SB202 MSO Community Action Plan

REQUEST FOR APPLICATION

SIGNAL BEHAVIORAL HEALTH NETWORK

6130 GREENWOOD PLAZA BLVD, #150, GREENWOOD VILLAGE, CO 80111

Residential Services RFA (S2-1617-RS)

1 Overview and Timeline

1.1 About Signal Behavioral Health Network

Signal Behavioral Health Network (Signal), is one of Colorado's Managed Service Organizations. Signal is responsible for providing a continuum of substance use disorder (SUD) services in three regions on behalf of the State of Colorado. Additionally, Signal seeks to ensure a consistent level of quality and compliance with State and Federal requirements relating to services offered. Signal may choose to deliver these services by subcontracting with local providers who demonstrate competency, compliance with quality standards, and positive outcomes.

The regional map for Managed Service Organizations is known as Sub-State Planning Areas (SSPAs). There are seven SSPAs in Colorado:

- SSPA 1: Northeast Colorado (Signal)
- SSPA 2: Metro Denver (Signal)
- SSPA 3: Colorado Springs Area
- SSPA 4: Southeastern Colorado including San Luis Valley (Signal)
- SSPA 5: Northern Western Slope
- SSPA 6: Southern Western Slope
- SSPA 7: Boulder

Signal is responsible for providing services in three of these seven regions (Northeast Colorado, Metro Denver, and Southeastern Colorado including San Luis Valley).

1.2 About the Increasing Access to Effective Substance Use Disorder Services Act (SB16-202)

During the 2016 Colorado Legislative Session, the Increasing Access to Effective Substance Use Disorder Services Act was passed, directing and empowering Colorado's Substance Use Disorder Managed Service Organizations to perform several tasks:

1) Conduct a statewide needs assessment reviewing and identifying gaps in SUD services, including issues with capacity, access, and sustainability
2) Develop and refine community action plans, with intentions around addressing as many areas of priority as possible
3) Direct coordination, strategy, and funding towards as many of these areas as possible

The needs assessment is a previously completed report, outlining community feedback, gleaned from interviews, stakeholder meetings, surveys, and previous research and needs assessments. Much of this report is based on that needs assessment. It can be found by visiting:

http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf

Readers of this request for application are encouraged to review that report in its entirety to allow for context and support for the initiatives targeted.

1.3 RFA Community Action Plan Priority Area

Residential Services

1.4 Objective

Signal seeks to expand and sustain substance use disorder residential treatment. Residential substance use disorder (SUD) treatment can be viewed as the equivalent of inpatient rehabilitation services for other severe illnesses. "Residential" in this use should not be thought of as "housing." It is a 24/7 treatment environment that can vary in duration, intensity, and dose of treatment. There are levels of SUD residential treatment that range from: acute stabilization to intensive rehabilitation to transitional care.

1.5 Location

The services outlined in this document should be located in any or all of the following Colorado counties: Adams, Arapahoe, Denver, Douglas, Jefferson, Broomfield, Gilpin, Clear Creek.

1.6 Submission Deadline and Instructions

Providers interested in offering this service should submit their proposal in Word format. The associated budget should use OBH's capacity budget protocol in Excel format (base template can be provided upon request). Proposals should be submitted via email to the below email address. Signal will acknowledge receipt of each proposal. If no acknowledgement occurs, respondents to this request for proposal should resubmit.

proposals@signalbhn.org

The deadline for submission is no later than 5/19/2017. Signal will begin considering requests for funding as soon as we have received those applications and will begin funding as soon as possible.

1.7 Budget

Providers should include a budget for offering this service in one or more of the locations, using the State Office of Behavioral Health (OBH) capacity budget protocol worksheet (Appendix A). Signal recognizes that this funding is only a part of the support necessary to provide the service. Additional funds are required via Medicaid, other governmental sources, client fees, grants, local hospital support, and other sources. The OBH capacity protocol provides a mechanism to capture all funding sources relative to total expenses. Signal's funding can be used to cover any shortfall that may exist. Details of the protocol are available upon request.

