SB202 MSO Community Action Plan

REQUEST FOR APPLICATION

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

Withdrawal Management Services RFA (S1-1718-WMS)

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

Withdrawal Management Services

1.4 Objective

Signal seeks to sustain and expand detoxificaiton services. American Society of Addiction Medicine (ASAM) Level 3-WM is Residential/Inpatient Withdrawal Management. What has commonly been called "social detoxification" in Colorado, is actually ASAM Level 3.2-WM [Clinically Managed Residential Withdrawal Management]. ASAM Level 3.7-WM [Medically Monitored Inpatient Withdrawal Management] has a higher involvement of medical professionals, and most frequently would be found in a freestanding withdrawal management center. Detoxification units are "urgent care" settings that provide: intoxication management; withdrawal management; assessment; brief intervention; Naloxone/Narcan for opioid overdose reversal; comprehensive case management (including outreach) attached to and integrated with the detoxification unit; coordination and collaboration with other health care providers including primary care and crisis/emergency services.

1.5 Location

The services outlined in this document should be located in any or all of the following Colorado counties: Weld or Larimer

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

Withdrawal management/detoxification units provide opportunities to engage with a diverse group of individuals seeking services, some of whom will have a substance use disorder, some of whom will have substance-use conditions, or some of whom simply made a bad decision with regard to substance-use and operation of a motor vehicle or other high risk behavior. Entry into a detoxification unit is an opportunity to engage and assist individuals to understand options available to them at the point of service, at discharge, or sometime in the future.

The requirement is to establish and maintain access to quality care for withdrawal management, including intoxication management. There is a distinct interest in facilitating engagement in treatment of individuals entering detoxification units who have substance use disorder conditions, including those with severe substance use disorder. There is also priority in improving health outcomes for individuals and the community. Detoxification units are not only an opportunity to engage individuals in treatment, but also an opportunity to provide immediate harm reduction, and decrease undesirable utilization of emergency services. It is expected that detoxification units will provide ongoing services to frequent users of detoxification, that these services will not be contingent upon entry into treatment, and that these services will include comprehensive community-based case management targeted at reducing harm and producing incremental improvement of overall health.

Any agency that is interested in providing these services will need to maintain close relationships with treatment providers to ensure appropriate transfers of clients in need of treatment services.

Of most value to achieve these goals is ASAM Level 3.2-WM (Clinically Managed Residential Withdrawal Management) with the integration of Level 1-WM and Level 2-WM. 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.[1]

[1] "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions", The Change Companies, Third Edition 2013; in particular Chapter 6 Addressing Withdrawal Management and Intoxication Management.

2.2 KEY ELEMENTS

Detoxification units are "urgent care" settings that provide: intoxication management, withdrawal management, assessment, brief intervention (outpatient), Naloxone/Narcan for opiate overdose reversal, comprehensive case management (including outreach) attached to and integrated with the detoxification unit, coordination and collaboration with other health care providers, including primary care and crisis/emergency services. Providers shall explicitly and intentionally provide both intoxication management and withdrawal management as part of the overall community health services.

2.2.1 Involuntary Commitments and Emergency Commitments

It is required that entities operating detoxification units provide services related to Involuntary Commitment (IC) and Emergency Commitment (EC), for individuals afflicted with substance use conditions, as is as defined for both alcohol (C.R.S. §27-81-112) and drug (C.R.S. §27-82-108). Compliance is required 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. This manual covers both Emergency Commitment (EC) and Involuntary Commitment procedures and relies heavily on statutory guidance. Detoxification units shall assist in the initiation of involuntary commitments.

2.2.2 Community Partnerships and Coordination of Care

It is expected there will be meaningful collaboration and coordination of care with primary care providers, and existing crisis services including hospital emergency departments, mental health, law enforcement, emergency medical services, etc. It is essential over-the-counter (OTC) comfort medications be provided, and existing prescribed medications be maintained in collaboration and coordination with the prescribing medical provider. It is imperative that memorandums of understanding with each Colorado Crisis Services provider in the geographic region served by the detoxification unit exist, and are included in the proposal response. Demonstrated history of interaction is also important to indicate in the response.

2.2.3 SAMSHA TIP 45

Signal endorses the entirety of practices recommended by SAMHSA TIP 45.[2]

The consensus panel of "Detoxification and Substance Abuse Treatment", SAMHSA Treatment Improvement Protocol (TIP) 45, agreed on a number of guidelines for nonmedical (social) detoxification units including: "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". They note that "the course of withdrawal is unpredictable and currently available techniques of screening and assessment do not predict who will experience life threatening complications."

In addition, the consensus panel noted, "Although it is the philosophy of some 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, therapeutic doses of medication should be continued through any withdrawal if the patient has been taking the medication as prescribed.

[2] "Detoxification and Substance Abuse Treatment", Treatment Improvement Protocol (TIP) Series 45 (revised 2015), SAMHSA, CSAT

Decisions about discontinuing the medication should be deferred until after the individual has completed detoxification."

The entirety of recommended practices in TIP 45 are endorsed by Signal. TIP 45 including appendices is 254 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.

2.2.4 SAMHSA TIP 27

Signal endorses the entirety of practices recommended by SAMHSA TIP 27.[3]

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 answers the question, why case management? "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."

The whole of recommended practices in TIP 27 are endorsed by Signal. TIP 27 including appendices is 133 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.

