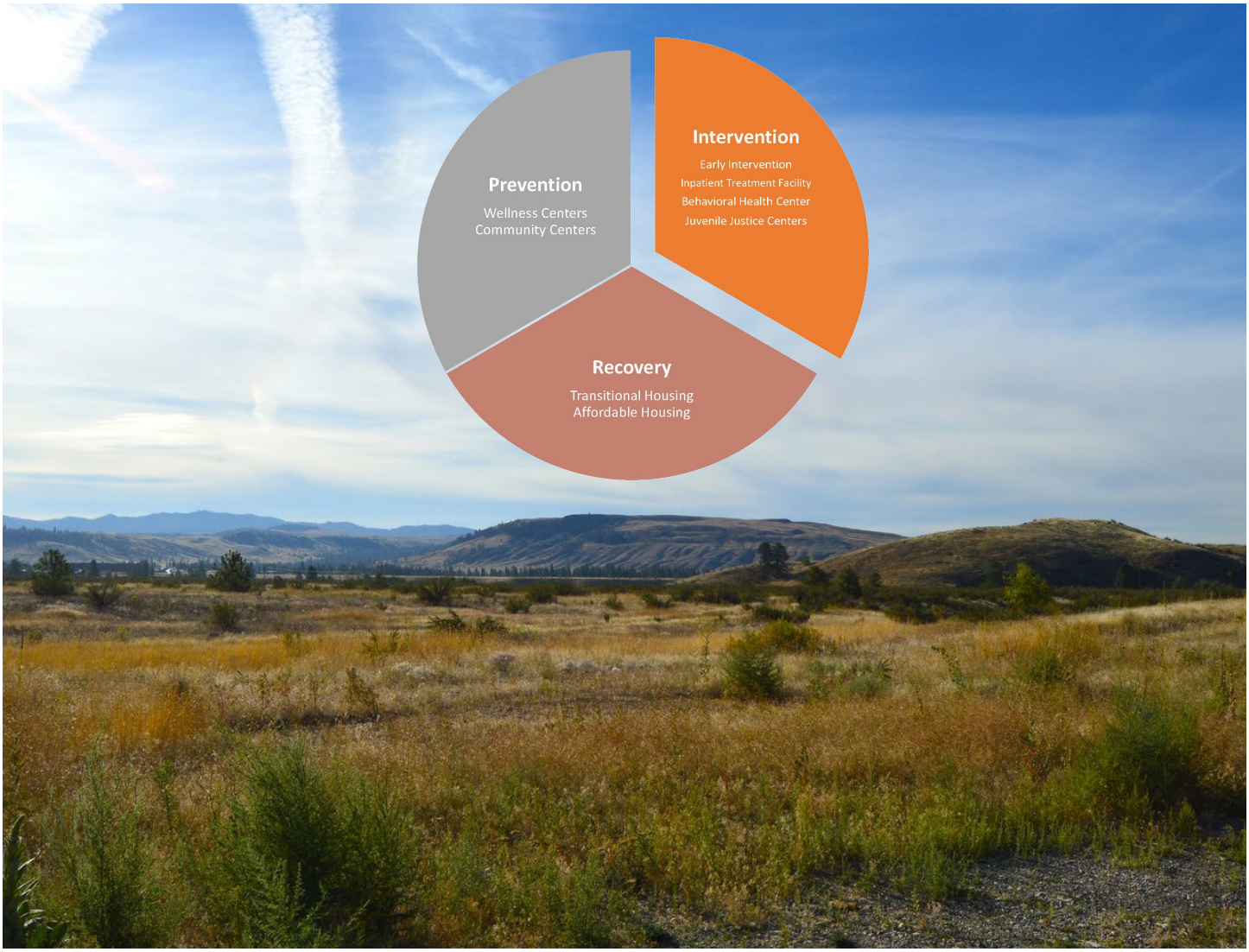
# FEASIBILITY STUDY FOR THE CONFEDERATED TRIBES OF THE COLVILLE RESERVATION




7 DIRECTIONS
architects / planners

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# *Executive Summary*

The primary objective of this document is to present findings of a feasibility study for a residential substance abuse treatment facility and recovery homes for the Confederated Tribes of the Colville Reservation (Colville). This feasibility study contains the following sections: *Executive Summary; Methods; Background; Understanding Treatment Services; Health Care and Treatment Access; Clients and Areas Served, Services; Case Studies & Washington Tribes' Behavioral Health; Accreditations, Licensures, & Certifications; Challenges, Opportunities, and Keys to Success; Next Steps; References;* and *Appendixes*. This Executive Summary provides highlights from the full document. Our investigation was informed by Tribal administration, the Colville Business Council, historical and contemporary Tribal documents, qualitative and quantitative data, the Native American Connections' model of holistic residential care and transitional/supportive group housing, and a modified SWOT (Strengths, Weaknesses, Opportunities, and Threats) methodology.

A new treatment facility and recovery homes are integral components  of Colville's broader vision of wellness, as described below. Development of such facilities will also help fill a gap in Colville's overall health services delivery system by serving those who suffer with substance abuse challenges. The new treatment facility will not only serve Colville citizens, but also other American Indians and Alaska Natives, and non-Natives from within the region, the State of Washington, and across the U.S. who have been medically determined to need residential substance abuse treatment services.

Careful planning and implementation of local, easy to access, residential treatment services are not only important to the overall health and wellness of the community, but such services are cost effective. Health care facilities, child welfare agencies, justice systems, police forces, fire departments, and other tribal entities save  limited financial and staff resources when fewer community members are actively addicted to substances.

We conclude that the development, construction, and sustainability of a new residential substance abuse treatment facility and four recovery homes are feasible and in the Tribes' best interest. Our analysis indicates the following:

- An initial 24-bed residential substance abuse treatment facility is a reasonable endeavor for the first two to four years of operations.
- As the Tribes expand its workforce and build systems capacity to provide additional treatment services to a larger population, the residential substance abuse treatment facility can be expanded up to 48 beds.
- As individuals complete residential treatment, many will be at risk for relapse; therefore, it is advised that up to four recovery group homes be established to help sustain healthy living among those who have been successful in completing their residential treatment.

The process and data that informed each of these conclusions is discussed in more detail the full report as are the conclusions themselves.

# *Vision*

This project is a significant step toward fulfilling the overall wellness vision of the Tribes. Development of the residential facility and four recovery homes are contextualized within the Tribes' vision to offer a broad range of holistic services. Colville envisions a continuum of behavioral health services. These are aimed at preventing substance misuse; providing intervention services - from early intervention through high level treatment services; and promoting recovery for those who have completed residential substance abuse treatment. An overview of the Tribes' behavioral wellness vision is presented in Figure 1. The Colville Continuum of Behavioral Health Services was drafted based on identified values and goals from historic documents and present day feedback. Programs and facilities will be community and data driven, and financially viable and stable. This feasibility report was developed while considering Colville's long-term vision of a continuum of behavioral health services.


*Figure 1. Colville Continuum of Behavioral Health Services*

To help fulfill the vision and reach the goals related to the residential substance abuse treatment and recovery home project, we offer a series of "Keys to Success" that involve both short-term and long-term planning and activities. These suggestions are based on our data gathering and analysis presented in the body of this Feasibility Study report. Additional discussion of the Keys to Success can be found in the *Challenges, Opportunities, and Keys to Success* section. A summary of the Keys to Success is as follows:

- Enroll clients and potential clients in the most appropriate medical coverage for providing residential substance abuse treatment services
- Recruit and retain staff and contract health care providers while building a pipeline for Colville citizens to gain employment in health care and health services
- Choose an electronic health care (EHR) system, update computer equipment, and train staff on EHR systems
- Reduce the current burden and expand the capacity of the Billing Department in an effort to prepare for the new facility
- Take advantage of the high Indian Health Services encounter rate of $391 available for serving Medicaid eligible American Indians and Alaska Natives (AIANs) and the incentive to serve AIANs over non-Natives

- Consider the unique time period of expanded health coverage for low income individuals who have gained and continue to gain access through the Affordable Care Act
- Take caution as Congress and the new administration continue to persist in their efforts to reverse at least some of the ACA statutes and provisions

# *Methods*

The investigation and analysis for this report was informed by Tribal administration, the Colville Business Council (CBC) site visits; staff interviews and discussions; historical and contemporary Tribal documents; qualitative and quantitative data from Tribal, County, State, and Federal sources; academic literature; the Native American Connections' model of holistic residential care and transitional/supportive group housing; ongoing consultations with Diana "Dede" Yazzie Devine (CEO of Native American Connections)[1]. The process was a collaborative effort involving 7 Directions Architects and Planners, the Colville Health and Human Services Department, and the Colville Planning Department. In person consultations were conducted with the CBC and staff on two occasions including with the Community Development Committee in November of 2016 and the Health and Human Services Committee in March of 2017. We approached our work by utilizing a combination of a modified Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and indigenous methodologies. In doing so, we provide a realistic analysis that is observant of the current sociopolitical climate while honoring the important cultural knowledges and historical work and visions of the Tribes community and the ancestors.

# *Background*

In Indian Country, substance abuse contributes to high rates of morbidity and mortality, chronic disease onset and severity, violence exposure, and family and community hardship. The drug induced death rate for American Indians and Alaska Natives (AIAN) is almost twice that of the U.S. rate and many of the top ten causes of death among AIAN's are associated with substance use. For example, motor vehicle accidents and other unintentional injuries (third leading cause of death), liver disease (sixth leading cause of death), and stroke (seventh leading cause of death) are all understood to be associated with high alcohol use. High rates of AIAN child maltreatment, intimate partner violence, and suicide are also associated with substance use.

Challenges such as those described above are far-reaching and deep-seated on the Colville Reservation. Community problems are largely affiliated with substance abuse either directly or indirectly by way of high rates of poverty, historic traumas resulting in cycles of normalized violence, undiagnosed or under treated behavioral health challenges, and unhealthy coping strategies. High rates of crime and violence are reported on the Colville Reservation. In one year, there were 260 criminal intimate partner reports, four reports of forcible rape, 26 sexual assault reports other than forcible rape, 44 reports of child maltreatment, and 44 substance related incidents reported in Colville Tribal Police records. Some of the individuals who commit crimes are then mandated by the courts to enter residential treatment to avoid incarceration. Moreover, individuals, families, and communities are losing loved ones through incarceration and death because of substance misuse. The Community Economic Development Strategies report and the Health Needs Assessment both identified community concerns of drugs and the need for a drug treatment facility as a high community priority.

1 Dede has more that 40 years of experience in the development, operation and management of residential treatment centers for the Native American community; and residential substance abuse treatment center case studies. Native American Connections is located in Phoenix, AZ.

Careful planning and implementation of local, easy to access, residential treatment services are not only important to the overall health and wellness of the community, but such services are cost effective. Health care facilities, child welfare agencies, justice systems, police forces, fire departments, and other community resources are relieved of burden and save on limited resources when fewer community members are actively addicted to substances.

Although substance-related loss, disease, poverty, and violence is tragic, we also witness signs of hope. Tribal members are seeking treatment for their disorders so that they can become well for their families and community. The high rates of Colville citizens in need of residential substance abuse treatment are the impetus for the development of this project.

## The Confederated Tribes of the Colville Reservation

The Reservation land base covers 1.4 million acres or over 2,100 square acres located in North Central Washington, primarily in the rural counties of Okanogan and Ferry. The Reservation consists of tribally-owned lands held in federal trust status, individual lots owned by Colville tribal citizens, and land owned by non-Colville Tribal Members. Over 5,000 live in small communities or rural settings on the reservation. Approximately 50% of the estimated 9,365 Colville citizens live on or near the reservation. Descendants of 12 distinct Tribes comprise the current Confederated Tribes of the Colville Reservation (Colville).
The 12 Tribes, commonly known by their English and French names are: the Colville, the Nespelem, the Sanpoil, the Lake, the Palus, the Wenatchi (Wenatchee), the Chelan, the Entiat, the Methow, the southern Okanogan, the Moses Columbia and the Nez Perce of Chief Joseph's Bands. (see Figure 2.)


