SB202 MSO Community Action Plan

REQUEST FOR APPLICATION

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

Outreach, Case/Care management, System navigation RFA (S2-1920-CC)

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

Outreach, Case/care management, System navigation

1.4 Objective

Signal seeks improvements in the SUD delivery system to achieve better continuity of care and step down of treatment intensities as clients progress through a treatment plan. Such supportive services to individuals take several forms, including comprehensive case management, and system navigation. The function of this in the general health system has been performed by community health workers.

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. Please limit the project narrative to no more than 5 pages. 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 **6/7/2019.** 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 must include a budget and budget narrative for the proposed project under this RFA 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 that can take place. Please note under this RFA all projects MUST result in an expansion of services.

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, 2019 through June 30, 2020

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

Improving coordination across agencies and organizations, connection to community resources with engagement and retention for persons who present with SUD and SU with the intent of increasing positive health outcomes with those individuals.

2.2 STAKEHOLDER PERSPECTIVES: POPULATION- SPECIFIC FEEDBACK

Across the state, stakeholders expressed the need for coordination of care in all forms, including fully integrated care models; collaboration among state agencies that address substance use; warm referrals between providers; and coordinated transitions among facilities and levels of treatment. In cases where care is not systematically coordinated, stakeholders identified value in care coordinators or navigators, a role that can be served by a peer or a medical professional." [Keystone Policy Center p 27]

The response to this RFA may include any of the following services: Comprehensive Case/Care Management, Health System/Patient Navigation, Outreach, and increased use of Peer Coaches

Because of the diversity of approaches under each one of these service categories, this RFA does not provide an in-depth description in this document regarding the services desired. There are brief descriptions of the services and outcomes desired by Signal. You will find a variety of links which provide resources to select and blend the mix of services most appropriate for the community or region in which the applicant organization provides, or proposes to provide, services.

In a broad sense comprehensive case management, navigation, and community health outreach have a great deal in common regarding function and delivery. Each has a diverse workforce in terms of the range of qualifications, including lived experience, education, certification, and connection to health services. There are many ways of providing these services to benefit individuals with substance use conditions. All three of these are of benefit to increasing positive health outcomes for those with substance use conditions including substance use disorders.

2.3 SERVICES DESIGNED TO MEET THE NEEDS OF THOSE WITH SUBSTANCE USE

Services should be designed and implemented from the perspective that engagement in treatment of those persons with substance use conditions/disorders frequently requires multiple interventions and contacts. This means 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, as well as community outreach, health system navigation, and comprehensive case management with "on the street" interventions. It may occur over a period of months or years.

Transitions from one level of care to another level of care continue to provide challenges to providing an adequate dose of treatment for individuals. These transitions, whether they be from one provider to another, or two different service sites within one organization, are the Achilles' heel of continuity of treatment, and transitions from more intensive to less intensive service levels and vice versa. 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 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 services leading to recovery involves: community health work, health system navigation, recovery support, and comprehensive case management with "warm handoffs", assistance with transportation, obtaining safe housing, etc.

2.4 COMMUNITY HEALTH WORKERS, HEALTH/PATIENT NAVIGATION AND COMPREHENSIVE CASE MANAGEMENT

SAMHSA's navigation approach has included Community Health Workers, Neighborhood Navigators, and Peer Support Specialists to provide health/patient navigation. The concept is to have Community-based organizations provide comprehensive recovery support services and transition assistance (substance misuse prevention, co-occurring medical care access, housing, employment, family, education, and community health services) that will reduce morbidity and mortality for high risk groups.

Community health workers have provided services for decades in a broad range of countries as well as the United States. The American Public Health Association defines a community health worker as "…a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy." Community health workers have functioned in public health settings and community health centers. Recovery coaches, peer specialists, and peer mentors are functioning as specialty community health workers in many settings. They have a positive impact upon social determinants of health resulting in improved individual and community health outcomes. Patient/Health Navigators are an evolution of Community Health Workers who have functioned in the health community for an extended period of time.

Navigation has a broad range of meanings that are continuing to evolve. In general, the current intent of navigation has been to enhance outreach to individuals of concern and assist them in receiving health care. Navigators are necessary to improve health outcomes given the complexities of health services and systems, payment eligibility and mechanisms, challenges in accessing care, transportation, variable language fluency, inadequate housing, etc. Patient navigators have been created to help individuals navigate the "health system". Patient Navigator Training Collaborative is focused upon health/patient navigator workforce development. One can access them at http://patientnavigatortraining.org/

Community health outreach, health/patient navigation, and comprehensive case management all have a potential relationship with primary medical care, as well as emergency departments (EDs). Care coordination is an essential benefit in establishing this relationship. This includes providing "… access to 'patient navigation' services that focus on benefits and financial counseling, transportation, home care, and access to social services, peer support, and treatment, including medications." http://www.integration.samhsa.gov/workforce/care-planning-care-coordination

For individuals with substance use disorders and more than one chronic condition, intensive case management models are most appropriate. These conditions may include mental health related, physical health conditions created by substance use or exacerbated by substance use. The most useful models are "Assertive Community Treatment" and "Clinical/Rehabilitation" represented as described in SAMHSA TIP 27 "Comprehensive Case Management for Substance Abuse Treatment." Case management needs to be at a level appropriate to the needs of the individual served.