2.3 BEST PRACTICES

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 detoxification 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 to enhance engagement. 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 detox admissions and discharges, several attempts at treatment services in different levels of care,

[3] "Comprehensive Case Management for Substance Abuse Treatment", Treatment Improvement Protocol (TIP) Series 27, (revised 2015), SAMHSA, CSAT

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 detoxification services involves comprehensive case management with "warm handoffs", assistance with transportation, finding safe housing, etc.

Use of evidence-based and best practices is required. The respondent should demonstrate a mechanism for ensuring fidelity to the specific evidence-based practice models employed.

As noted in the section regarding services provided, evidence-based practices should include comprehensive case management and care management for individuals receiving services in detoxification 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. Both SAMHSA TIP 27 and TIP 45 should be regarded as defining best practices.

All detoxification units, regardless of levels of care provided, shall have Narcan available on their unit with staff trained in the administration of Narcan to reverse opiate overdose.

All detoxification units shall refer clients, appropriate for medication assisted SUD treatment, to treatment entities providing such treatment. This includes methadone maintenance, buprenorphine, Suboxone, naltrexone, Vivitrol, and appropriate psychiatric drugs for those with mental illness. Clients will not be referred to providers who are "philosophically opposed" to medication assisted treatment. Detoxification providers who are "philosophically opposed" to medication assisted treatment will not be funded. Signal regards denial of access to medication assisted treatment as malpractice.

For some existing providers, the scope of services and best practices may mean expansion of existing services, enhancement of relationships with community crisis 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 specially services as needed.

2.4 OUTCOMES

There is a significant relationship between emergency departments and detoxification units. Individuals that are frequent users of detoxification units tend also to be frequent users of emergency departments. It is important in goalsetting for detoxification units to remember the interdependent relationship between emergency departments and detoxification units. It is also important to remember that high utilization does not necessarily equal overutilization. It is very possible that individuals who utilize detox units may be under-utilizing the service in the context of achieving overall health improvement. One major goal is to improve both individual health and community health. Over- and under-utilization of detoxification services needs 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.

In terms of improving health outcomes, it is important that providers focus on specialty populations with high health risk (and potential high health cost) due to substance-use disorders (e.g., pregnant women, adults with dependent children, injection drug users)

There is benefit offered by the specialty behavioral health provider, adding value to community health outcomes, through focus upon SUDs alone. In addition, there is significant value to focus on those with a substance use condition and one or more co-occurring condition (e.g., diabetes, HIV/AIDS, tobacco use, compromised liver function, mental illness, etc.). This can be thought of as working with high utilizers of health services of all kinds.

Respondents will be encouraged to indicate their ability and familiarity with collaboration with mobile crisis teams, primary care providers, hospital emergency departments, EMS, law enforcement, and other community partners in the healthcare of individuals receiving detoxification services.

2.4.1 Medical Policy

Quality detoxification requires some degree of medical staff access and/or supervision, nursing staff availability to and/or in detoxification 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 access to enhanced medical services for those served.

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 detoxification intensity, dose, duration, and restrictiveness of care. This needs to be attached to the concept of clinical necessity and medical necessity. Internal care management enhances the ability to relate to external pre-authorization, utilization review, and continuing stay authorizations.

2.5 OTHER REQUIREMENTS

Signal requires certain documentation delivery requirements from providers contracting for the offering of services associated with supported programs.

2.5.1 Data delivery

Signal requires the State's SUD reporting survey, known as DACODS as well as encounters relating to the delivery of each admission. Further, if applicable, Signal may require additional data reporting as required by State and Federal funding and contracting requirements.

2.5.2 Invoicing requirement

As noted previously, providers are required to use the OBH Capacity Budget Protocol (Appendix A) to be funded through Signal. Additionally, monthly invoicing is required.

2.5.3 Licensing

Providers must be licensed to provide detoxification services with the State's Office of Behavioral Health.

2.5.4 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 **#S1-1718-WMS**
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 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
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 **6/15/2107**). 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

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/Accrural			
	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.

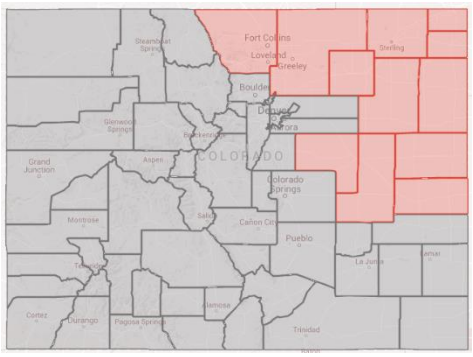
a) Copies of all current OBH licenses
b) Copies of any current licenses/certificates from any organization regulating any portion of the Provider's treatment services. These may include, but not limited to:
    - JCAHO/CARF/COA approvals, if applicable
    - Residential Child Care Facility license, if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

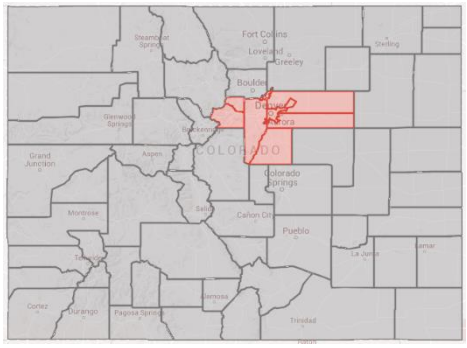
SSPA 1: Northeastern Colorado

- 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