It is important to note that there are two forms a service expansion may take:

1) **Increase of clients serviced:** In other words, an existing program could be expanded to serve more clients.
2) **Expansion of facility:** A new or expanded facility may be required to serve more clients. Effectively, these are one-time costs associated with the expansion.

1.8 Term of Agreement

Signal seeks provider agencies who will offer or deploy the services outlined beginning as soon as possible, with optional renewals of the contract in subsequent years. Signal will be interested in a

provider who could begin offering or expanding this service at a facility prior to July 1, 2017, and may issue a partial term agreement prior to July 1, 2017. Interested providers should indicate the date they are able to first begin services, indicating a date no later than July 1, 2017.

2 REQUESTED SERVICES

The objective of the utilization of these funds is to provide access to effective substance use disorder services across the state of Colorado, in the regions identified.

2.1 OVERVIEW OF SERVICES

The requirement is to establish and/or expand, and maintain access to, quality care for 24 hour/7 day per week substance use disorder (SUD) treatment. Residential treatment units' primary function is to stabilize individuals to a point where a less restrictive level of care is appropriate to provide the balance of needed treatment.

There is a distinct interest in residential treatment that facilitates stabilization, followed by engagement in continuing outpatient services, and continuing care to support the individual's ongoing management of their substance use condition. There is also priority on improving health outcomes for individuals and the community. Residential treatment provides not only an opportunity to stabilize and engage individuals in treatment, but also an opportunity to provide immediate harm reduction, and initiate connection to comprehensive community-based case management targeted at reducing harm and producing incremental improvements to overall health. In addition, residential treatment provides opportunities to engage families, primary care medical providers, appropriate social support, and recovery-oriented services and supports.

2.1.1 Specific Need

Five levels of care within residential services (also known as inpatient services) have been defined by the American Society for Addiction Medicine (ASAM) based on the intensity and dose of services that correspond to identified patient needs. Signal is interested in four of those levels of care, as stated below. Care should be provided within the ASAM guidelines of these levels of care.[1] For a complete discussion and definition of these levels of care, please see "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions"; third edition 2013.

Signal is interested in all of the following American Society of Addiction Medicine (ASAM) defined levels of residential care, with ASAM short definitions[1]:

- *Clinically Managed Low-Intensity Residential Services (Level 3.1)*, "24-hour structure with available trained personnel, at least five hours of clinical service/week";
- *Clinically Managed Population-Specific High-Intensity Residential Services (Level 3.3)*; "24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community";
- *Clinically Managed High-Intensity Residential Services (Level 3.5),* 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community."
- *Medically Monitored Intensive Inpatient Services (Level 3.7),* "24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day

[1] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, & Miller MM, Eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance -Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013

counselor availability.” [Note: Dimension 1 is acute intoxication and/or withdrawal potential; Dimension 2 is biomedical conditions and complications; Dimension 3 is emotional, behavioral, or cognitive conditions and complications]

Signal Behavioral Health Network is not managing *Medically Managed Intensive Inpatient Services (Level 4)*; "24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patients in treatment.” While this is not a service managed by Signal, it is important to note ASAM Level 4 care is needed for a few individuals with severe, multidimensional, comorbid disorders. This level of care is most frequently provided in a psychiatric hospital or general acute care hospital setting. [See: “The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions”; third edition 2013 [1]].

