SB202 MSO Community Action Plan

REQUEST FOR APPLICATION

SIGNAL BEHAVIORAL HEALTH NETWORK
6130 GREENWOOD PLAZA BLVD, #150, GREENWOOD VILLAGE, CO 80111

Prevention and Early Intervention RFA (S2-1718-PEI)

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 ensure 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 reporting, 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

Prevention and Early Intervention

1.4 Objective

The objective is to provide increased effective substance use prevention and access to early intervention services across the state of Colorado. The requirement is to establish and/or expand, and maintain access to, quality prevention and early intervention. The intent is to increase access to a complete substance care continuum, including enhancing health, prevention, early intervention, treatment, and recovery support services.

Entities submitting proposals must have significant experience providing primary prevention and/or early intervention.

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. 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 6/15/2017. 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. This funding is available for the State Fiscal Year of July 1, 2017 through June 30, 2018.

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

"Primary Prevention" as defined in the Surgeon General's chart of the Substance Use Care Continuum states: "Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies." "Early Intervention" is: "Screening and detecting substance use problems at early stage and providing brief intervention, as needed."[1] These are consistent with the types of prevention interventions as defined by the Institute of Medicine (IOM), which are: "*universal*, *selective*, and *indicated*." *Universal* interventions are aimed at all members of a given population (for instance, all children of a certain age); *selective* interventions are aimed at a subgroup determined to be at high-risk for substance use (for instance, justice-involved youth); *indicated* interventions are targeted to individuals who are already using substances but have not developed a substance use disorder."[1,2]

Early intervention is most familiarly represented through the SBIRT (Screening, Brief Intervention, and Referral for Treatment) protocol. One can think of SBIRT as having component parts of: *screening*, identifying those who may benefit from brief intervention; *brief intervention*, nonjudgmental advice or counseling; *referral for treatment* of a person who does not benefit from brief intervention or who have moderate or greater substance use conditions. "Given the significant public health impact of substance misuse, it is important to prevent individuals from misuse and to identify and intervene early with individuals who are misusing substances before that develops into substance use disorder and ultimately addiction."[1]

The Surgeon General report includes key findings in each chapter. Rather than paraphrase those key findings, the following are selected key findings regarding primary prevention and early intervention prevention.

Surgeon General's Report Prevention Key Findings[a]

- "Well-supported scientific evidence exists for robust predictors (risk and protective factors) of substance use and misuse from birth through adulthood. These predictors show much consistency across gender, race and ethnicity, and income.
- Well-supported scientific evidence demonstrates that a variety of prevention programs and alcohol policies that address these predictors prevent substance initiation, harmful use, and

[a] Key Findings are presented with a caveat: The Centers for Disease Control and Prevention (CDC) summarizes strength of evidence as: "Well-supported": when evidence is derived from multiple controlled trials or large-scale population studies; "Supported": when evidence is derived from rigorous but fewer or smaller trials; and "Promising": when evidence is derived from a practical or clinical sense and is widely practiced.

substance use-related problems, and many have been found to be cost-effective. These programs and policies are effective at different stages of the lifespan, from infancy to adulthood, suggesting that it is never too early and never too late to prevent substance misuse and related problems.

- Communities and populations have different levels of risk, protection, and substance use. Well-supported scientific evidence shows that communities are an important organizing force for bringing effective EBIs (Evidence-Based Interventions) to scale. To build effective, sustainable prevention across age groups and populations, communities should build cross-sector community coalitions which assess and prioritize local levels of risk and protective factors and substance misuse problems and select and implement evidence-based interventions matched to local priorities.
- Well-supported scientific evidence shows that federal, state, and community-level policies designed to reduce alcohol availability and increase the costs of alcohol have immediate, positive benefits in reducing drinking and binge drinking, as well as the resulting harms from alcohol misuse, such as motor vehicle crashes and fatalities.
- There is well-supported scientific evidence that laws targeting alcohol-impaired driving, such as administrative license revocation and lower per se legal blood alcohol limits for adults and persons under the legal drinking age, have helped cut alcohol-related traffic deaths per 100,000 in half since the early 1980s.
- Currently, though, insufficient evidence exists of the effects of state policies to reduce inappropriate prescribing of opioid pain medications."
- "Supported scientific evidence indicates that substance misuse and substance use disorders can be reliably and easily identified through screening and that less severe forms of these conditions often respond to brief physician advice and other types of brief interventions. Well-supported scientific evidence shows that these brief interventions work with mild severity alcohol use disorders, but only promising evidence suggests that they are effective with drug use disorders."

2.1.1 Early Intervention Objective

The objective of early intervention is to address substance misuse problems or mild disorders and help to prevent more severe substance use disorders. "Regardless of the substance, the first step to early intervention is screening to identify behaviors that put the individual at risk for harm or for developing a substance use disorder. Positive screening results should then be followed by brief advice or counseling tailored to the specific problems and interests of the individual and delivered in a non-judgmental manner, emphasizing both the importance of reducing substance use and the individual's ability to accomplish this goal. Later follow-up monitoring should assess whether the screening and brief intervention were effective in reducing the substance use below risky levels or whether the person needs formal treatment."[1] The Surgeon General's report specifically mentions SBIRT as an effective early intervention.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an established and well researched method to execute early intervention in a variety of settings.[3,4,5,6,7] It includes screening, and if so indicated brief intervention. If the individual has a substance use disorder, or brief interventions to not benefit the individual, then a referral to treatment is made with the appropriate support to assist the individual to engage in that treatment. SBIRT can occur in many different locations and environments. One which is of interest to Signal is to expand SBIRT in a variety of medical settings including primary care clinics.

