days) | | | | |
| OUTCOME 1: At least 85% of clients will remain engaged in services 45 days after assessment. | | | | |
| ACTIVITY 2: Provide 14,000 targeted case management services to clients who have an identified need for coordination of care, support addressing social determinants of health, or accessing benefits | | | | |
| OUTPUT 2: 14,000 targeted case management services will be provided to clients | | | | |
| OUTCOME 2: Clients will maintain or improve in key health outcomes, as measured by the SAMHSA National Outcome Measure set or similar standardized health and functioning outcome tool | | | | |
| OUTCOME 2 Target: Reduction in clients reporting serious psychological distress, less than 20% at reassessment | | | | |
| OUTCOME 2 TARGET: Improvements in ratings of positive daily functioning, above 35% at reassessment | | | | |
| OUTCOME 2 TARGET: Improvements in ratings of positive social connectedness, above 60% at reassessment | | | | |
| OUTCOME 2 TARGET: At least 90% of surveyed clients will indicate positive experience of care at reassessment | | | | |

| Community Infant Program | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Receive referrals for 340 pregnant women or families with young children, and provide services including trauma-informed care, public health nursing supports, evidence-based therapy, solution-focused brief therapy or other counseling supports, crisis support, and psychoeducation and other prevention services | | | | |
| OUTPUT: 340 referrals to be received, with engaging clients receiving services based on individualized care plans | | | | |
| OUTCOME: Of the client referrals that begin services with CIP, approximately 70% will demonstrated progress across domains such as social supports, family conflict, basic needs, and emotional availability | | | | |

| Partnership for Active Community Engagement | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Provide services to 40 clients, including individual therapy, psychiatric medication services, psychoeducation and other group services, care coordination, supportive counseling, and targeted case management | | | | |
| OUTPUT: At least 85% of clients will receive an assessment appointment within 7 days of registration | | | | |
| OUTPUT: At least 50% of continuing clients will receive updated assessments within 6 months (+/-30 days) | | | | |
| OUTCOMES: Clients will maintain or improve in key health outcomes, as | | | | |
| OUTCOMES Target: Reduction in clients reporting serious psychological distress, less than 20% at reassessment | | | | |
| OUTCOMES TARGET: Improvements in ratings of positive daily functioning, above 35% at reassessment | | | | |
| OUTCOMES TARGET: Improvements in ratings of positive social connectedness, above 60% at reassessment | | | | |
| OUTCOMES TARGET: At least 90% of surveyed clients will indicate positive experience of care at reassessment | | | | |

| Community Health Worker Program | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY 1: Provide salient contacts to community members, defined as meaningful and engaging conversations about resources, discussing the health of a family member or loved one, and/or discussing barriers to care; services typically include referral for behavioral healthcare or primary care, assistance accessing public benefits (e.g., Medicaid, TANF), brief counseling interventions, and navigation support for other resources | | | | |
| OUTPUT 1: 2,500 community members will participate in CHW services | | | | |
| OUTCOME 1: Participants will receive referrals based on individual need (e.g., behavioral health or primary care services, Medicaid access), and will report satisfaction | | | | |
| ACTIVITY 2: Facilitate or participate in special events, including wellness groups, library activities, farmers markets and other community fairs or events | | | | |
| OUTPUT 2: Facilitate or participate in 80 special events with approximately 14,000-15,000 attendees | | | | |
| OUTCOME 2: Participants will report satisfaction, including learning new skills for health and wellbeing | | | | |

| Senior Reach | | | | |
|---|---|---|---|---|
| CY2023 | Q1 | Q2 | Q3 | Q4 |
| ACTIVITY: Provide community- and home-based therapeutic services for older adults with moderate and low-level mental health needs | | | | |
| OUTPUT: Services to be provided to 75 older adults, age 60 and above | | | | |
| OUTCOME: Clients will engage in services, report satisfaction on custom surveys, and demonstrate behavioral health outcome improvement when applicable per individual care plan goals (e.g., PHQ9, GAD7) | | | | |