*Figure 2. Aboriginal Territories of the 12 Tribes that Formed the Confederated Tribes of the Colville Reservation, Pre-1900*

***Pre-Contact.*** Prior to the influx of Canadians and Europeans in the mid-1850's, the ancestors of the 12 Tribes were spiritually, traditionally, and practically tied to the cycles of nature; nomadically following sources of food through the seasons. Their aboriginal territories were grouped primarily around waterways such as the Columbia River, the Sanpoil River, the Okanogan River, the Snake River and the Wallowa River. Many traveled throughout their aboriginal territories and other areas in the Northwest, of what is now the U.S. and parts of Canada. Travel was an opportunity for gathering with other Native peoples for traditional activities such as feasts, celebrations, sports, gambling, food harvesting, and trading.

Source: Images from University of Washington Library

The arrival of European settlers in the 19th century led to many changes for the 12 Tribes including the establishment of the reservation system and restricted access to traditional lands. In 1872, the Colville Indian Reservation (Reservation) was established by Executive Order. The Reservation was originally twice as large as it is today.  Today's reservation boundaries are shown on Figure 3.


*Figure 3. Washington Tribes Map*

Source: www.aaanativearts.com

***Governance.*** On February 26, 1938, the U.S. government approved the Confederated Tribes of the Colville Reservation's (Colville) constitution and by-laws. From this, the 14 member Colville Business Council (CBC or 'Council') was established as the governing board of the Colville, as were four distinct voting/ political districts (i.e. Omak, Nespelem, Keller, and Inchelium). These districts are based on traditional aboriginal territories. (See Figure 2.) Eligible adult Colville citizens may register in one district to vote in the yearly tribal election.

***Development and Workforce.*** Today, the Tribes oversee a 65-million-dollar administration that operates from a yearly budget financed primarily from state and federal grants, legal settlements, and revenue generated from sale of the Tribes' timber products and casinos. This governmental operation provides a variety of services for Colville tribal members living mostly on or near the reservation and is responsible for 75 different departments and programs. (Tribal services are discussed in more detail in the Service's section.) The Tribes employ between 800 to over 1600 staff-dependent on the season. Recruitment and selection practices that comply with Indian preference are followed for hiring. Although economic recovery has taken hold in most parts of the U.S in recent years, it has been slow on the Reservation. Resources remain strained.

Colville has developed its own corporation, the Colville Tribal Federal Corporation (CTFC), which oversees several divisions- including a gaming division with three casinos. The CTFC employs several hundred permanent and part-time employees. The Tribes' work force is composed primarily of Colville Citizens and others from the communities that surround the gaming facilities. Additional discussion of workforce can be found in the *Challenges, Opportunities, and Keys to Success* section.

***Other Challenges.*** Notwithstanding the employment opportunities, and in addition to the challenges described above, other social problems are widespread on the Reservation. Unsafe roadways, and a shortage of adequate, affordable housing remain pressing issues. In 2011, the Tribal unemployment rate was 55% and Washington's Office of Financial Management lists Ferry and Okanogan Counties, on its list of "Distressed Counties" (i.e. having a 3-year unemployment rate that is at least 20% higher than the state's unemployment rate). Other poverty issues are discussed in the Clients and Areas Served section. The Tribes are working diligently to address these concerns, and other challenges previously mentioned. The CBC, administrators, staff, and others remain steadfast in protecting citizens, families, and communities while enhancing the quality of life for Colville citizens, maintaining strong governance, and exercising sovereignty as a tribal nation.

## Continuum of Care

Substance abuse treatment services fall along a continuum of care. There are several models, in addition to the Model proposed in the Executive Summary, that reflect this continuum. Two are presented here. First, as seen in Figure 1 , the Behavioral Health Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders, and recognizes that prevention is part of an overall continuum of care. This model is based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report. The Behavioral Health Continuum of Care Model includes the following components:

- **Promotion**— These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention**—Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment**—These services are for people diagnosed with a substance use disorder.
- **Recovery**—These services support individuals' abilities to live productive lives in the community and can often help with abstinence.

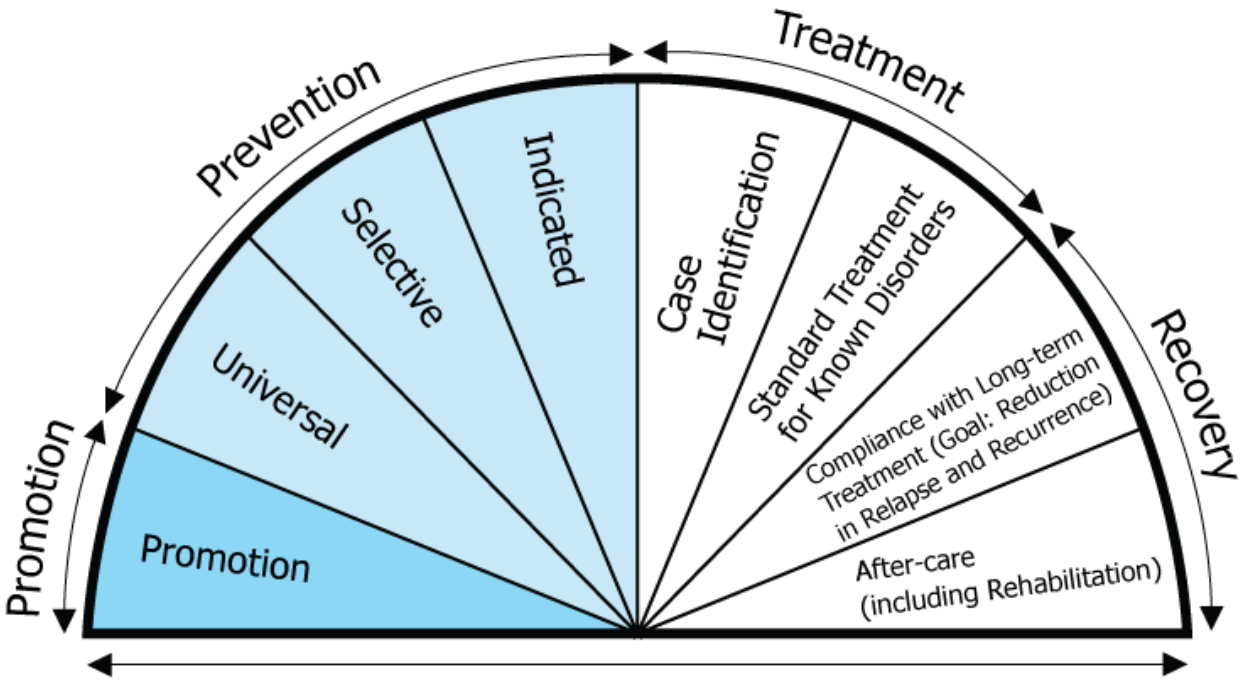



*Figure 4. The Substance Abuse and Mental Health Services Administration's Behavioral Health Continuum of Care Model.*

The second model that represents substance abuse treatment as a continuum of care is the American Society of Addiction Medicine (ASAM) model. (See Figure 5.) This model similarly conceptualizes behavioral healthcare along a spectrum and provides detailed steps of service levels within both outpatient and residential treatment settings. In this model, treatment is conceptualized by five broad levels of service, including an early intervention level.

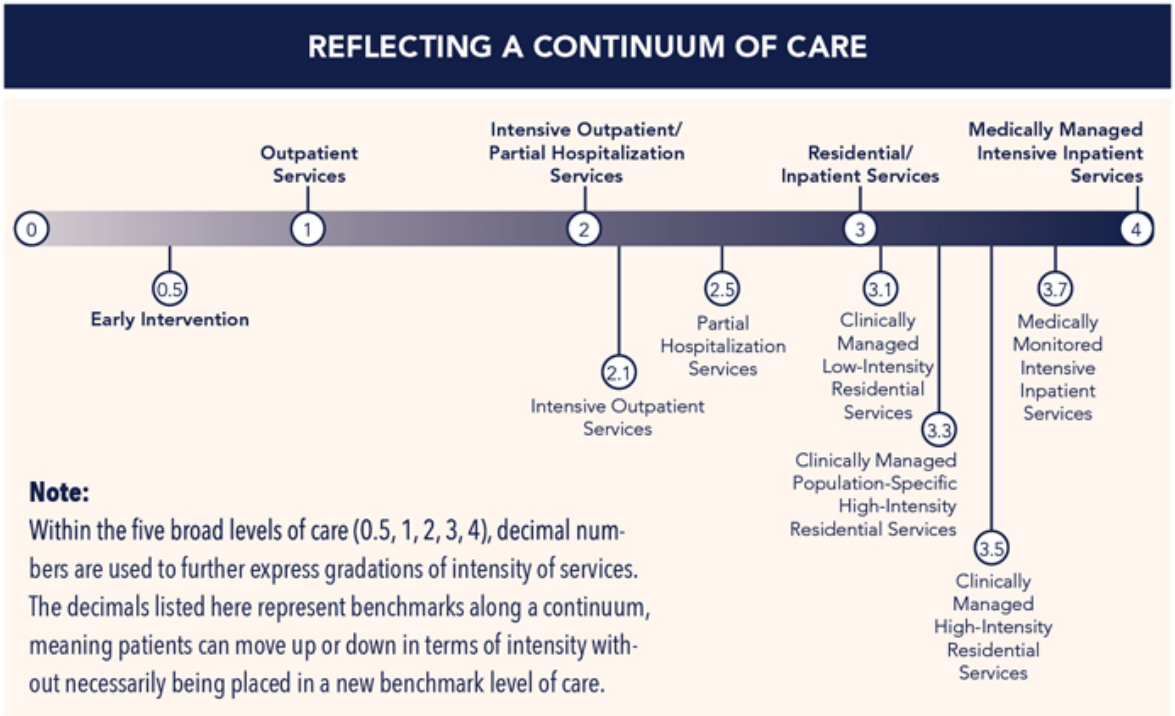



*Figure 5. The ASAM Level of Care Model*

For purposes of this feasibility study, the primary areas of interest from these two models are: 1) the *Treatment and Recovery* portion of the Behavioral Health Continuum of Care Model; and 2) the *Residential/Inpatient Services* section from the ASAM Level of Care Model.

## ASAM – American Society of Addiction Medicine

ASAM is a professional society representing over 3,000 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment; educating physicians, other medical professionals and the public; supporting research and prevention; and promoting the appropriate role of physicians in the care of patients with addictions.

## ASAM's Mission

- to increase access to and improve the quality of addiction treatment;
- to educate physicians (including medical and osteopathic students), other health care providers and the public;
- to support research and prevention;
- to promote the appropriate role of the physician in the care of patients with addiction;
- and to establish addiction medicine as a specialty recognized by professional organizations, governments, physicians, purchasers and consumers of health care services, and the general public.

## Residential Substance Abuse Treatment Facilities

According to the Centers for Medicare and Medicaid (CMS), a *Residential Substance Abuse Treatment Facility* is defined as a facility which provides SUD treatment to live-in residents who do not require acute medical care. Services generally include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. Residential treatment includes a structured, 24-hour environment with housing and meals, combined with intensive daily substance abuse treatment and recovery promotion. Participants are removed from their typical environment so that they can focus solely on becoming well and address root causes of their SUD. These root causes are complex, particularly for Native people .

Facilities offer a broad range of services and treatment lengths based on the needs of clients. Residential treatment programs typically last between 30 and 90 days.