2.1.2 Provisions of Prevention and Early Intervention Within a Regional Continuum

SAMHSA has approaches to structure prevention implementation. This framework assists in operationalizing the targets of prevention as defined by SAMHSA and the Surgeon General. Implementing prevention approaches requires, at the minimum, understanding *Risk and Protective Factors*[8], applying the *Strategic Prevention Framework (SPF)*[9], and developing a *Logic Model*[10] specific to the region in which services are being provided.

SAMHSA developed the Strategic Prevention Framework which is a planning process to develop prevention services to prevent substance misuse. There are five steps and with two overarching, guiding principles. SAMHSA defines those steps as: assess needs, build capacity, plan, implement, and evaluate. The two guiding principles are cultural competence and sustainability. The graphic below has been developed by SAMHSA to illustrate the relationship between the steps and guiding principles.

Figure 1. Source: https://www.samhsa.gov/capt/applying-strategic-prevention-framework

It is Signal's expectation that proposals will use the Strategic Prevention Framework. For more information regarding how to apply the Strategic Prevention Framework, please see information at Center for the Application of Prevention Technologies (CAPT)[9].

2.1.3 Risk and Protective Factors

The likelihood of a person developing difficulties with substance use is based on many factors. At a high level, it may be understood that there are factors that increase the risk of developing substance use conditions, and factors that are protective and may counteract risk. Prevention is aimed at reducing risk and increasing or strengthening protective factors related to the specific problem. Both risk and protective factors may exist in individuals, communities, and social cultures. SAMHSA recommends applying the Strategic Prevention Framework (SPF) to help prevention professionals

identify factors having the greatest impact on the population about which they are concerned. For more detailed information please see, https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors

2.1.4 Logic Model

Logic models are used to plan strategically. Logic models are mechanisms to provide detail for the implementation of a prevention strategy. SAMHSA sees it as specifying activities to address the risk and protective factors identified by assessment and produce anticipated outcomes. The Center for the Application of Prevention Technologies has an example of a logic model on their webpage that can be used as a template for a logic model for prevention. The content, of the example model "Examples of Community- and State-level Logic Models for Addressing Opioid-related Overdose Deaths"[10], is specific to an intervention targeting opioid use. In a different community, the specific content of that logic model would be based on the assessment of that community. This would be the case whether target for intervention was also opioid use, or a different issue. (See: https://www.samhsa.gov/capt/sites/default/files/capt_resource/sample-opioid-logic-models.pdf). It is Signal's expectation that proposals will develop a Logic Model for their prevention strategy.

2.1.5 Sustainable and Geographically Accessible Rural Services

Rural prevention has the same challenges as urban prevention. Additionally, rural and frontier prevention programs are saddled with challenges around economies of scale, geographic distance, professional workforce shortages that tend to be greater than urban areas. Additionally, local resources may be insufficient to sustain a rural or frontier services, therefore offsetting funds may need to provide a continuum of care in rural locations.

2.1.6 Specialty Prevention Services to Provide Individual and Overall Health Improvement

Colorado is blessed with a rich array of diversity in its population. Services sensitive and tailored to such diversity is important to increase positive health outcomes. Some of that diversity is present in a large portion of our population. For example, women experience a variety of complications from substance use disorders that require extra attention via prevention. Women also are more likely than men to be single parents of households where there are dependent children. When women experience substance use disorders, they require specialty services that address their unique needs, including such factors as having dependent children or accessing services for her and her children as a family unit.

2.1.7 Primary Care SUD Integration and Education: SBIRT

Medical, nursing, and other health and behavioral health professionals have had limited education and training with regard to substance use disorder. Integration of behavioral health, SUD, and primary services necessitates bidirectional workforces. Education needs to be made available to enhance the specific workforce. Primary care is in a position to identify developing substance use conditions, as well as provide continuing care to individuals who are in recovery from substance use disorders. "Integration" refers to having substance use specialty behavioral health providers available in primary care practices, as well as having primary care services delivered in specialty SUD treatment settings.

Integration into the continuum should consider:

- Utilization of evidence-based and best practices, including use of SBIRT, as well as technology solutions that increase access.

- Training and CME events regarding substance use conditions for primary care, and training regarding primary care for SUD providers
- It is critical there be a connection of substance use professionals and community resources provided in a variety of settings, including primary care and other medical settings.

2.1.8 Prevention and Opioid and Other Drug/Alcohol Crisis Management

The resources from the 21st Century Cures Act are seen as specifically addressing the opioid crisis; the impact of SB 202 resources should be seen as creating a better foundation for the substance use disorder services system to more effectively utilize opioid crisis funds, holistically address the impact of the crisis, and develop infrastructure and experience regarding drug/alcohol crisis management.

