# TEAM UP Scaling and Sustainability Center

Welcome, and thank you for your interest in partnering with the TEAM UP Scaling and Sustainability Center! This application is intended to gather information from practices in the Commonwealth who would like to be part of our next cohort of partners to implement the TEAM UP ModelTM.

***A note about terminology:*** We know that practices are sometimes part of larger organizations, e.g., an ambulatory pediatrics practice within a hospital, and that care can be delivered across multiple locations, e.g., a family medicine practice with multiple clinics in different neighborhoods. Most of the time throughout this application, we will use the term “practice”, which refers to the physical primacy care practice site where patients are seen by the care team. In some instances when we want to ensure we are capturing information at the highest level of your organization, e.g., the hospital where your practice is based, we will use the term “organization”. When we refer to “community”, we mean the services and supports available locally around your practice or organization.

For any questions related to this opportunity or application, please contact [teamuprecruitment@bmc.org](mailto:teamuprecruitment@bmc.org).

**All applications are due by Friday, May 9, 2025.**

***Please Note:*** *This document is meant to help practices organize their responses in preparation to apply. All final responses should be submitted via REDCap:* [*redcap.bumc.bu.edu/surveys/?s=NA7YXJXW3C9ENAEY*](https://redcap.bumc.bu.edu/surveys/?s=NA7YXJXW3C9ENAEY)*.*

### Section 1: Organizational Overview

Please share some basic information about your organization and your affiliations.

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|  | |
| Organization name |  |
| Organization address |  |
| Organization tax ID number |  |
| Type of organization | Federally Qualified Health Center  Hospital Licensed Health Center  Group or Private Practice  Academic Medical Center  Hospital  Other; please specify: Free text |
| Type of primary care model | Pediatrics  Family Medicine |
| Number of locations where primary care is delivered |  |
| Is your organization affiliated with a MassHealth ACO and, if so, which one? |  |
| Which is your practice’s current tier level designation within the MassHealth primary care sub-capitation program? | Tier 1  Tier 2  Tier 3 |
| Is your organization affiliated with a hospital and, if so, in what capacity? |  |
| Primary contact person |  |
| Name |  |
| Title |  |
| Email |  |
| Phone number |  |

### Section 2: Patient Population

Please share some basic information about your patient population with particular focus on pediatric patients (0-18 years) receiving care over the last 12 months. Please feel free to use readily available data sources (e.g., UDS, panel reports, etc.).

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| --- | --- |
|  | |
| Total patients seen within practice (all ages) | # |
| Total pediatric patients (if different from above) | # |
| Pediatric population by age |  |
| 0-4.99 years | # |
| 5-12.99 years | # |
| 13-18.99 years | # |
| Payer mix (% Medicaid-all products, % Commercial, % Other/Uninsured) |  |
| Most common commercial payers (list up to three, in order of prevalence) |  |
| Primary language other than English spoken by patients within your practice (list up to five, in order of prevalence) |  |

***Please Note:*** *The TEAM UP Center works with a range of practices at different stages of behavioral health integration. Questions in Sections 3-5 help us better understand the needs of your pediatric patient population and your current practice environment.*

### Section 3: Pediatric Developmental and Behavioral Health Needs and Services

Please tell us a little bit about the developmental and behavioral health needs of your pediatric patient population and the services your organization currently provides to address these needs.

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| Based on our experience, the most commonly presenting developmental and behavioral health needs in the pediatric population are anxiety, depression, ADHD, autism spectrum disorder (ASD), and exposure to trauma. Does this match the needs of your pediatric population? If not, please describe what additional or different needs you see and how they impact your pediatric population. |  |
| What are the most common social and/or behavioral health risk factors for your pediatric population, e.g., immigration stress, language/health literacy? Please list up to five, in order of prevalence. |  |
| Are pediatric developmental and behavioral health services currently available within your organization? | Yes – branching see below  No |
| (IF YES ONLY) Please describe the types of developmental and behavioral health services currently available to pediatric patients and their families, e.g., outpatient behavioral healthcare, developmental evaluation, and the range of professionals who provide these services, e.g., mental health clinicians, psychiatric nurse practitioners. |  |
| (IF YES ONLY) Please select the option that best describes the current level of integration between these existing services and primary care? If existing services are structured in multiple ways, e.g., outpatient behavioral health department and integrated behavioral health clinicians in primary care, please select the highest level of integration that exists to serve the pediatric patient population. | Coordinated – separately located, some minimal collaboration  Co-located – located on-site together, basic collaboration  Integrated – physically located in clinic together, collaborating as a unified care team |
| Which services in your community do you rely on most to address the developmental and behavioral health needs of your pediatric patient population? Please list up to five, in order of prevalence. |  |
| What are the most common challenges or barriers to care that your pediatric patients experience when seeking services for developmental and behavioral health needs? Please list up to five, in order of prevalence. |  |

### Section 4: Pediatric Primary Care Clinical Model

Please tell us a little bit more about the services offered to pediatric patients within your primary care practice. For each item below, indicate the response that best represents how often the activities captured in the statement occur at present. Please respond to the best of your ability and select only one response to each question.