Types and sub-types of services and setting are defined as follows:

- ☐ **Outpatient treatment**—Includes individual, family, and/or group services and may include medication-assisted therapies, including those with methadone and buprenorphine
- ☐ **Intensive outpatient treatment**—A minimum of 2 or more hours per day for 3 or more days per week
- ☐ **Short-term residential treatment**—Typically, 30 days or fewer of non-acute care in a setting with treatment services for substance abuse
- ☐ **Long-term residential treatment**—Typically, more than 30 days of non-acute care in a setting with treatment services for substance abuse; some include transitional living arrangements as a form of long-term residential treatment
- ☐ **Hospital residential treatment**—24-hour medical care in a hospital facility in conjunction with treatment services for substance abuse and dependence
- ☐ **Detoxification**— Three sub-types are discussed below. Each subtype may include medication assisted therapy.
    - Free-standing residential detoxification—24-hour per day services in a non-hospital setting providing for safe withdrawal and transition to ongoing treatment. In 2013, 82% of detox discharges involved free-standing residential detoxification facilities.
    - Hospital detoxification—24-hour per day acute medical care services in a hospital setting for persons with severe medical complications associated with withdrawal.
    - In 2013, 15% of detox discharges involved hospital detox facilities. Outpatient detoxification treatment services providing for safe withdrawal in an outpatient setting. In 2013, 3% of detox discharges involved outpatient detoxification facilities.

Residential facilities range in size and are regulated by federal and state law. There are large facilities with as many as 50 beds and small facilities that tend to have approximately 8 to 10 beds 3 . An important federal regulation regarding size of facility states that there can be no more than 16 beds "per facility" or unit/pod. (This is discussed in more detail in the *Regulations, Licensure, Certification, & Accreditation* section.)

As of February 2017, there were a total of 19,446 substance abuse treatment facilities in the U.S. Of these, 14,757 were state approved. In March 2017, 121 new facilities opened in the U.S. Of these, 72 are state approved. After deducting the number of facilities that closed from February to March of 2017, a net of 95 additional new facilities were opened.

## Recovery / Transitional Housing

Recovery or transitional housing facilities are group homes (hereafter referred to as recovery housing or recovery homes) which are often utilized upon completion of a residential program and include social support services. Frequently, support services within recovery homes are provided through peer support delivered by people who have experienced both SUD and recovery. Recovery homes are much less intensive and structured compared to residential care, yet aim to fill the needs of people in recovery, thus increasing their likelihood of remaining well. Peer support staff are discussed further in the *Challenges, Opportunities,* and *Keys to Success* section and the *Development Plan* and *Recommendations* section.

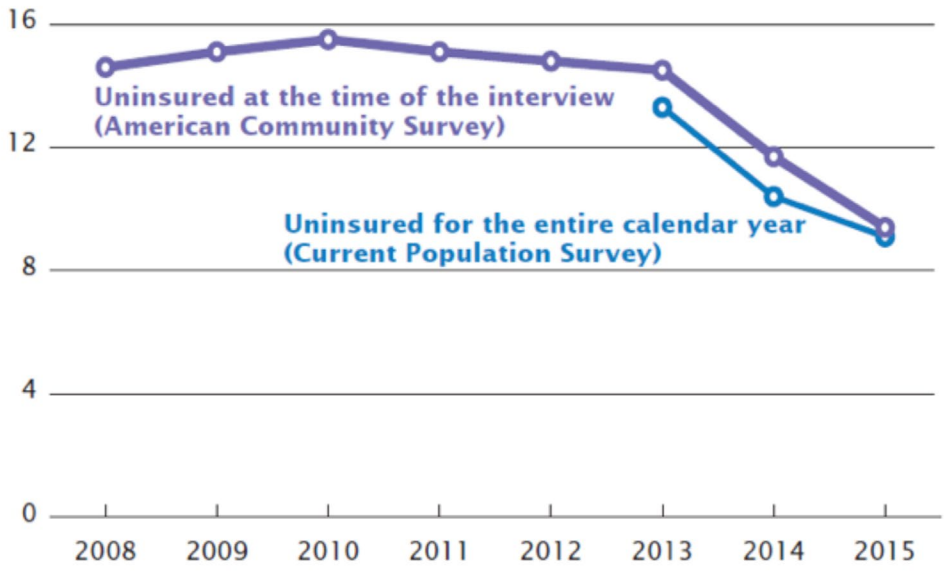
# Health Care and Treatment Access

This section provides a brief discussion of the current sociopolitical environment of health care and treatment access in the U.S. and the State of WA.

## Increased Access to Care

More individuals have gained and continue to gain access to health insurance coverage through the Affordable Care Act (ACA) of 2010. (Further discussion can be found in the *Challenges, Opportunities,* and *Keys to Success* section.) According to the U.S. Census Bureau, between 2008 and 2015 the uninsured rate decreased by 5% (from 14.6% to 9.4%; See Figure 6). This equates to 13.75 million individuals.

*Figure 6. U.S. Uninsured rate from 2008 to 2015.*

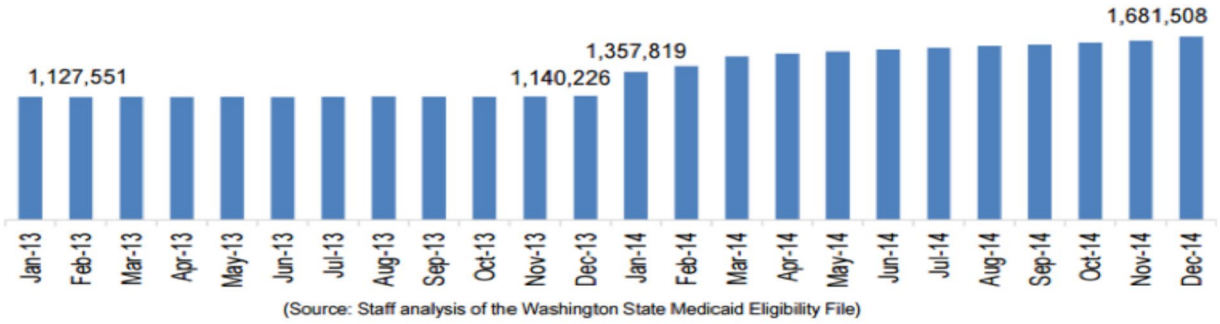



In some states, individuals with preexisting conditions, those within the working class, and poor adults without children now have access to health resources which were unattainable prior to the passage of the ACA. Moreover, the Indian Health Care Improvement Act was permanently reauthorized through the ACA, providing some stability in resources provided to tribes. Caution must be noted however, as Congress and the new administration continue to persist in their efforts to reverse at least some of the ACA statutes and provisions. Nevertheless, signs indicate that if Congress and the administration were successful in passing new legislation, the ACA "scale back" would not begin until at least 2019.

**State of Washington.** In 2014, in the State of WA, two main coverage provisions of the ACA were implemented. These were Medicaid expansion (i.e. expansion of coverage to eligible individuals under age 65 with incomes below 138% of the federal poverty level) and subsidized coverage for low income individuals (i.e. individuals with incomes at or above 138% of the federal poverty level but below 400% of the federal poverty level who can purchase insurance through the Health Benefits Exchange).

From 2013 to 2014, WA's uninsured rate declined from 14% to 8%. From January 2013 to December of 2014, Medicaid enrollment  grew by over 540,000 individuals, for a total of over 1.68 million (nearly a 50% increase over the enrollment at the end of 2013; See Figure 7).

*Figure 7. Medicaid Monthly Enrollment in WA from January 2013 to December 2014.*



(Source: Staff analysis of the Washington State Medicaid Eligibility File)

State of Washington-specific information is further discussed in the *Clients and Areas Served* section.

# *Clients and Areas Served*

Colville plans to serve adults who have been diagnosed with a substance use disorder (SUD) and classified as having a medical need for residential SUD services, as determined by the Tribe's Chemical Dependency unit or the state of WA's Behavioral Health Organization (BHO)[1]. We recommend that American Society of Addiction Medicine (ASAM) criteria be used to assess client needs. This is consistent with WA's *Access to Care Standards* for BHOs. Moreover, Colville's Chemical Dependency Department uses these criteria within their standards of practice already. ASAM criteria are discussed further in the *Regulations,  Licensure, Certification, & Accreditation* section.

1 A Behavioral Health Organization (BHO) is a single or multiple county authority or other entity operating as a prepaid health plan with which WA's Health Care Authority or its designee contracts for the delivery of community outpatient and inpatient mental health and SUD services in a defined geographic area. In March 2014, legislation mandated that the State's publicly funded mental health system (operated by the Regional Support Networks) and the county operated SUD program have been integrated in most counties. However, it is likely that the BHO system will be eliminated by the time the facility is live. ( https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/ACS_201602.0.pdf ; https://www.hca.wa.gov/assets/billersandproviders/Tribalhealthbi20170401.pdf )

*Figure 8. American Society of Addiction Medicine's Six Dimensions of Multidimensional Assessment*


## Substance Abuse Treatment Market

The U.S. substance abuse treatment market has been divided based on abuse type, treatment type, and enduser's segments. In terms of abuse type, segmentation categories can include alcohol dependence, tobacco/nicotine addiction, and opioid addiction. Based on treatment type, the market can be segmented into alcohol addiction treatment with or without drugs (e.g. Disulfiram, Acamprosate); tobacco/Nicotine addiction treatment with or without nicotine replacement treatment and non-nicotine medications; and drug abuse treatment segment with or without medication assistance (e.g. Methadone, Buprenorphine), as previously described. The enduser segment of the substance abuse treatment market is divided into outpatient treatment, residential treatment centers, and inpatient/hospitalization treatment centers.

In response to varied client markets, myriad treatment facilities and services exist across the U.S. and within the State of WA. Facilities and programs offer general and specialized services to clients in response to their treatment needs. Some facilities are considered more mainstream, providing generalized models of services, while others provide targeted services. For example, culturally specific or drug specific services may be offered to a narrow sub-population.

## Colville Client Markets

The Colville Residential Substance Abuse Treatment Facility intends to provide services to Colville citizens, other AIANs, and non-Tribal clients within 3 geographic market areas. Colville Recovery Supportive Housing intends to provide services to individuals within on or near the Colville reservation. In this feasibility plan, we have segmented the market by geographic region and demographics. Clients within 3 areas/ regions will be targeted for marketing, as will three groups of individuals based on demographics. The regions include: **On or near the Colville Reservation**, including Okanogan, Ferry, and Grant counties; the **State of Washington**; and the **U.S.** The market segments based on demographics include: **Colville citizens**, **AIAN's**, and **Non-Natives**. Figure 9 summarizes the market segmentation of the clients to be served by the Colville Residential Substance Abuse Treatment Facility.

*Figure 9. Market Segments to be Served by the Colville Residential Substance Abuse Treatment Center.*

| Geographic / Regional Market | Priority Demographic | Secondary Demographic |
|---|---|---|
| 1. On or near the Colville Reservation / 3 County Region | Colville Citizens* | Non-Colville citizens (AIANs & Non-Natives) |
| 2. State of Washington | AIANs | Non-AIANs |
| 3. United States | AIANs | Non-AIANs |

**Colville citizens also live outside of this region and will be prioritized as appropriate at each level of geographic market.*

***Geographic / Regional Market Segment 1: On or near the Colville Reservation and 3 County Region.*** Regional market segment 1 includes the Colville reservation and the counties of Okanogan, Ferry, and Grant. This area includes towns of Omak, Nespelem, Keller, Coulee Dam, Grand Coulee, Ephrata, Moses Lake, Chelan, Wenatchee, Elmer City, Twisp, Riverside, Conconully, Republic, and Quincy. (Figure 10.) The new facility location will be within this market area. The exact location will be decided in the near future and will be based on agreed criteria. Additional discussion on location criteria can be found in the Next Steps section. Market Segment 1 is discussed below under subsections: Colville Citizens, Okanogan County, Ferry County, Grant County.


*Figure 10. Geographic / Regional Market Segment 1: On or near the Colville Reservation and 3 County Region.*

## Colville Citizens and the Colville Reservation

About 50% of the approximately 9,365 Colville citizens live on or near the reservation or within Geographic / Regional Market Segment 1 . In many instances, Colville families are living below the national poverty standards year after year. Many depend on the Tribe's cash assistance, Temporary Assistance to Needy Families (TANF) services, and other safety net systems to survive. Just over a quarter of families (26.8%) on the Reservation live below the national poverty level. The average Colville Tribal TANF[2] monthly caseload is 302 families with a total of 362 adults. These adults are at higher risk for substance abuse, and therefore more likely to need residential treatment services.