2.1.2 Overview

Alcohol and drug treatment services have existed largely outside of mainstream medicine for decades. Substance use conditions contribute significantly to poor health outcomes. The transformation of healthcare delivery, including an emphasis on individual and community health outcomes, has resulted in substance use services now being perceived correctly as a necessity to improve health outcomes, and contain overall cost. The near universal adoption of the Institute for Healthcare Improvement’s “Triple Aim,” to simultaneously attain goals of: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care, has had a significant impact upon the delivery of care. Historically, many substance use disorder safety-net providers have assisted the most vulnerable and underserved people, a number of whom are high users/super users of health services of all kinds. Substance use treatment adds value to individual and community health outcomes. It is essential that providers continue targeted focus upon improving substance use conditions and disorders within both the general population, as well as specialty populations at high health risk and potential high health cost (e.g., pregnant women, adults with dependent children, injection drug users,etc.). In addition, there is significant value in focusing on high utilizers of health services of all kinds; those with a substance use condition and one or more co-occurring conditions (e.g., diabetes, HIV/AIDS, tobacco use, compromised liver function, mental illness, etc.).

The health system’s recognition of alcoholism(s) and addictions as illnesses has initiated increased integration into medicine as well as public health. The transition, to the coordinated delivery of a broad range of health services that integrates behavioral health, brings advantages and challenges for providers of SUD services. In the context of this transformation, providers of SUD residential treatment services must enhance existing skills and services, be part of a community-based continuum of care to increase positive health outcomes, add value to health care, and provide quality services. It is imperative providers of SUD services augment existing service structures, and enhance community collaboration to improve outcomes.

Residential treatment services need to be positioned within a continuum of substance-use care and to manage transition along that continuum to achieve positive outcomes. This continuum of care should include outreach, assessment, outpatient services, access to multiple types of residential treatment, community-based case management, and continuing care. It is critical that connection to this continuum of community-based services be an essential outcome of care for persons served within residential treatment units. There need to be relationships with detoxification units, assessment, outpatient treatment, and continuing care provided in a variety of settings, including primary care and other medical settings. It is vital that comprehensive community-based case management services be directly connected to residential treatment units.

2.2 KEY ELEMENTS

Residential treatment for substance use disorder is 24/7 treatment with core elements that include a "safe, separate, secure, and stable environment in which to respond to the needs of individuals with deficits in cognitive, social, interpersonal, emotional, and/or coping skills". Care needs to be appropriate to:

- "the need to individualize care to the needs, strengths, severity of brain dysregulation and resulting functional deficits of the individual, the status within the progression and/or remission of the of the chronic conditions;
- the matched intensity and frequency of the essential care services and structured activities (the dosage);
- the required credentials and ratio of staff to the patient population."[2]

2.2.1 Duration of Stay

Residential treatment varies in terms of dose, duration, intensity, and restrictiveness depending upon the unique needs of the individual. There should be no fixed length of stay, or program duration. Services may be focused on "habilitation" or "rehabilitation. Length of stay shall be determined by ASAM best practices (see, Care Management in Required Best Practices section).

2.2.2 Use of Evidence-based Practices

The content of residential treatment should employ known evidenced-based practices; in particular, those published by National Quality Forum (NQF), [2]Substance Abuse and Mental Health Services Administration (SAMHSA)[3], National Institute on Alcohol Abuse and Alcoholism (NIAAA)[4], and National Institute on Drug Abuse (NIDA)[5]. Use of evidence-based and best practices is required. The provider should demonstrate a mechanism for ensuring fidelity to the specific evidence-based practice models employed.

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[2] NQF (National Quality Forum) *National voluntary consensus standards for the treatment of substance use conditions: Evidence-based treatment practices*. Washington, DC: NQF; 2007

NQF (National Quality Forum) Power EJ, Nishimi RY, Kizer KW, Eds. *Evidenced-Based Treatment Practices for Substance Use Disorders*. Washington, DC: NQF; 2005.

National Quality Forum. A Path Forward to Measuring Continuing Care Management for Substance Use Illness: Patient-Focused Episodes of Care, Washington DC 2009

[3] Center for Substance Abuse Treatment. (2015). Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 45. HHS Publication No. (SMA) 15-4131. Rockville, MD: Center for Substance Abuse Treatment.