One key area that should be highlighted in every region is that there is clearly a significant opioid problem that includes both prescription drugs and illicit drugs. Crises around specific drugs arise from time to time; they are symptomatic of the insufficiencies and gaps in prevention and treatment of substance use conditions. The goal in each geographic region is to create a continuum of care that eventually will be sufficiently robust to address drug/alcohol crises as they arise.

2.2 KEY ELEMENTS

The following care requirements are presented as some of the areas of highlighted need; they are not exhaustive:

- Engage families, primary care medical providers, appropriate social support, in person-centered recovery-oriented services and supports.
- Endorse harm reduction, support use of FDA approved medication for substance use disorder treatment. This applies to all FDA approved medications for treatment of substance use disorders. Organizations that are "philosophically opposed" to medication assisted treatment will not be funded. Signal regards denial of access to FDA approved recovery support as unethical. A proposal for services funding must include an explicit statement of support for medication assisted therapy. Failure to state this may result in disqualification of the proposal.
- Utilization of evidence-based and best practices
- Collaborative services with primary care and/or specialty medical providers

3 RESPONSE FORMAT

Respondents to this proposal request should include the following elements:

1. When referencing this RFA, use RFA **#S1-1718-PEI**
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. Certifications and credentials of prevention staff.
5. This RFA is supported using 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 Appendix A) budget for SFY1718
6. The goal of for increased number of indigent persons served or reached. This funding is intended to serve indigent clients. Indigent persons are defined as individuals whose household income is at or below 300% Federal Poverty Level (FPL).
7. 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
8. A timeline, including
   a. Project start
   b. Intermediate milestones
   c. Service delivery start (if applicable)
9. Location (or multiple locations) that this proposal covers.

4 EVALUATION AND DECISION

Signal will review all proposals upon receipt (no later than 6/15/2017). 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.

5 REFERENCES

[1]Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

[2]National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: National Academies Press. Quoted in [1]U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration. *Risk and Protective Factors*.

[3]Centers for Disease Control and Prevention. Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.
https://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf

[4]American Academy of Pediatrics. (2015). *Substance Use Screening and Intervention Implementation Guide*. Elk Grove Village, IL.
https://www.aap.org/en-us/Documents/substance_use_screening_implementation.pdf

National Institute on Alcohol Abuse and Alcoholism
[5]https://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf

[6]https://niaaa.nih.gov/publications/clinical-guides-and-manuals/helping-patients-who-drink-too-much-clinicians-guide

[7]https://niaaa.nih.gov/publications/clinical-guides-and-manuals/alcohol-screening-and-brief-intervention-youth

[8]U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration. *Risk and Protective Factors*.
https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors

[9]U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, *Applying the Strategic Prevention Framework (SPF)*
https://www.samhsa.gov/capt/applying-strategic-prevention-framework

[10]SAMHSA's Center for the Application of Prevention Technologies. *Examples of Community- and State-level Logic Models for Addressing Opioid-related Overdose Deaths* [the content of this example model is specific to opioid-related overdose deaths; is important to note content for a specific community in Colorado may be significantly different]
https://www.samhsa.gov/capt/sites/default/files/capt_resource/sample-opioid-logic-models.pdf

Appendix A

OBH Capacity Budget Template

Provider Name:				
Program Name:				
Contract Period:				
		Budget	**YTD Actual**	**Variance**
	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*				
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

Signal Behavioral Health Network

Credentialing for Membership as a Signal Provider

CREDENTIALING DOCUMENTATION

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

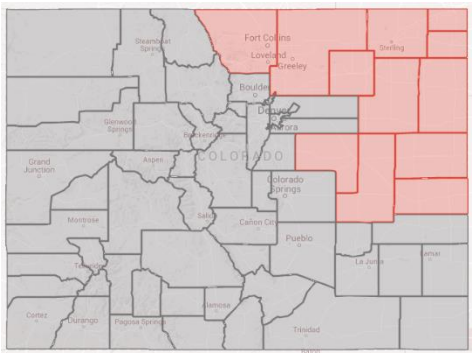
a) Copies of all current OBH licenses
b) Copies of any current licenses/certificates from any organization regulating any portion of the Provider's treatment services. These may include, but not limited to:
    - JCAHO/CARF/COA approvals, if applicable
    - Residential Child Care Facility license, if 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

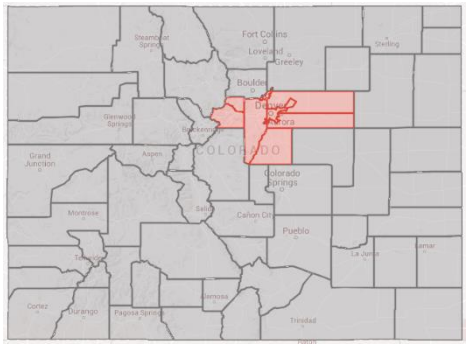
SSPA 1: Northeastern Colorado

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



SSPA 2: Denver Metro and Foothills

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



SSPA 4: Southeastern Colorado & SLV

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