Data from Colville's Chemical Dependency office suggests that about 70 Colville citizens are referred to residential substance abuse treatment per year. However, CBC members indicated that this estimate seems too low based on their observation and experience in the community. Another indicator of need for treatment is the number of individuals referred out from chemical dependency offices to residential substance abuse treatment. In 2016, 13 citizens of Colville were referred to just one of the many treatment facilities within the State of Washington.

Substance related criminal offenses are an additional indicator of a need for a treatment facility. In 2014, substance related criminal offenses accounted for 472 of the 1717 reportable criminal offenses on the Reservation. Community focus groups about crime on the Reservation were conducted by the Planning and Police Departments and revealed that "drugs" are the most common concern regarding crime on the reservation. Crime and violence are also discussed in the Background section.

## Okanogan County

Okanogan is the largest county in the state with a population density of 7.52 persons per square mile. According to the National Center for Health Statistics (NCHS), the population in Okanogan County as of 2015 is 41,516 – up from 41,347 in 2014. The median income in Okanogan County in 2015 was $41,426 compared to $63,439 for the state of WA. In 2015, the drug poisoning death rate is approximately 18.1 – 20 individuals per 100,000, compared to the Washington State rate of 14.7 per 100,000. This is up from 2014, when the rate was 16.1 – 18 individuals per 100,000. At that time, Okanogan had the lowest drug poisoning death rate of the Okanogan-Ferry-Grant tri-county area. The entire county is classified as a medically underserved area and medically underserved population.

## Ferry County

In Ferry County, the 2015 population is estimated at 7,582 with a population density of only 3.3 persons per square mile. The median income in Ferry County was $40,340 compared to $63,439 for the state of WA. In 2015, the drug poisoning death rate was approximately 28.130 persons per 100,000 – which is about 33% higher compared to 2010 estimates and about twice that compared to the State of WA in the same year. The age adjusted motor vehicle traffic-related death rate for Ferry County, WA is 35.7 per 100,000; whereas the rate for the U.S. is 19.2 per 100,000.

## Grant County

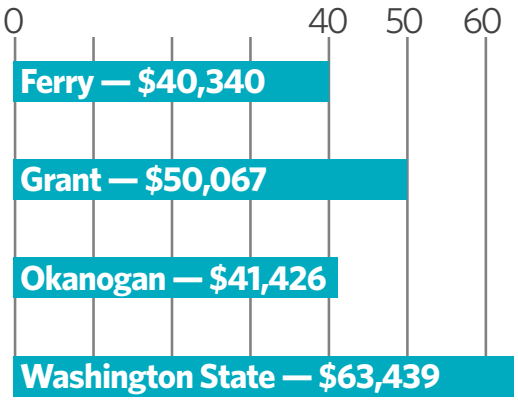
As of 2015, the population in Grant County was approximately 93,259 and the median income in Grant

2 Colville Tribal TANF serves "Native American families" in Okanogan, Ferry, Douglas, and Chelan Counties. A "Native American Family" is one in which at least one member of the family receiving assistance is a member of, or eligible for membership in a federally recognized Tribe. In Lincoln, Grant and Stevens counties Colville will serve Colville Tribal families only. A "Colville Tribal Family" is one in which at least one member of the family receiving assistance is an enrolled member of the Colville Tribes .

County was $50,067 – compared to $63,439. The 2015 drug poisoning death rate in Grant County was 18.12 per 100,000 persons which is the same rate since 2013. This is compared to the state of WA rate of 14.7 per 100,000 in 2015. In 2012, the drug poisoning death rate in Grant County was about 16.12 deaths per 100,000. The rate of violent crime for Grant County, WA is 299.4 per 100,000; whereas, in the U.S. it is 199.

As is evident aabove, Ferry, Grant, and Okanogan counties experience greater poverty (See Figure 11.) and increased substance abuse rates in comparison with state averages. In combination with rurality and limited social service availability, significant health disparities are evident. In 2015, the number of adults across all three counties was 26,762.  No-premium Medicaid is available to the aged, blind, and disabled, as well as adults with incomes up to 138% of the federal poverty level, pregnant women with incomes up to 185% of the federal poverty level, and children with household incomes up to 200% of the federal poverty level. Children with household incomes between 200-300% of the federal poverty level are eligible for Medicaid with a premium. (See Figure 12.)

*Figure 11. Median Income of Okanogan, Ferry, & Grant Counties and the State of WA, 2015*




Source: Washington Office of Financial Management

*Figure 12. Medicaid Eligibility Income Limits in the State of WA[3].*

Effective April 1, 2017

| Apple Health for Adults Eligibility | |
|---|---|
| Household Size | Monthly Income Limit |
| 1 | $1,337 |
| 2 | $1,800 |
| 3 | $2,263 |
| 4 | $2,829 |
| 5 | $3,310 |
| 6 | $3,790 |

***Geographic / Regional Market Segment 2: Washington State.*** Regional market segment 2 is the State of Washington. The State of Washington has approximately 580 certified chemical dependency treatment agencies. In rural Eastern Washington Counties, there are few. For example, in Okanogan, Ferry, Pend Oreille, Douglas, Grant, Stevens, and Lincoln counties there are zero. Because the Reservation is generally

3 Exceptions to income limits for AIANs can be found at http://www.aihc-wa.com/files/2013/10/AIHC-AI-AN-Income-Exemptions-for-Medicaid-MAGI-Determinations-7-31-14.pdf

located across Okanogan, Ferry, and Stevens counties, this means there are no residential substance abuse treatment facilities exist within the same counties as the reservation and few in neighboring counties. The closest county with adult treatment facilities is Spokane which has six adult residential substance abuse treatment facilities. The next closest county with an adult facility is Chelan with one facility. (See Figure 13.)

*Figure 13. Sites of Adult Residential Substance Abuse Treatment Facilities within 150-mile Radius and within the State of WA.*


*Sites of adult inpatient substance abuse treatment facilities within 150-mile radius, in State of WA*

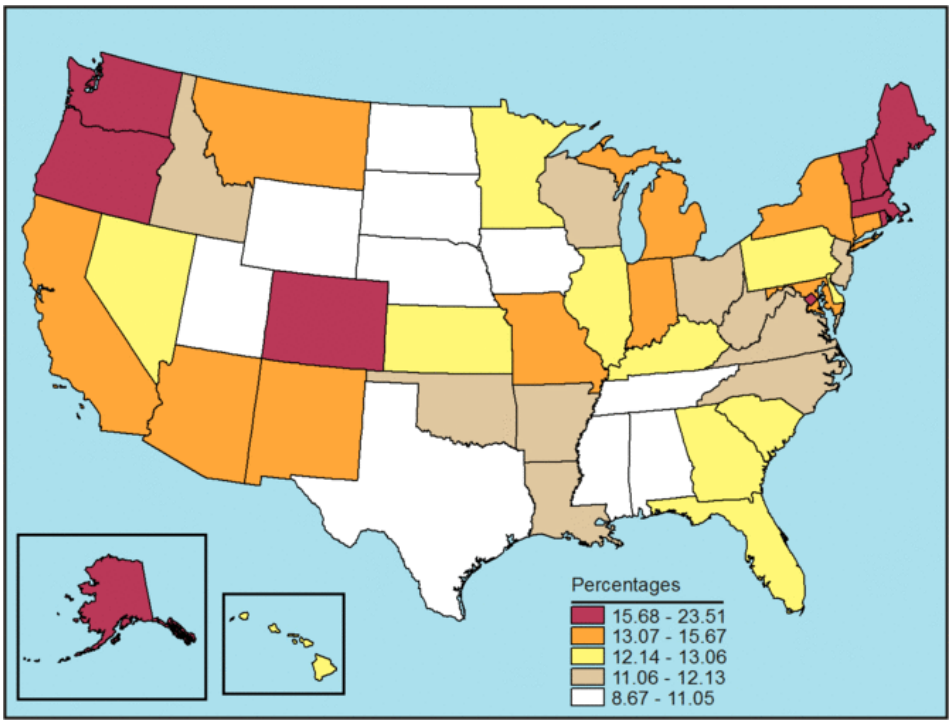
Washington Apple Health is the Medicaid program in Washington State. As of June 2016, adults age 19 to 65 in Washington State generally qualified for "expanded" Medicaid under the Affordable Care Act if their income was at or below 133% of the federal poverty level. As of April 2017, adults with incomes up to 138% of the federal poverty level can qualify for coverage. Enrollment in Apple Health has increased by 62% since the expansion of Medicaid and the opening of the Health Insurance Marketplaces. As of December, 2016 there are over 1.8 million Washingtonians enrolled in Apple Health.

Market Segment 2 is discussed further under sub-sections: Washington AIANs and Washingtonians below.

***Washington AIAN's.*** In Washington state, trends of substance abuse and related outcomes are similar to national AIAN trends. AIANs have higher rates of drug and alcohol related hospitalization and death than whites, and 46% of AIAN men in Washington reported binge drinking in the past month. Approximately one in five AIAN adults in the state report living with someone during their childhood who abused drugs. In years 2013- 2015 approximately 9% - 11% (9.1% - 10.9%) of individuals who entered treatment in the State of WA were AIAN. This compares to 1.9% of the State's population that identifies as AIAN (single race only); suggesting that there is a major disparity in substance abuse and need for treatment among AIANs in the State of WA. Moreover, in 2010, the Northwest Portland Area Indian Health Board pointed to the critical need for substance abuse recovery and transitional programs in the Northwest.

***Washingtonians.*** The estimated rates of substance abuse among Washingtonians are represented in the following maps[4]. In the first map (Figure 14.), one can see that the state of WA ranks in the top 20% of all states in terms of past year marijuana use among adults 26 years and older. Between 15.7% and 23.5% of adults ages 26 or older reported marijuana use in the past year.

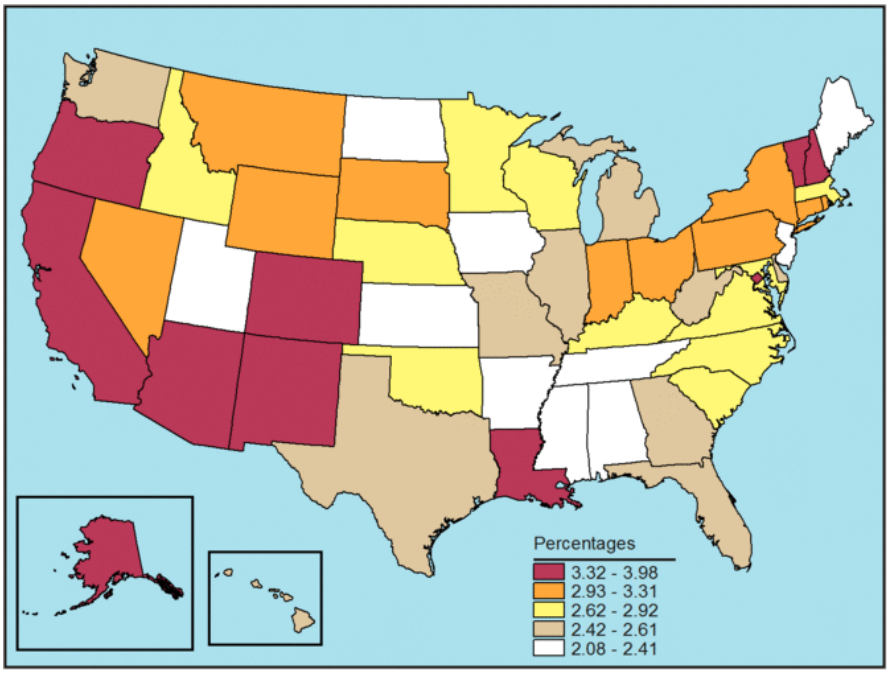
*Figure 14. Percent of Adults Aged 26 or Older, Past Year Marijuana Use by State (2014 – 2015).*




In measures of alcohol dependence, heroin use, and cocaine use, Washington ranks somewhere in the middle of the spectrum of past year substance dependence and use compared with other states. Washington ranks in the lowest 40% of states in terms of adults reporting alcohol dependence in the last year (Figure 15), with less than approximately 2.4% to 2.6% of adults 26 and older reporting alcohol dependence within the past year.