Center for Substance Abuse Treatment. (2015) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series, No. 27, (revised 2015), Rockville, MD: Center for Substance Abuse Treatment.

Substance Abuse and Mental Health Services Administration. (2013). Substance Abuse Treatment for Persons with Co-occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. HHS Publication No. (SMA) 13-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[4] National Institute on Alcohol Abuse and Alcoholism. (2016) professional Education Materials: Resources for clinicians, physicians, social workers, and other health professionals. Retrieved from https://www.niaaa.nih.gov/publications/clinical-guides-and-manuals

[5] National Institute on Drug Abuse. (2012). Principles of Effective Treatment. In Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition).Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment.

2.2.3 Involuntary Commitments

It is required that entities operating residential treatment units provide services related to Involuntary Commitment (IC) for individuals afflicted with substance use conditions, as is as defined for both alcohol related IC (C.R.S. §27-81-112) and drug related IC (C.R.S. §27-82-108). Compliance with the "Involuntary Commitment Manual" published by Office of Behavioral Health (OBH), a guide and resource for OBH licensed addiction treatment providers that are involved in the care and dispositioning of clients that require Involuntary Commitment (IC) to addiction treatment, is required. This manual covers both Emergency Commitment (EC) and Involuntary Commitment procedures and relies heavily on statutory guidance. A primary function of residential treatment units is to stabilize individuals under involuntary commitment to a point where a less restrictive level of care is appropriate to provide the balance of needed treatment.

2.2.4 Care Requirements

Patients currently receiving FDA approved medication for substance use disorder treatment will be admitted to all residential treatment units. Admission will not be denied, nor will medication be discontinued as a routine condition admission. This applies to all FDA approved medications for treatment of substance use disorders. Providers shall explicitly and intentionally provide assessment for appropriate medication which can be initiated prior to discharge to a lower level of care. It is essential existing prescribed medications be maintained in collaboration and coordination with the prescribing medical provider. Substance use disorder treatment medications, which will be continued in an outpatient environment, should be initiated while individuals are still in residential treatment units. Transportation shall be arranged where appropriate.

The TIP 45 consensus panel noted, "Although it is the philosophy of some residential treatment facilities to discontinue all medications, this course of action is not always in the best interest of the patient. Abrupt cessation of psychotherapeutic medications may cause severe withdrawal symptoms or the reemergence of a psychiatric disorder. As a general rule after medical review, therapeutic doses of medication should be continued through a course of residential treatment. Decisions about discontinuing the medication should involve the individual's prescribing physician" [3]/nurse practitioner/physician assistant, as well as the substance use disorder treatment provider.

There shall be comprehensive case management (including outreach) attached to and integrated with the residential treatment unit, coordination and collaboration with other health care providers, including primary care, and community-based social support and recovery services. It is expected there will be meaningful continuing care collaboration and coordination of care with, primary care providers, existing outpatient services, drug-free housing resources, as well as other community treatment resources.

All treatment units must include "personnel who are familiar with the features of substance use withdrawal syndromes, have training in basic life support, and have access to an emergency medical system that can transport patients to emergency departments and other sites for clinical care"[3]. It is essential that staff in residential, and other clinical services, have a sufficient level of knowledge regarding withdrawal symptoms so they can recognize any delayed withdrawal symptoms that may require management.

2.2.5 Required Best Practices

It is a best practice for providers to have a formal mechanism to ensure fidelity to the specific evidence-based practice models employed.

Services should be designed and implemented from the perspective that engagement in treatment of those with substance use disorders frequently requires multiple interventions and contacts. It is

expected that residential treatment services will recognize the value of harm reduction, be committed to persistent efforts at engagement, and operate services accordingly.