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| --- | --- | --- | --- | --- | --- |
|  | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** |
| Patients birth to 18 years are screened at all well-child visits for social, developmental, and behavioral health concerns in our practice. |  |  |  |  |  |
| Primary care providers in our practice do “warm hand-offs” to others on the care team according to patient developmental and behavioral health needs. |  |  |  |  |  |
| Primary care providers in our practice diagnose and treat, including with medications, commonly occurring pediatric behavioral health conditions, such as ADHD, depression, and anxiety. |  |  |  |  |  |
| Patients birth to 18 years have access to real-time behavioral health care within primary care which may include short-term, bridge, and ongoing treatment. |  |  |  |  |  |
| Patients birth to 18 years have access to care coordination and navigation services to support developmental and behavioral health needs. |  |  |  |  |  |
| Our practice consistently follows an established clinical pathway or protocol for at least one special population of focus (e.g., families at-risk during the perinatal period, patients with ADHD, etc.) |  |  |  |  |  |

Please select each screening instrument that your practice currently uses to assess for developmental and behavioral concerns, health-related social needs, and/or parental issues such as domestic violence, depression, and substance use at each well-child visit outlined within the periodicity schedule.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Infancy** | | | | | **Early Childhood** | | | | | | | **Middle Childhood** | | | | | | **Adolescence** | | | | | | | |
| **Screener** | **1M** | **2M** | **4M** | **6M** | **9M** | **12M** | **15M** | **18M** | **24M** | **30M** | **3Y** | **4Y** | **5Y** | **6Y** | **7Y** | **8Y** | **9Y** | **10Y** | **11Y** | **12Y** | **13Y** | **14Y** | **15Y** | **16Y** | **17Y** | **18Y** |
| SWYC |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EPDS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PEDS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| M-CHAT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PSC-17 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PHQ-2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PHQ-9 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CRAFFT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| GAD-7 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| THRIVE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PRAPARE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| If you selected ‘other’ for any of the well-child visits, please specify. | | | | | | | | | | Free text | | | | | | | | | | | | | | | | |

### Section 5: Operational Infrastructure

Please describe the current clinical staffing structure within your practice. If your organization provides primary care to pediatric patients as part of both pediatric and family medicine models, please focus on your pediatric team or the practice applying for this opportunity.

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| --- | --- | --- |
| **Primary Care Clinical Staff** | **# of Individuals** | **Total FTE** |
| Primary Care Providers |  |  |
| Medical Assistants |  |  |
| Registered Nurses |  |  |
| Behavioral Health Clinicians (i.e., clinicians providing therapeutic care) |  |  |
| Case Managers (Nurse or Social Worker) |  |  |
| Community Health Workers |  |  |
| Other (e.g., Care Coordinators, Nutritionists, etc.) |  |  |

For each item below, please indicate the response that best represents how much you agree with each statement as it relates to aspects of your practice. Please respond to the best of your ability and select only one response to each question.

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| --- | --- | --- | --- | --- | --- |
|  | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** |
| All roles identified above as primary care clinical staff are physically located in the same space together. |  |  |  |  |  |
| All roles identified above as primary care clinical staff share access to the same EMR/patient chart. |  |  |  |  |  |
| Our practice captures payment for behavioral health services covered by major health plans. |  |  |  |  |  |
| Our practice elicits input from patients and families on the services provided within the practice in a systematic way. |  |  |  |  |  |

Please share some basic information about your Electronic Medical Record (EMR) system.

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| --- | --- |
|  | |
| What EMR system does your practice utilize? |  |
| Are there any changes or significant upgrades to your EMR system planned for the next 36 months? | Yes – branching see below  No |
| (IF YES ONLY) Please describe the changes or upgrades that are planned for your EMR system. |  |

### Section 6: Organizational Priorities

Please tell us a little bit more about the goals and priorities of your practice and organization as they relate to this opportunity and the advancement of integrated pediatric behavioral health care within your practice. Please keep your answers succinct; responses should be no more than about a paragraph or two at maximum.

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| --- | --- |
|  | |
| What is your practice most eager to gain through participation in this opportunity with the TEAM UP Center? |  |
| How does the TEAM UP model and/or the mission of the TEAM UP Center align with your organization’s strategic goals and priorities? |  |
| How does this opportunity align with your ACO’s priorities (e.g., quality metrics) as they relate to your pediatric population? |  |
| Describe why your practice and/or organization is currently well positioned to participate in this opportunity with the TEAM UP Center? |  |
| What barriers to success do you anticipate over the course of the project?  ***Please Note:*** *Our aim in understanding anticipated barriers is simply to help us plan how best to ensure your practice’s success.* |  |

### Section 7: Additional Information (Optional)

Provide any additional information that your practice or organization would like the TEAM UP Center to consider that has not been covered above.

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### Section 8: Practice Leadership Plan

Please provide an outline of your planned leadership team for this initiative.

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|  | |
| Executive Sponsor – Member of the organization’s executive leadership who will champion the TEAM UP model within the organization, participate in a few select events, and attest to the completion of initiative activities and milestones. | |
| Name |  |
| Title |  |
| Email |  |
| Clinical Champion – Pediatric primary care clinical lead who will champion the TEAM UP model within the practice, participate regularly in events, and lead initiative activities and implementation. | |
| Name |  |
| Title |  |
| Email |  |
| Clinical Champion – Behavioral health clinical lead who will champion the TEAM UP model within the practice, participate regularly in events, and lead initiative activities and implementation. | |
| Name |  |
| Title |  |
| Email |  |
| IT Representative – Member of the organization’s information technology team who will support EMR development, participate in select activities, and collaborate on data sharing. | |
| Name |  |
| Title |  |
| Email |  |
| Other – Please share the name and information of anyone else that will be involved in leading this effort within your practice. | |
| Name |  |
| Title |  |
| Email |  |

### Section 9: Required Attachments

1. Pease upload brief bios for individuals identified to serve in the roles of Executive Sponsor and Clinical Champions using the ‘upload file’ field in REDCap (maximum of 100 words each).

***Please note:*** *As part of the selection process, organizations will be asked to provide the following documents prior to working with the TEAM UP Center:*

* *Most recent independent financial audit or account review; and*
* *Organization operating budget (revenue and expenses) approved by the board for the fiscal year, with actual-to-budget comparison for the year-to-date.*