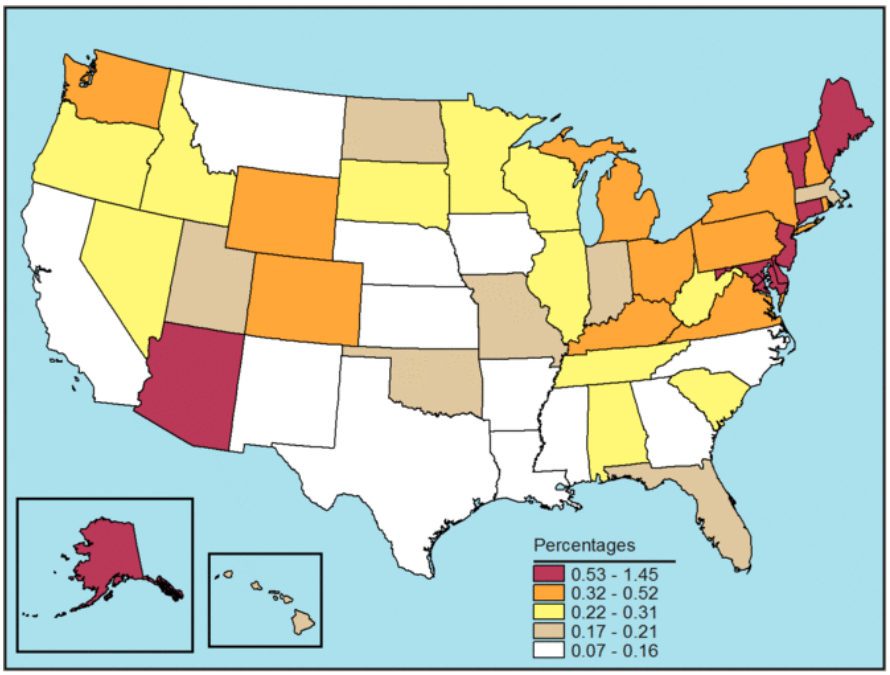
4 The color of each state on the maps indicate how the state ranks relative to other states. States fall into one of five quintile groups according to their ranking. States with the highest rates for a given measure are in red, while those with the lowest estimates are in white. The upper and lower limits of each quintile shown in the map legend collectively define a continuum and are not necessarily the actual values of a state.

*Figure 15. Percent of Adults Aged 26 or Older, Past Year Alcohol Dependence by State (2014 – 2015).*



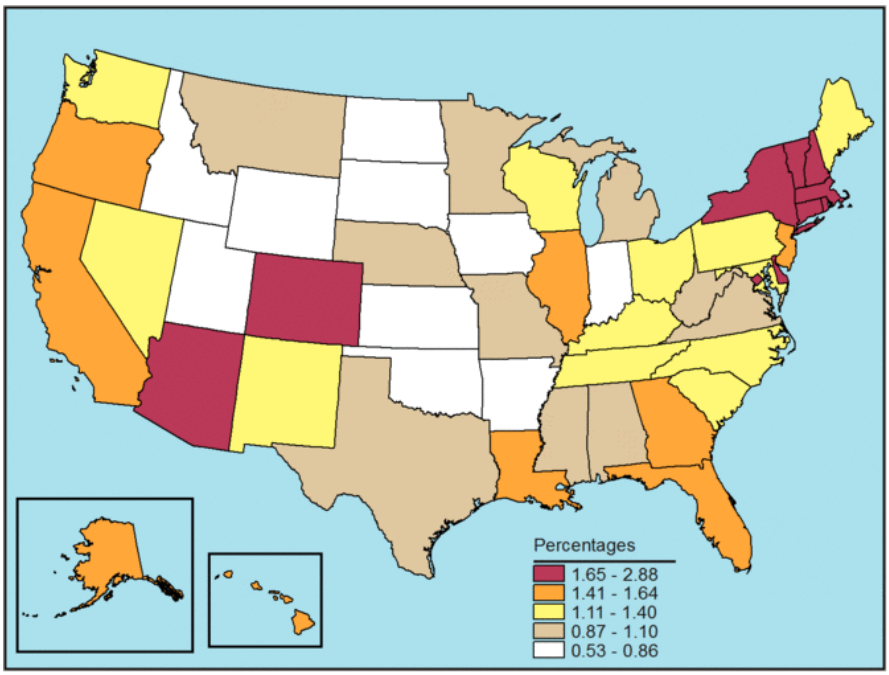

Washington is in the top 40% of all states in terms of past year heroin use (Figure 16). One third to one half of 1% of Washington adults 26 and older reported past year heroin use.

*Figure 16 . Percent of Adults Aged 26 or Older, Past Year Heroin Use by State (2014 – 2015).*




Regarding past year cocaine use, Washingtonians report past year use at a rate that is about average for the country. About 1.1% to 1.4%, of the state's adult population reported past year cocaine use. (Figure 17.)

*Figure 17. Percent of Adults Aged 26 or Older, Past Year Cocaine Use by State (2014 – 2015).*




***Geographic / Regional Market Segment 3: United States.*** Nationally, in 2014, 90.5% of individuals who were treated for substance abuse were 18 year of age or older. About two-thirds of these individuals were male (66.4%) and about one-third were female (33.6%). Most of those who were treated for substance abuse were seen in an outpatient setting (59.7%). About 80% (79.7%) of those who entered treatment had at least one prior treatment episode. Treatment episodes are defined as admissions to public or private substance abuse treatment programs. In 2015, the percentage of people identified as needing substance use treatment was highest among the young adult population - aged 18 to 25. Approximately 1 in 6 young adults, and 1 in 14 adults aged 26 and over were classified to be in need of treatment.

*In 2014, 2.7% of those who entered treatment in the U.S. identified as AIAN (single race only). This is more than twice the percentage (1.2%) of self-reported AIANs (single race only), suggesting a significant disparity in substance abse and need for treatments services.*

Alcohol was the primary substance problem for 36% (36.2%) of those entering treatment and 20% (20.3%) reported only alcohol as a problem substance. Heroin was the primary substance problem for 22% (22.1%) of those entering treatment. Eight percent (8.4%) of those entering treatment named methamphetamines as their primary substance problem. Similarly, 8% (7.9%) listed other opiates, such as those prescribed for pain, as their primary substance problem. About half (46.5%) of those entering treatment reported that only non-alcohol drugs were a problem substance. More than one third (31.6%) reported that alcohol and other drugs were their problem substances. About one-quarter (25.8%) of persons entering treatment began use of their primary substance at age 14 or under and about the same rate of persons had a psychiatric problem in addition to a substance use diagnosis (25.9%)[5].

5 These data were derived from the Treatment Episode Data Set ( TEDSA). Data are regarding treatment admissions to state licensed or certified substance abuse treatment centers that receive public funding; this includes some IHS facilities.

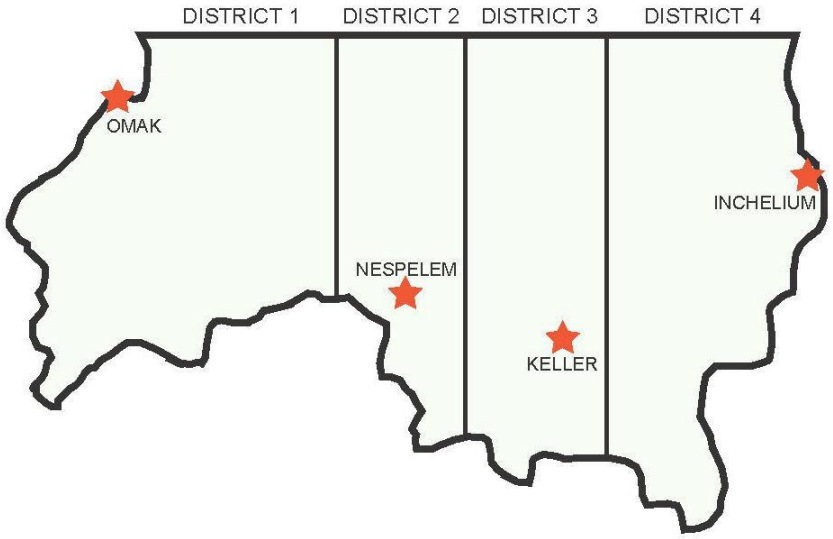
The Colville Reservation has made steady progress in providing healthcare to its members. Throughout its history, many roadblocks, issues, and restraints have existed; however, the Confederated Tribes have steadily addressed issues by providing quality healthcare by utilizing their own resources to make consistent progress. The Tribes' provide health services in several different ways, and service expansions have occurred when needs and resources align. Distances and geography on and around the Reservation have always played a role in the planning process for new services and facilities. These services are reviewed here as they are integral to the success of the proposed residential treatment center.

# Health Services

The current health care system on the Colville Reservation can be divided into three general categories: those managed by the Lake Roosevelt Community Health Center (LRCHC) and under tribal control, the Indian Health Services (IHS) clinics, and other segments of the health care delivery system that are tribally run through 638 contracting. Substance abuse and mental health services are generally delivered through tribal self-management.

The four health clinics within the Colville Reservation are represented in Figure 18.

*Figure 18. Health Clinics on the Colville Reservation.*




***Lake Roosevelt Community Health Center.*** The Lake Roosevelt Community Health Centers (LRCHC) is a tribally owned entity that operates two community health clinics on the eastern side of the Reservation; one in Inchelium and one in Keller.

*The mission of the Lake Roosevelt Community Health Centers is: To provide reponsive high-quality healthcare services to meet the needs of our communities in a non-discriminatory, confidential, compassionate and professional atmosphere*

Native and non-Native patients and those living on and off the Reservation are served at the LRCHC clinics which are in Ferry County. (See section *Clients and Areas Served for more on Ferry County*.) The clinics receive funding and Section 330 Community Health Center funding. Comprehensive programs and services are provided at these facilities and include the following: medical, dental, lab, radiology, optometry, pharmacy, and physical therapy. Additional details are presented in Figure 19.

*Figure 19. Services Provided at Lake Roosevelt Community Health Centers.*

**Inchelium Community Health Center**

- Primary Health Care
- Dental
- Pharmacy
- Optometry
- Laboratory
- X-Ray
- OB/GYN Services
- Cardiology Services
- Physical Therapy
- Referral Services
- Outreach Services

**San Poil Valley Community Health Center**

- Primary Health Care
- Dental
- Pharmacy
- Laboratory
- X-Ray

***Indian Health Services.*** IHS runs clinics in Nespelem and Omak it is the main operating division responsible for providing public health and direct medical services to members of federally recognized Tribes.

IHS provides behavioral health, medical, nursing, laboratory, radiology, dental, optometry, pharmacy, referred care, and health administration services are provided for Colville Reservation residents.

*Colville is currently in planning stages to build a new health care facility in Omak. The exact site is yet to be determined. This new clinic is expected to be a 638 clinic with tribal self-management of services. It will include a medical clinic, dental clinic, mental health, imaging, administrative space, physical and occupational therapy, lab, pharmacy, optical and community space.*

***Colville Chemical Dependency.*** Presently, substance abuse treatment on the Colville Reservation involves the Chemical Dependency unit housed within the Health and Human Services Department. The unit staff provide assessment, referral, case management, and monitoring services to tribal citizens who are referred to them through tribal health services, the Tribal Justice Department, and self-referral. Currently, no residential substance abuse treatment services are available on the Reservation. The Tribes refer clients to residential treatment services at several facilities in Washington and Northern Oregon.