It is important to note that engagement of individuals with severe and persistent substance use disorders often takes more than one admission, more than one contact, and usually requires active outreach on a continuous basis. In general, there is a population of individuals for whom treatment is not a one-time admission-discharge event. An episode of treatment should be viewed as a series of interventions over time. This episode may involve multiple admissions and discharges, several attempts at treatment services in different levels of care, as well as community outreach, comprehensive case management, and "on the street" interventions. It may occur over a period of months or years.

Engagement in services of all individuals requires that service providers have access to a diverse collection of approaches to meet the individual needs of the persons they serve. A referral for service that consists of a phone number and/or an address to where the individual needs to go to enter treatment services is usually *not* an adequate referral that results in engagement and retention in treatment. The creation of an effective set of residential treatment services involves continuous discharge planning, comprehensive case management including such things as "warm handoffs,", assistance with transportation, finding safe housing, etc.

As noted in the Statement of Work section, evidence-based practices should include comprehensive case management and care management for individuals receiving services in residential treatment settings. This case management should ensure those served are connected with primary care or other appropriate health services, inclusive of the appropriate level and intensity of case management. SAMHSA TIP 27 should be regarded as defining best practices. Signal endorses the entirety of practices recommended by SAMHSA TIP 27.[6]

It is a requirement that the case management be provided and be comprehensive as defined in SAMHSA TIP 27 "Comprehensive Case Management for Substance Abuse Treatment." This needs to be at a level appropriate to the needs of the individual served. For individuals with multiple chronic conditions intensive case management models are most appropriate. These conditions may be mental health related and/or physical health conditions created by substance use or exacerbated by substance use. These models are represented by those described in TIP 27 as "Assertive Community Treatment" and "Clinical/Rehabilitation".

The consensus panel for TIP 27 addresses the prompt for case management. Namely, "Because addiction affects so many facets of the addicted person's life, a comprehensive continuum of services promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community. Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case management can help accomplish all of the above."[4]

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[6] Center for Substance Abuse Treatment. (2015) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series, No. 27, (revised 2015), Rockville, MD: Center for Substance Abuse Treatment.

TIP 27 including appendices is 134 pages. Portions from that document are included here for illustrative purposes, but the whole set of recommended practices, as appropriate to the specific level of care, are endorsed. Providers are encouraged to review the TIP when preparing proposals.

All residential treatment units shall refer or transfer clients, appropriate for medication assisted SUD treatment, to treatment entities providing such treatment. This includes methadone, buprenorphine, naltrexone, extended-release naltrexone, medications for reduction of alcohol and drug relapse, and appropriate psychiatric drugs for those with mental illness. When appropriate to the individual and medication, it is preferred induction be in the residential treatment setting. Clients will not be referred to providers who are "philosophically opposed" to medication assisted treatment. Residential treatment providers who are "philosophically opposed" to medication assisted treatment will not be funded. Signal regards denial of access to FDA approved medication assisted treatment as malpractice. A proposal for residential services funding must include an explicit statement of support for medication assisted therapy, even if the provider does not directly offer the service. Failure to state this may result in disqualification of the proposal.

For some existing providers, the scope of services and best practices may mean expansion of existing services, enhancement of relationships with community social and medical services, and creating new service capacity to increase access. It is helpful to those served for providers to formalize relationships with primary care to enhance engagement of those served in primary care medical services, as well as substance use and other specialty services as needed.

2.2.6 Utilization Review and over-utilization of treatment services

It is important to remember that high utilization does not necessarily equal overutilization. It is very possible that individuals who utilize treatment services may be under utilizing the services in the context of achieving overall health improvement. One major goal of service enhancement is to improve both individual health and community health. Over- and under-utilization of treatment services need to be evaluated in the context of health improvement and at times, in the context of harm reduction. Effective services will be measured by harm reduction, reduction in use of emergency services, engagement of individuals served in case management and/or treatment.

Providers will be required to manage admissions and review the need for continued care via the ASAM criteria.