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." Comprehensive case management is a very effective and appropriate means of assisting individuals with multiple challenges improve their health status.

2.5 HEALTH CARE INTERSECTION

Integration of substance-use services into the rest of healthcare has been ongoing for a significant period of time. At this time that integration is not robust or complete. The primary foci of this RFA are to:

- increase identification and early intervention for individuals with problematic alcohol and other drug use;
- establish enhanced connections with Emergency Departments and Withdrawal and Intoxication Management (detoxification) services to increase post-discharge access to treatment for persons with substance use conditions and disorders;
- improve overall health outcomes and wellness;
- ensuring adequate communication to individuals' primary care providers so that continuing recovery care can be provided in a primary medical care setting/home.
- the outreach/case management model including peer coaches can be used in Emergency Departments with any person admitted with substance use; and in Withdrawal Management Units for individuals with SUD and/or 2-3 admissions with problematic substance use in a year.

2.6 BEST PRACTICES

Use of evidence-based and best practices is required. The vendor should demonstrate a mechanism for ensuring fidelity to the specific evidence-based practice models employed. It is expected that all elements of a service continuum will recognize the value of harm reduction, be committed to

persistent efforts at engagement, and operate services accordingly. Following best practices are highlighted, and best practices are not limited to those presented here.

Evidence-based practices should include comprehensive case management and care management for individuals receiving services in detoxification, treatment, extended care settings. This case management should ensure those served are connected with primary care or other appropriate health services. It is expected that level and intensity of case management will be appropriate to the needs of the individual. Every specialty substance use detoxification and treatment service should include attached/affiliated comprehensive community-based case/care management appropriate for high utilizers of emergency services including detoxification units, as well as for persons under emergency and involuntary civil commitment.

Hospital emergency departments and substance use detoxification units are often the initial point of access for individuals with substance use conditions. It is important to view this initial access as an opportunity to begin engagement of individuals, provide motivational enhancement, and link people to case management. There shall be meaningful collaboration with, and coordinating care with, primary care providers, and existing crisis services including hospital emergency departments, mental health, police agencies, emergency medical services, etc. This includes, ensuring maintenance of existing prescribed medications in collaboration and coordination with the prescribing medical provider.

Navigators, community health workers, comprehensive case managers and peer providers shall be familiar with assessment and brief intervention, the features of substance use withdrawal syndromes, and have training in basic life support.

Community-based case managers should have Narcan with them and be trained in the administration of Narcan to reverse opiate overdose.

Clients, appropriate for medication assisted SUD treatment, should be referred 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. Providers who are "philosophically opposed" to medication assisted treatment will not be funded. Signal regards denial of access to medication assisted treatment as malpractice.

Substance use disorder specialty providers should formalize relationships with primary care to enhance engagement of those served in primary care medical services, as well as engagement in substance use and other specially services as needed.

2.7 SAMPLE OF RESOURCES AVAILABLE IN ENHANCING CARE FOR INDIVIDUALS WITH SUBSTANCE USE CONDITIONS AND DISORDERS

Community Health Workers

https://www.apha.org/apha-communities/member-sections/community-health-workers

http://healthaffairs.org/blog/2015/01/16/how-community-health-workers-can-reinvent-health-care-delivery-in-the-us/

http://www.countyhealthrankings.org/policies/community-health-workers (Robert Wood Johnson Foundation)

Health/Patient Navigator
http://patientnavigatortraining.org

Peer Providers
http://www.integration.samhsa.gov/workforce/team-members/peer-providers

Comprehensive Case Management
The U.S. Department of Health and Human Services. (2015). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215

Care Planning and Care Coordination
http://www.integration.samhsa.gov/workforce/care-planning-care-coordination

2.8 KEY ELEMENTS

The following best practices are not all-inclusive, and are noted only to highlight some of the elements of outreach, case and care management that are of key importance to Signal:

- 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 as highlighted in the RFA
- Signal is interested specifically in proposals that show the use of peers/recovery coaches or case managers in medical practices, withdraw management facilities and emergency departments that assist with connection to the next level of care.
- Interest in specialized services for adolescents and youth
- Peer specialists, coaches, mentors focused on the junction of initial identification of SUD and next levels of needed clinical care including:
    - intensive outpatient
    - outpatient
    - residential treatment
- Peer recovery mediated general support services focused on individuals engaged in attaining long-term recovery in the community, including:
    - housing
    - recovery support networks/mutual aid
    - employment and job readiness
    - community engagement
    - health & wellness

3 RESPONSE FORMAT

Respondents to this proposal request should include the following elements- please limit your response to no more than 5 pages, single spaced, Times New Roman 12pt font:

1. When referencing this RFA, use RFA #S2-1920-CC
2. Business Proposal- please address each of the following:
    a. Describe in detail the project/program that expands Outreach, Case/care management system navigation in the targeted community(s). Describe how you will provide this project/program, key partners and how it meets the recommendations outlined in Section 2.
    b. Describe the client population to be served, include counties that will be served and the physical location of where the service will be provided. Please keep in mind that the goal of the funding is to increase the number of indigent clients served. Indigent clients are defined as individuals whose household income is at or below 300% Federal Poverty Level (FPL) who have no other payor source for this service.
    c. Describe how success with be measured for this project/program. Please include not only the number of individuals that will be served but also a quality measure of success.
    d. Describe the timeline of the project, include major milestones and start date.

3. Additional documentation required:
    a. Budget: This RFA is supported using Capacity as the reimbursement. Respondent should include a budget narrative, as well. Provider should submit an OBH capacity budget for FY1920 (see Appendix A)
    b. Credentialing: If you are not a current credentialed Signal provider you must also submit the Credentialing Documentation outlined in Appendix B.

4 EVALUATION AND DECISION

Signal will review all proposals upon receipt and provide responses (no later than 6/14/2019). 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

Budget Template

5 BUDGET

Offerors will find the Colorado Office of Behavioral health capacity budget protocol documentation on Signal's website as one of the resources listed with this RFP, or use the following link:

http://signalbhn.org/wp-content/uploads/2019/02/FD-Protocol-5-Capacity-Based-Protocol-7-1-18.pdf

Offerors will find the Colorado Office of Behavioral health capacity budget template on Signal's website as one of the resources listed with this RFP, or use the following link:

http://signalbhn.org/wp-content/uploads/2017/11/OBH-Capacity-Invoice-Template.xlsx

Offerors may find the HCPF and OBH Behavioral Health Accounting and Auditing Guidelines on Signal's website as one of the resources listed with this RFP, or use the following link:

https://www.colorado.gov/pacific/sites/default/files/Accounting%20Auditing%20Guidelines%202018.pdf

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.

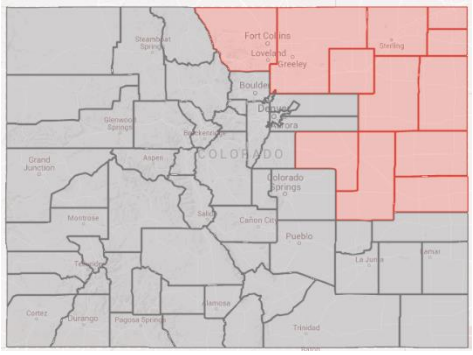
a) Copies of all current OBH licenses
a) Copies of any current licenses/certificates from any organization regulating any portion of the Provider's treatment services. These may include, but not limited to:
    - JCAHO/CARF/COA approvals, if applicable
    - Residential Child Care Facility license, if 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
b) Federal tax ID number
c) 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.
d) Certificate of worker's compensation insurance, if applicable
e) Certification of malpractice insurance for doctors/nurses, if applicable
f) Certification of Director's and Officer's Insurance, if applicable
g) Notification if insurance was ever denied or canceled and the reason(s) for any such denial or cancellation
h) Most recent list of the members of the Provider's Board of Directors, if applicable
i) 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.
j) 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
k) 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.
l) Notification of compliance with all HIPAA regulations, if applicable
m) Documentation of Medicaid Billing Practices
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

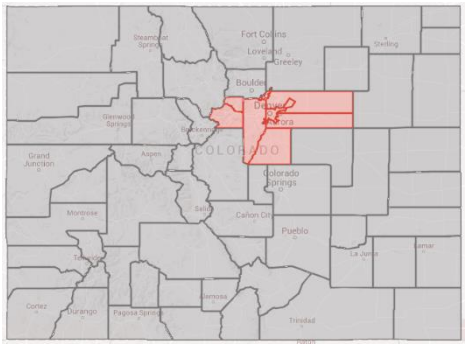
SSPA 1: Northeastern Colorado

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



6 SSPA 2: Denver Metro and Foothills

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



7 SSPA 4: Southeastern Colorado & SLV

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