According to the Chemical Dependency Unit staff, they preffer to send referrals to the following off-reservation residential treatment centers. Staff provided the reasons they preferred to send individuals to those facilities:

- ☐ Northwest Indian Treatment Center in Elma, WA
    - o Offers culturallycentered substance abuse
    - o Offers mental health treatment services through a 45-day inpatient program
- ☐ Native American Rehabilitation Association in Portland, OR
    - o Offers a holistic treatment program that aims to treat the whole family
- ☐ The Healing Lodge of the Seven Nations in Spokane, WA
    - o Offers inpatient treatment for youth ages 13-17
- ☐ Evergreen Manor in Everett, WA
    - o Offers treatment services to pregnant and parenting women
- ☐ Daybreak Star in Seattle, WA
    - o Offers services to youth with a flight risk.

The following facilities were also named as locations that staff refer to; however, reasons for referral to these institutions were not provided.

- ☐ Seadrunar: Seattle Drug & Narcotic Treatment Center in Seattle, WA
- ☐ Pioneer Center East in Spokane, WA & Pioneer Center North, in Sedro Woolley
- ☐ Sundown M Ranch in Selah, WA
- ☐ Sunray Court in Spokane, WA

New residential treatment and recovery facilities on the Colville Reservation would significantly augment the existing programs that are already in place around the region, and provide treatment and recovery opportunities closer to home.

# *Justice Department*

The Administrators of the Tribal Court, Colville Tribal Police Department (CTPD), and the Prosecutor's Office have programs that share the responsibility to meet the safety and justice needs of the Reservation. The programs collaborate on case-by-case short-term levels, as well as, long-term efforts, and planning goals to meet specific and pressing needs. The Justice Department often has a direct role in referring patients for SUD treatment, often as part of an alternative sentencing program.

Efforts include the CED's Community Economic Development Strategies, the Tribal DOT Traffic Safety Plan, the 2013 Health Needs Assessment, the FEMA Threats and Hazard Identification and Risk Assessment (THIRA), and the incomplete Tribal Planning Comprehensive Plan, which does not include planning for Tribal Court, Law Enforcement, Corrections, Emergency or Fire Services, Prosecutor's Office, or the Public Defender's Office. While these references touch on problems shared with the Tribal Justice Programs (e.g. poverty, behavioral health) they do not provide strategies for creating Tribal Justice-involved solutions.

# *Planning Department*

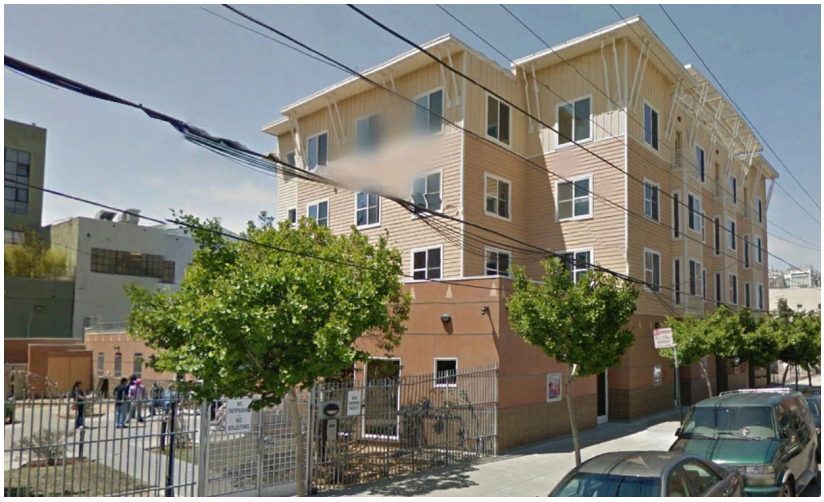
The Planning Department provides comprehensive planning for the Tribes and "addresses a myriad of issues within the Reservation; the development of a Comprehensive Plan, Community and Economic Development Strategies (CEDS), land use regulation (i.e., permitting and zoning), facilitates the work of the Colville Tribe's Land Use Review Board (LURB), works with other tribal departments to develop federal, state and local grant proposals, as well as conducts advanced level research into health issues as a part of a NARCH research grant, "according the department's website." The Department will be key to the successful development of new treatment and recovery facilities, to determine sites for construction, integrating the facilities into the planning of the host communities, and determining funding sources.

The Department employs 14 positions including one Director, one Administrative Assistant, two Office Assistants, one Research Coordinator, one Research Assistant, one Data Assistant, one Grant Writer III, one Grant Development Specialist, one Grant Development Assistant, two Senior Planners, Two Associate Planners, one Shoreline and Land Use Administrator, and one Code Enforcement Officer.

The case studies were selected with input from Colville staff and analyzed by the team. This informed potential staffing, budgeting, and programs for the new Colville treatment facilities. This process also helps to understand client needs and demand for services. These examples were also presented and discussed with tribal staff and leadership as part of the information gathering process. Figure 20 is a map of the facilities represented in this report.

*Figure 20. Map of Case Studies.*

## *1. Friendship House, Association of American Indians, INC, 2005*

**Location:** San Francisco, CA

**Location Type:** Urban

**Service Population:**
Targeted to the American Indian community, and 85% of clients are American Indian. Clients come from across the nation, including the Bay Area and the Navajo Nation. 45% of Native clients are from California tribes, and 27% are Navajo. Alcohol and amphetamine use are the most commonly reported substances of choice.

**Length of Stay:**
Short term & Long term Residential
Separate Residential Program for women with children 0-5yrs.

**Project Info:**
80 Bed Facility
150-165 Clients per year.
4 Story
17,000 SF

**Faculty Status:**
Accreditations: AAAHC, CARF

**Annual Operating Budget:**
$5 Million annual operational budget.

**Operation:**
65 Full time Staff
50%60%
Successful Completion Rate

## *2. Healing Lodge of the 7 Nations, Indian Health Services in WA, 1996*


**Location:** Spokane Valley, WA

**Location Type:** Rural

**Service Population:**
Targeted to the American Indian community and non-native
Youth: Males and Females 13-17

**Length of Stay:**
Short term 90-120 day intensive In-patient treatment program
Separate Residential Program for women with children 0-5yrs.

**Project Info:**
45 Bed Facility
150-165 Clients per year.
3 Story
26,856 SF

**Accreditations:** AAAHC, CARF

**Annual Operating Budget:**
$5 Million annual operational budget.

**Operated by:**
IHS in WA
The Colville Confederated Tribes
The Spokane Tribe of Indians
The Kalispel Tribe of Indians
The Kootenai Tribe of Idaho
The Coeur d'Alene
The Nez Perce Tribe
The Confederated Tribes of the Umatilla

**Successful Completion Rate:** 50%-60%

**Operational Cost:**
$3,600 (30 days)

## *3. Patina Wellness Center, Native American Connections, 2016*

**Location:** Phoenix, AZ

**Location Type:** Urban

**Service Population:**
Men & Women
Pregnant, post-partum, & parents with children

**Length of Stay:**
Residential short term - 45 days
Long-term residential
Accepts clients on opioid medication

**Treatment Approaches:**
Cognitive/behavioral therapy
Dialectical behavioral therapy
Substance abuse counseling approach
Trauma- related counseling
Rational emotive behavioral therapy

**Ancillary Services:**
Individual counseling
Group, Family, & Marital/couples counseling
12-step facilitation
Brief intervention
Contingency
Management/ motivational incentive
Anger management
Relapse prevention

**Accredidations/ Licensures:**
AZ Dept. of Health Services

**Operated by:**
IHS in WA
The Colville Confederated Tribes
The Spokane Tribe of Indians
The Kalispel Tribe of Indians
The Kootenai Tribe of Idaho
The Coeur d'Alene
The Nez Perce Tribe
The Confederated Tribes of the Umatilla

| **Program Area:** | SQ FT. |
|---|---|
| Activity Space | 1575 |
| Administration | 5504 |
| Counseling | 1988 |
| Daycare | 1129 |
| Food Services | 2155 |
| Independent Living | 2100 |
| N Residential Units | 8570 |
| S Residential Units | 8572 |
| Supportive Services | 1633 |
| **Total SQ FT:** | 37,406 |

# *4. Healing Lodge of the 7 Nations, Indian Health Services in WA, 1996*


**Location:** Elma, WA
**Location Type:** Rural Town

**Service Population:**
Men and Women
Primarily Native American population from Washington, Oregon and Idaho.

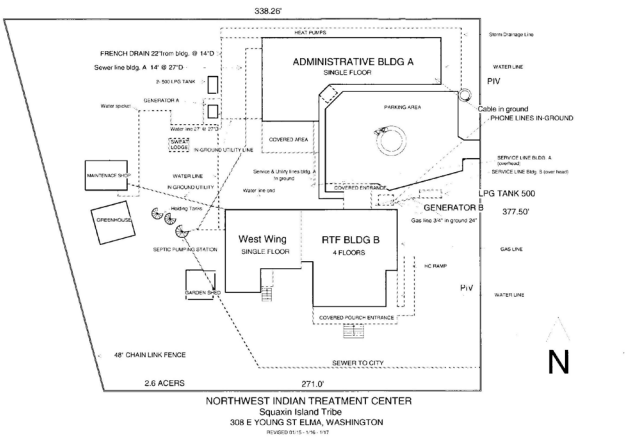
**Length of Stay:**
Short term - 45 days residential treatment program
Separate Residential Program for women with children 0-5yrs.

**Project Info:**
28 Bed Facility
61 Annual Clients
3 Story
37,406SF

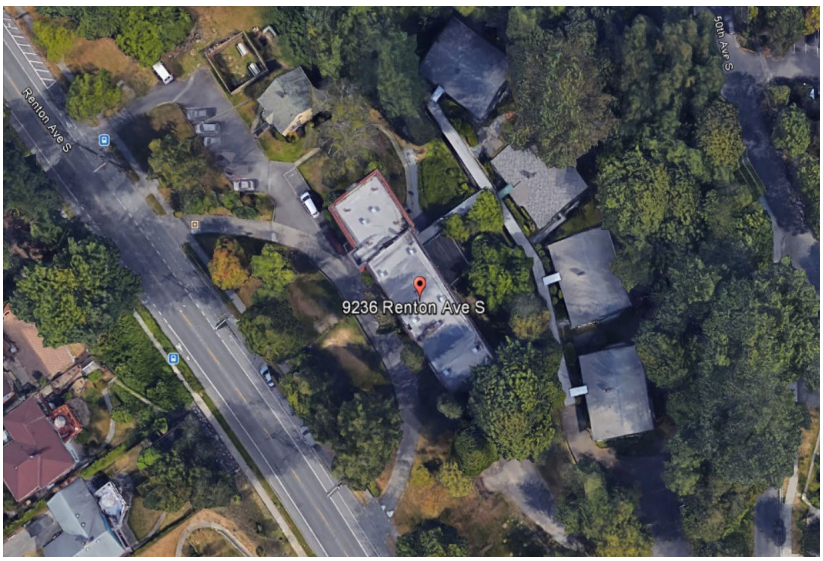
**Faculty Status:**
Director (1), Lead Counselor (1)
Counseelor (5), Nurse (1),
Intake Coordinator, Office Assistant,
Billing, Psychologist 1 time/mo, Psychiatrist 2 times/year for review.
Psychiatric NP 1 time/week.

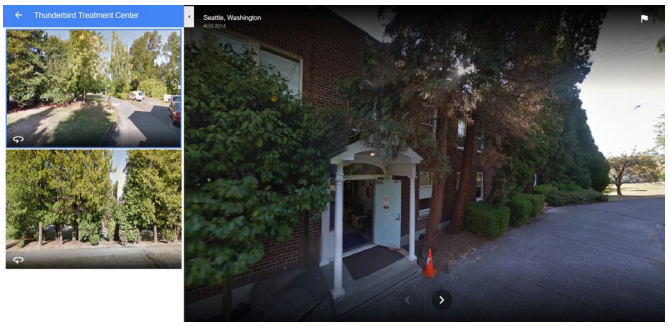
**Accreditations:** CARF

**Daily Cost:** $165
**Operation:** 60% Success Rate



## *5. Thunderbird Treatment Center, Seattle Indian Health Board, 1970*




**Location:** Renton, WA

**Location Type:** Urban

**Service Population:**
Men & Women Adults,
Serve Seattle area in general & statewide for Native clients,
Targeted treatment to meet the needs of American Indian and Alaska Native clients.
Expanding services for those with opioid-dependence.