2.2.7 Medical Policy

Quality treatment services require some degree of medical staff access and/or supervision, nursing staff availability to and/or in treatment units, and some level of mental health expertise with addiction knowledge. Collaboration, and some level of integration with, primary care in the community is one way to enhance the quality of services, as well as enable access to enhanced medical services for those served. Residential treatment units shall have physician services, directly or via consultancy (perhaps via nurse practitioners), to provide appropriate oversight related to protocols, involuntary commitments, and supervise or directly provide consultation and direction as needed to residential treatment unit staff. There shall be appropriate 24 hour/7 day per week access to medical staff for consultation

2.2.8 Care Management

ASAM "criteria support individualized, person-centered treatment that is responsive to the patient's specific needs and progress in treatment"[1]. "Program-driven" fixed lengths of stay should not exist. Lengths to stay should be individualized and dependent upon that specific individual's progress in terms of needs, function, and readiness to move to a less restrictive level of care. Treatment focus should be ".... on functional improvement as the determinant of level of care and ongoing chronic-disease management (with certain episodes of care being offered with increased intensity for a

relatively brief span of time) being what is needed for most patients with a substance-related or co-occurring disorder". "Admission criteria for residential treatment encompass such severity and imminent danger that a 24-hour treatment setting is necessary." "By definition, it is a misunderstanding of residential treatment to place a person on a waiting list."[1] If unable to access Level 3.3 or 3.5 residential treatment service, it is required there be immediate access to appropriate interim services for individuals requiring residential treatment. Interim services are required and may include 24-hour safe therapeutic housing (as provided by Level 3.1) with intensive outpatient services, while waiting for admission to a Level 3.3 or 3.5 residential treatment service.

There are also requirements for the management of care within the organization. Internally there should be clinical processes which enhance the ability for clients to step up and/or down in treatment intensity, dose, duration, and restrictiveness of care. This needs to be attached to the concept of clinical and medical necessity. Internal care management enhances the ability to provide quality care, and relate to external pre-authorization, utilization review, and continuing stay authorizations.

2.2.9 OBH C-Stat Measures

Residential treatment units shall track and report to Signal/MSOs instances when it is necessary for them to divert individuals to other providers. This will enable coordination of utilization across regions to be able to enhance access.

In compliance with our agreement with the State Office of Behavioral Health, Signal is required to meet certain contractual measures, in this case the Residential Continuation of Care measure, which tracks the number of clients that enter lower levels of care from residential treatment. Providers shall be required to support and participate in transition support to achieve this outcome.

2.2.10 Signal Credentialing

If not currently a Signal provider, then the provider must complete the Signal credentialing packet, included in Appendix B (with exception of the OBH licensing process which may begin concurrently following selection as a provider offering these services). The required information should be included in the submission.

3 RESPONSE FORMAT

Respondents to this proposal request should include the following elements:

1. When referencing this RFA, use RFA **#S2-1617-RS**
2. Business Proposal, indicating compliance, understanding, and restatement of all provisions and requirements listed in section 2. Document should be in Microsoft Word format.
3. Signal Credentialing: except for the OBH license, all documents and items required in the Signal Credentialing list in Appendix B.
4. This RFA is supported using fee-for-service and/or Capacity as the reimbursement. Respondent should include a budget narrative, as well as:
    a. If this RFA indicates fee-for-service reimbursement, then the provider should submit requested rates.
    b. If capacity funded, then provider should submit an OBH capacity (see Exhibit A) budget for the remaining term of SFY1617 and SFY1718 (optional, but preferred)

5. The goal of for increased number of indigent clients served. This funding is intended to serve indigent clients. Indigent clients are defined as individuals whose household income is at or below 300% Federal Poverty Level (FPL).
6. The following representatives should be identified. Include name, title, email address, and phone number for each.
    a. Proposal lead
    b. Chief Executive Officer, Executive Director, or equivalent.
    c. Chief Financial Officer, or equivalent
    d. Clinical Director
7. A timeline, including
    a. Project start
    b. Intermediate milestones
    c. Service delivery start (if applicable)
8. Location (or multiple locations) that this proposal covers.

4 Evaluation and Decision

Signal will review all proposals upon receipt (no later than 5/19/2017). Failure to provide a complete set of information requested in this document may result in exclusion from consideration.

Signal may seek clarifying information as necessary to make an informed decision either from the respondent provider or from other sources.

After selection of a provider or providers for these services, Signal will notify remaining respondents of the decision.

Appendix A

OBH Capacity Budget Template

		Budget	YTD Actual	Variance
Provider Name:				
Program Name:				
Contract Period:				
	EXPENSES			
Personnel:				
	Clinical	-		
	Support	-		
	Kitchen	-		
	Operations	-		
	Other	-		
	Total Personnel	-		
Client Expenses:				
	Kitchen Supplies			
	Client Food			
	Client Transportation			
	Medications			
	Medical Supplies			
	Personal Hygiene Items			
	Laundry/Linens			
	Client Recreation			
	Purchased Services			
	Contractors			
	Other			
	Total Client Expenses	-		
Occupancy:				
	Janitor			
	Supplies			
	Utilities			
	Phone			
	Rent			
	Equipment Lease			
	Building Maintenance			
	Grounds Maintenance			
	Other			
	Total Occupancy	-		
Operating:				
	Insurance			
	Auto Expense			
	Staff Development			
	Employee Training			
	Travel & Lodging			
	Business Meals			
	Mileage			
	Computer Supplies/Equipment			
	Office Supplies			
	Postage			
	Printing			
	Dues, Fees & Licenses			
	Equipment & Furnishings			
	Renovation & Construction			
	Depreciation			
	Advertising			
	Public Relations			
	Legal			
	Audit			
	Consultants			
	Other			
	Total Operating	-		
Indirect:				
	Finance & Accounting			
	Contracting & Purchasing			
	IT System & Services			
	Legal			
	Human Resources			
	Total Indirect	-		
	Grand Total Expenses	-		
	Revenue Offsets			
Client Services:				
	Medicaid Fee for Service Cash			
	Medicaid Capitation Encounters *			
	OBH Indigent Encounters *			
	3rd Party Insurance Cash Receipts			
	Medicare Cash			
	Self-Pay			
	Cash from Other Sources			
	Total Client Service Cash	-		

** Encounters valued using the current year's fee for service schedule issued by OBH and not to exceed contract amount*

		Budget	YTD Actual	Variance
Contracts and Grants:				
	MSO Revenue (from other OBH contract budget lines)			
	Non-Governmental Contracts			
	Other State Revenue/Accrual			
	Local Funds/Accrual			
	Federal Grant Funds/Accrual			
	Public Support			
	Other Funds (Specify below)			
	Description			
	Description			
	Total Contracts and Grants	-		
	Grand Total Revenue Offsets	-		
Net Cost Invoiced**		-		

**Net Cost Invoice may not exceed the OBH Contract to exceed price for this capacity based contract exhibit or contract.

Exempt Revenue Offsets			
Private Grant Funds			
Private support or donations			
In-kind donations			
Local Hospital funds			

Appendix B

Signal Credentialing

CREDENTIALING DOCUMENTATION

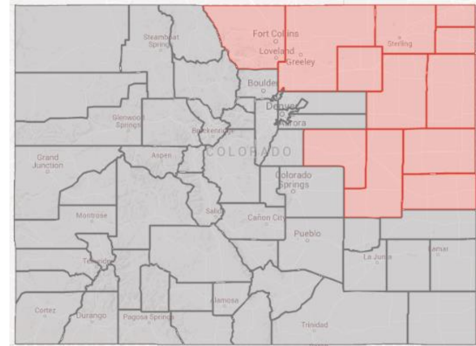
Below is a listing of the documentation required for application as a credentialed provider with Signal Behavioral Health Network.