**Length of Stay:**
Short Term - <30 days residential treatment program
Long Term - >30 days
Separate Residential Program
for women with children 0-5yrs.

**Project Info:**
65 Bed Facility
Annual Clients
2 Story
16,410 SF

**Accreditations:** AAAHC

In addition to the case studies, we conducted telephone interviews with tribal behavioral health leaders from the region. With the goal of gauging treatment referrals that occur throughout diverse parts of the inland and the Pacific Northwest, we interviewed a Puget Sound Area Tribal behavioral health clinic administrator and a Tribal Behavioral Health Director in Eastern Washington. Both administrators asked that tribal specific information not be shared.

***Puget Sound Area -*** The most common substances involved in treatment referrals in the region are alcohol, heroin/opiates, and meth. This clinic is currently referring clients for residential treatment to the following centers:

- ☐ Northwest Indian Treatment Center, Elma, WA*
- ☐ Thunderbird Treatment Center, Seattle, WA*
- ☐ Drug Abuse Prevention Center, Longview, WA
- ☐ Northwest Resources Inc., Shelton, WA

From this conversation, we learned that these centers are usually at capacity, but are generally able to accept new referrals quickly due to no-shows and other last minute changes. This administrator stated that Coastal tribes would be willing to send clients to Eastern WA if a new tribally-run facility were available. However, it was noted in this conversation that transportation would be a barrier. Currently, clients' families or behavioral health program staff transport clients to treatment after being referred from this particular tribal clinic.

***Eastern Region -*** The behavioral health director from one of the Eastern Region tribes informed us that 23 individuals attended inpatient treatment in fiscal year 2016, not including individuals sent to detox for whom data is not recorded. A stated problem was that individuals leave treatment before completing the recommended amount of care. Price and waiting lists were also mentioned as barriers.

# *Regulations, Licensure, Certification, & Accreditation*

Quality of care is associated with accreditation, licensure, and certification status. Generally in the U.S., health facilities are required to hold at least a license and often required or encouraged to acquire certifications and/or accreditations, each involving their own complex set of processes, standards, and policies to follow with different governing bodies as overseers. A comprehensive discussion of all aspects of accreditation, licensure, and certification is beyond the scope of this document; however, some key considerations that are relevant to early planning stages of the residential substance abuse treatment facility are provided here.

In the state of WA, the licensure process involves working with the Department of Health and the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR). This is to ensure that the facility and its employees are compliant with state laws. For newly proposed facilities, the applicant submits an application and fee to the Department of Health before receiving written authorization by the department to proceed with construction. A written function program outlining service categories (discussed later in this section), types of residents to be served, and how client needs will be met through program goals, staffing and healthcare; infection control; security and safety; seclusion and restraint; laundry; food and nutrition; and medication. The "initial license" application also includes submission of evidence of a variety of tasks that are found in WA Administrative Code (WAC) WAC 246337010. Occasionally exemptions to rules may be approved.

To acquire approval for the initial license, the Department of Health and the fire marshal are required to inspect facilities as part of the annual renewal of licensure. Inspections are unannounced and inspectors assess for patient safety risks. As with most facility inspections of this kind, administrators are provided with a report indicating if standards were met and if any deficiencies were identified. If deficiencies are found, the inspection team works with the facility to help addressing the deficiencies.

A licensee may provide services under a single state license for one or more of several service categories or may request separate licenses for different service categories. For example, a facility could be licensed as a chemical dependency acute detoxification facility and a mental health inpatient evaluation and treatment facility. A partial list of state recognized service categories includes: chemical dependency intensive inpatient; chemical dependency long-term treatment; chemical dependency recovery house; mental health adult residential treatment (includes crisis services for twenty-four hours or more); and mental health inpatient evaluation and treatment.

## Long-term residential treatment services

The state requires program-specific certification through the DBHR, as is the case for long-term residential treatment services. To gain certification, treatment service programs must provide each client with a minimum of two hours each week of individual or group counseling; a minimum of two hours each week of education regarding addiction; document progress notes in a timely manner; provide each individual with education on social and coping skills; offer social and recreational activities, assistance in seeking employment and with re-entry living skills including seeking and obtaining safe housing and conducting individual service plan reviews. By way of the state's DBHR, treatment facilities can expect to be:

- ☐ Surveyed onsite within 12 months of initial approval and every 3 years.
- ☐ In compliance with regulations.
- ☐ Evaluated rapidly when complaints are received.

It is necessary that Colville gain state approval (licensed and certified) to be recognized as a Residential Substance Abuse Treatment Facility in WA (Although there may be a rare tribe in the state that does not have licensure from the state, this tribe would not be eligible to receive CMS reimbursement; only IHS funds.) State level approvals should be thought of as the minimum set of standards for care. We suggest that Colville extend beyond this level of licensure and certification to seek accreditation from one of two national accreditation bodies: The Joint Commission (formerly: Joint Commission on the Accreditation of Healthcare Organizations or JCAHO) or Commission on the Accreditation of Rehabilitation Facilities (CARF). Although it is advised that accreditation be gained in year 3 of service delivery, it is important that this goal be built into early planning phases, as facility practices, policies, and standards need to be thought out clearly and well in advance of applying for accreditation. This will maximize speed for getting programming up and running while at the same time, provide wise and efficient foundational practices[6].

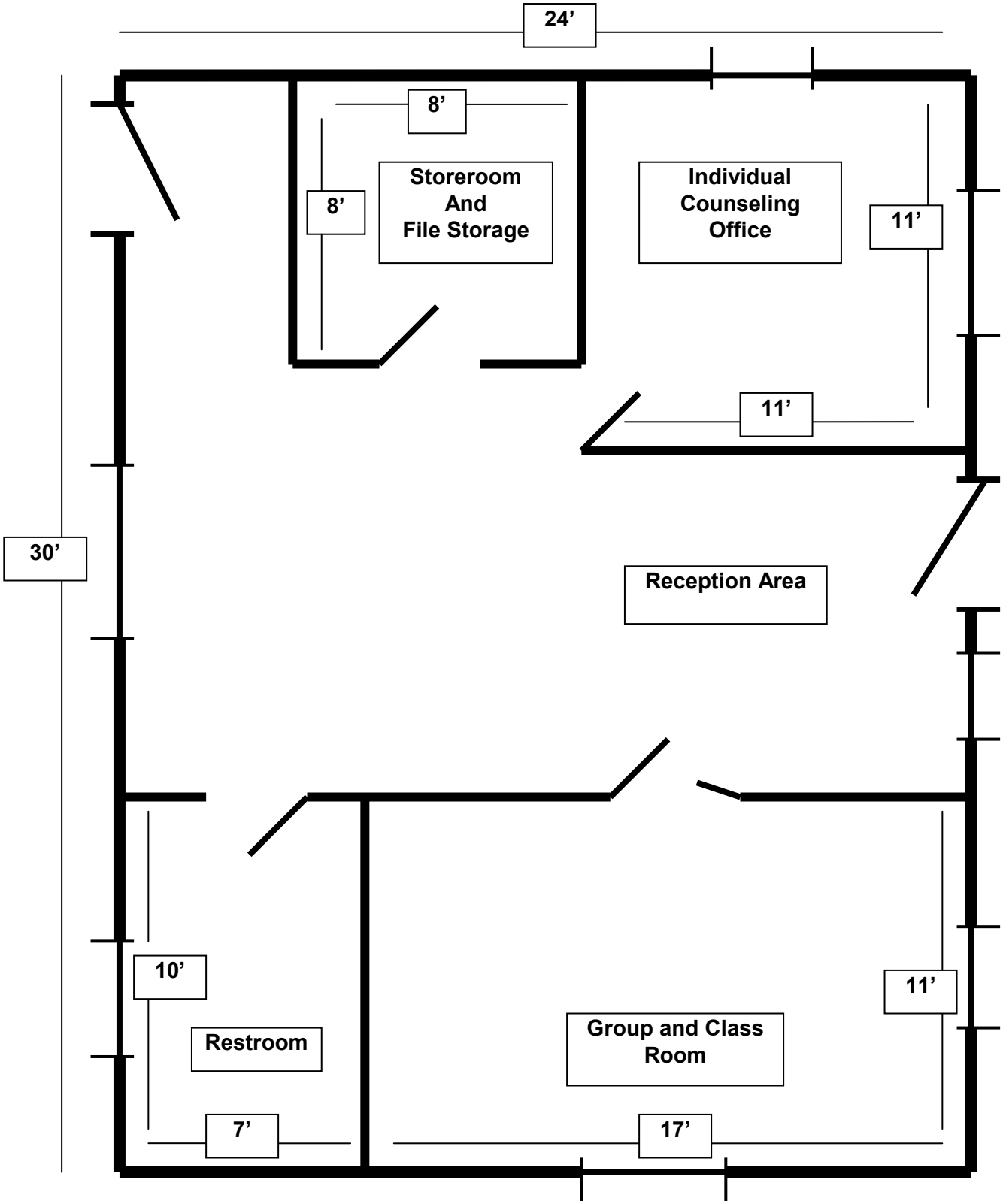
The state licensing requirements include approval of plans during the design process to ensure that the plans meet the standards required for licensure (See Fig. 21)

6 Neither the Commission nor CARF readily share their accreditation requirements publicly. A fee is required to gain access to detailed information on accreditation from these bodies.

*Figure 21. Sample of plan submittal required for licensure.*

# SAMPLE OF FLOOR PLAN

## TO BE SUBMITTED WITH AGENCY RELOCATION APPROVAL REQUEST FORM OR INITIAL LICENSURE AND BRANCH APPLICATIONS



# American Society of Addiction Medicine (ASAM) Criteria

As previously mentioned in section *Clients and Areas Served*, use of ASAM criteria are currently required by the state of WA. ASAM standards guide behavioral health assessments, intakes and continuing stay authorizations; and aid in determining who is in need of medically necessary treatment. In WA, this translates into eligibility for BHO services. (Non-Native individuals enrolled in Medicaid who are in need of residential SUD services are served through this system; however, BHOs may not be in effect at the time the facility is opened. (See the Challenges, Opportunities, and Keys to Success section for additional information.)

In order for a client to receive treatment services, the following criteria must be followed:

1. The individual has a SUD as determined by a Chemical Dependency Professional (CDP), or a Chemical Dependency Professional Trainee (CDPT) under the supervision of a CDP, in a face-to-face assessment in accordance with WAC 388-877 and 388-877B. The diagnosis must be included in the list of SUD Covered Diagnoses.

2. Using the ASAM Criteria, a multidimensional assessment of the individual's risk, impairment, and needs must be documented.

3. Additional medical necessity criteria are included in ASAM criteria.

*Figure 22. ASAM Framework.*
*www.asam.org/images*


Again, the Colville Chemical Dependency Unit is already utilizing ASAM criteria.

## Regulations on Size of Institution

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in treatment facilities that are larger than 16 beds. This requirement has led larger facilities to create separate residential wings with no more than 16 beds. The exclusion is one of a few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD.

## Medication Management Regulations

Regulations for medication management at Washington State residential treatment facilities are set forth in WAC 246337105. Dispensing of prescription medications from health care entities is regulated under WAC 246904050. In general, all prescription medications must be administered by a licensed health professional authorized to administer medications. Residential Substance Abuse Treatment Facilities are charged with ensuring that written drug orders are signed by an authorized health care provider with prescriptive authority and that any verbal orders are signed by the prescriber no more than seven days after such order. Facilities must also ensure that the use of self-administered, non-prescription drugs are used within established parameters and according to the established list approved by the pharmacist or prescriber.