a) Copies of all current OBH licenses
b) Copies of any current licenses/certificates from any organization regulating any portion of the Provider's treatment services. These may include, but not limited to:
   - JCAHO/CARF/COA approvals, if applicable
   - Residential Child Care Facility license, if applicable
   - Residential Treatment Center license, if applicable
   - Drug Enforcement Administration Provider certification, if applicable
   - Drug Enforcement Administration Physician license(s), if applicable
   - Federal Drug Administration and Pharmacy Board registration, if applicable
c) Federal tax ID number
d) Certificate of general liability and professional liability insurance, professional automobile, and general office insurance. The professional liability policies shall have a minimum coverage limit of $1,000,000 per individual occurrence and $1,000,000 aggregate. Exceptions to these minimum coverage requirements will be considered on a case-by-case basis.
e) Certificate of worker's compensation insurance, if applicable
f) Certification of malpractice insurance for doctors/nurses, if applicable
g) Certification of Director's and Officer's Insurance, if applicable
h) Notification if insurance was ever denied or canceled and the reason(s) for any such denial or cancellation
i) Most recent list of the members of the Provider's Board of Directors, if applicable
j) List of current Provider clinical staff including credentials, CAC level, and date of hire. Credentials refer to any educational degrees, any professional licenses, and any type of teaching certificates.
k) Notification that all current clinical staff have been reviewed in the DORA database for any disciplinary actions and a description of the Provider's response to any disciplinary actions discovered
l) Notification of any investigation of the agency by any regulatory agency that resulted in any type of corrective action or change in status during the two years prior to submission of the credentialing packet. Regulatory agencies include, but are not limited to, OBH, DMH, JCAHO, and CARF.
m) Notification of compliance with all HIPAA regulations, if applicable
n) Notification of any Federal debarment
o) Copy of most recent financial audit and management letter
p) Copy of most recent agency approved budget
q) Number of pregnant women and injecting drug users served in the past 18-months

Appendix C

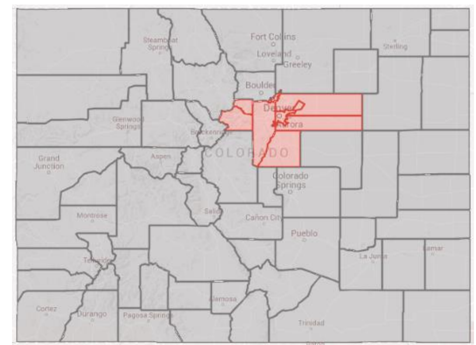
Signal Sub-State Planning Areas

SSPA 1: NORTHEASTERN COLORADO



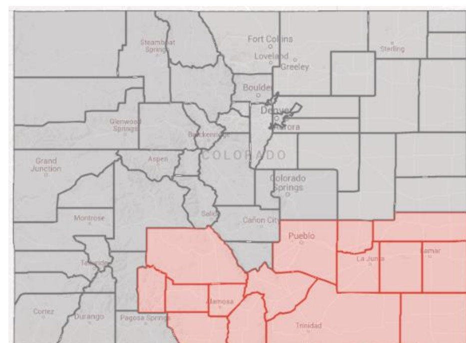
- Cheyenne
- Kit Carson
- Larimer
- Lincoln
- Logan
- Morgan
- Phillips
- Sedgwick
- Washington
- Weld
- Yuma

5 SSPA 2: DENVER METRO AND FOOTHILLS



- Adams
- Arapahoe
- Broomfield
- Clear Creek
- Denver
- Douglas
- Gilpin
- Jefferson

6 SSPA 4: SOUTHEASTERN COLORADO & SLV



- Alamosa
- Baca
- Bent
- Conejos
- Costilla
- Crowley
- Huerfano
- Kiowa
- Las Animas
- Mineral
- Otero
- Prowers
- Pueblo
- Rio Grande
- Saguache
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