# Challenges, Opportunities, and Keys to Success

Several challenges, opportunities, and keys to success are discussed below. This section was informed by a Strength, Weaknesses, Opportunities and Threats (SWOT) approach often used in developing business plans. Issues brought up in this section are often being both a challenge and an opportunity for the Tribes and the development of the Residential Substance Abuse Treatment Facility. For example, barriers to service for clients is an obvious challenge, yet staff and administration are aware of such barriers and can reduce their impact by being proactive. Most topics discussed below overlap in this way.

## Anticipate Barriers to Service

Several barriers for admitting clients into residential substant abuse treatment should be considered while engaging in systems and program planning. Colville behavioral health staff are aware of such barriers and will be integral in coming up with strategies to help facilitate minimizing the barriers. Barriers to service include the following:

1. **Clients may be ready to enter treatment but they are lacking enrollment in the managed care Apple Health plan or health insurance that covers residential treatment.** This is particularly important for low income AIAN individuals who are required to be enrolled in Apple Health managed care plan in order for Tribal entities to be paid directly CMS.
2. **Wait times for entering treatment are associated with myriad reasons** from TB testing requirements to lack of beds.
3. **Treatment centers' lack of understanding about the tribal fee-for-service pay structure associated with the BHO carveouts.** Some tribes in WA have experienced challenges with BHOs questioning actions of tribal behavioral health programs. For example, if a tribe conducts a biopsychosocial assessment of a non-Native client and the client then ends up entering treatment via the BHO, the BHO may not want to accept the tribal assessment[7].

## Capacity Building

For the project to be ultimately successful, there are areas of capacity building that the Tribe and Tribal departments should consider.

***Workforce -*** Recruiting and retaining professional staff, including nurses, licensed chemical dependency counselors, physicians, and management will be a challenge. The Colville Reservation is listed as a Medically underserved area (MUA) (i.e. there is a shortage of personal health services) and designated as a Health Professional Shortage Area (HPSA; i.e. meets criteria for having too few health professionals to meet the needs of the population). To fully understand Colville's challenges associated with the health-related workforce, an employment assessment was conducted with the Colville Convalescent Hospital (CCH) staff in March of 2017. The CCH employs 42 employees, of which 22 are Colville citizens. Of these 22, six have worked at CCH for more than five years. Of the remaining 16 Colville citizen employees, the mean length of time of employment is 9 months (9.31). Twelve of the 22 Colville citizen employees work in low-skill jobs such as laundry, kitchen, or maintenance and five of these 22 are direct care providers. Importantly, none of the registered nurse license/degree employees are Colville citizens. Of the administrators at CCH, four are Colville citizens[8]. In short, acquiring and retaining medical

7 This has implications for billing and reimbursement, as an assessment is billed separately as an outpatient service. Other time, BHOs have denied care based on tribal program's assessment only non-Native clients are reviewed by BHOs for payment.

8 One employee has an unknown status.

staff is likely to remain a great challenge for any new Tribal health service. It is further advised that the Tribes consider committing resources toward building a pipeline of health care and health services employees – especially registered nurses.

***Electronic health records and maximizing revenue -*** The Tribe is currently in the process of deciding on an electronic health records (EHR) system. Following a decision, implementing the EHR system will involve piloting the system, updating and/or purchasing hardware, training staff, and potentially hiring a contractor and/or additional staff. Full implementation of an EHR system is at least six months away.

Closely associated with implementation of EHR, is the challenge of maximizing revenue. The EHR system will greatly aid in recovery of dollars in a timely fashion. Currently, there is a lengthy health services billing backlog that should be addressed by the Billing Department addressed prior to additional service structures being added to the burdened Colville billing system.

Development of processes and procedures for EHR billing, and billing in general, should closely involve staff with historical knowledge of billing systems thus far. This will help ensure new streamlined processes as lessons learned will be able to be folded into new policies. Furthermore, this has implications for the Human Resources Department, as job descriptions will need to be revised. It is advised that EHR system implementation begin as soon as possible with the forethought of use with the new residential treatment facility and extensive behavioral health services utilization[9]. On a positive note, once staff are trained in EHR, there will be timed saved and better patient outcomes.

## Funding Residential Care

Early in the residential substance abuse treatment facility planning process, funding sources should be sought out. Long-term sustainability should be a significant consideration. Obvious and less obvious funding streams should be considered. These include IHS, 638 Contract Care dollars, Medicaid, Medicare, private insurance, contracts with other tribes, Access to Recovery Vouchers, TANF, SSI, and ICWA funds.

Colville should be sure to take advantage of the high IHS encounter rate of $391 available for serving Medicaid eligible AIANs. For an IHS or tribal facility to receive payment at the IHS published rates, it must become a Medicaid provider and be on the IHS facility list. This is a higher reimbursement rate than serving non-AIAN Medicaid beneficiaries. In addition, the ratio of patients with higher reimbursement rates (or selfpay) versus patients lower paying reimbursement rates is a particularly salient consideration in order for a break-even budget for the facility. This is mentioned again in the Development Plan & Recommendations section.

## Transitional/Recovery Supportive Housing

One advantage of the transitional housing group home model in supporting recovery, is that staff costs remain low. This is because peer support staff are hired for positions in these homes and earn less money than professional staff. Another advantage is that clinical help, social support and structured living leads to better recovery outcomes for patients.

## ACA

Because of relatively recent changes related to the ACA and the State of Washington's provisions for implementation of expanded Medicaid (Apple Health), Colville has a wider window of opportunity to address

9 Although, EHR implementation has implications for easing the burden of staff, a large systems change such as this can cause distress to employees. Therefore, it is advised that administration seek out a "champion" of EHR to help shepherd this significant change.

substance abuse. Although this is generally true for all low-income individuals in the State of WA, there is a greater incentive to serve Tribal citizens and other AIANs due to the high IHS Medicaid-related reimbursement rate. With expanded Medicaid, feasibility of developing a new residential substance abuse treatment facility is supported.

## Location

Colville is uniquely situated to be 1 of 7 adult residential providers within a 150-mile radius of the reservation and the only residential provider in this area to provide culturally appropriate services for Native people. However, a Colville Residential Substance Abuse Treatment Facility will be challenged by the lack of a nearby urban population which may prohibit the ease of achieving client service numbers.

## Upcoming IHS Mandates

Another consideration in the process of referral to treatment is the new SBIRT requirement coming down the pipeline from IHS. In FY 2017, a new GPRA measure will be established and clinics will be implementing SBIRT screening, which indicates positive alcohol risk, and the level of intervention type (e.g. brief intervention, intensive treatment) among patients ages nine through 75 years. This new screening practice within the clinics is likely to result in greater numbers of referrals to the treatment facility.

In summary, to fulfill the vision of the Tribes and reach the behavioral health related goals of developing the Residential Substance Abuse Treatment Facility and recovery home project, the following "Keys to Success" are offered. These involve short-term and long-term planning and activities:

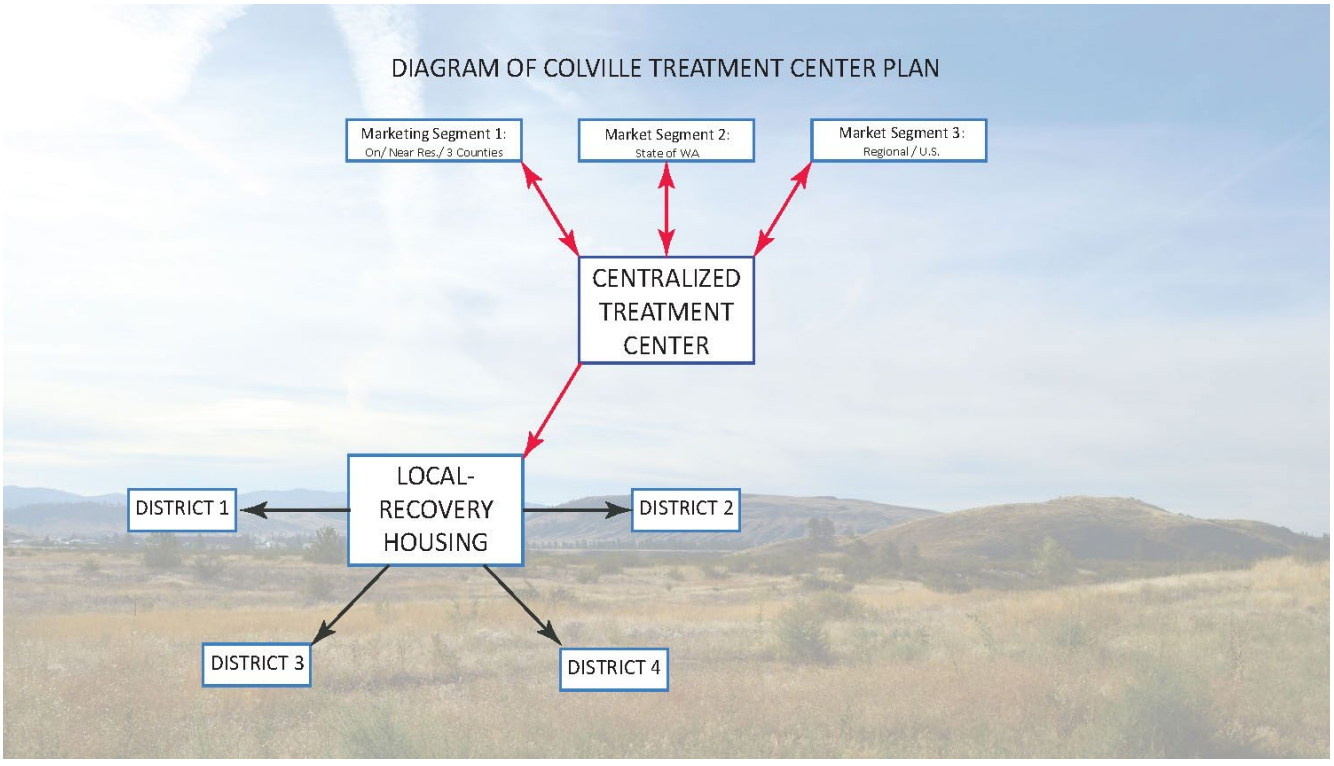
- ☐ Enroll clients and potential clients in the most appropriate medical coverage for providing residential substance abuse treatment services.
- ☐ Recruit and retain staff and contract health care providers while building a pipeline for Colville citizens to gain employment in health care and health services.
- ☐ Choose an electronic health care system, update computer equipment, and train staff on EHR systems.
- ☐ Reduce the current burden and expand the capacity of the Billing Department in an effort to prepare for the new facility.
- ☐ Take advantage of the high IHS encounter rate of $391 available for serving Medicaid eligible AIANs and the incentive to serve AIANs over non-Natives.
- ☐ Consider the unique time period of expanded health coverage for low income individuals who have gained and continue to gain access through the Affordable Care Act.
- ☐ Take caution as Congress and the new administration continue to persist in their efforts to reverse at least some of the ACA statutes and provisions.

We recommend starting with a 24-bed residential facility that operates as "voluntary" with 24/7 programming. This is a reasonable size for initial planning and operations in terms of utilization and cost. Other options such as a residential, psychiatric, fully secured facility with medical personnel is not practical nor suggested. Detox and medical services will need to be provided by other health care providers, (e.g. hospital based staff, Tribal health clinics, IHS clinics). We further recommend that the 24 bed facility be expanded to a 48 bed facility. In addition, we recommend developing 4 Recovery Group Homes, one in each district, to provide a supportive environment to transition from the treatment center back into the community.

## Location Criteria

The Tribe will need to determine the optimal location on the reservation for the Residential Treatment Center. As part of the next steps, a full criteria for the location will need to be determined and a process of site selection will need to be conducted in which potential sites are analyzed by the planning staff and design professionals to determine the suitability of the site. The following are some key locational criteria to be considered based on input from tribal staff, analysis of the case studies and input from the CEO of Native American Connections, Diana Yazzie Devine:

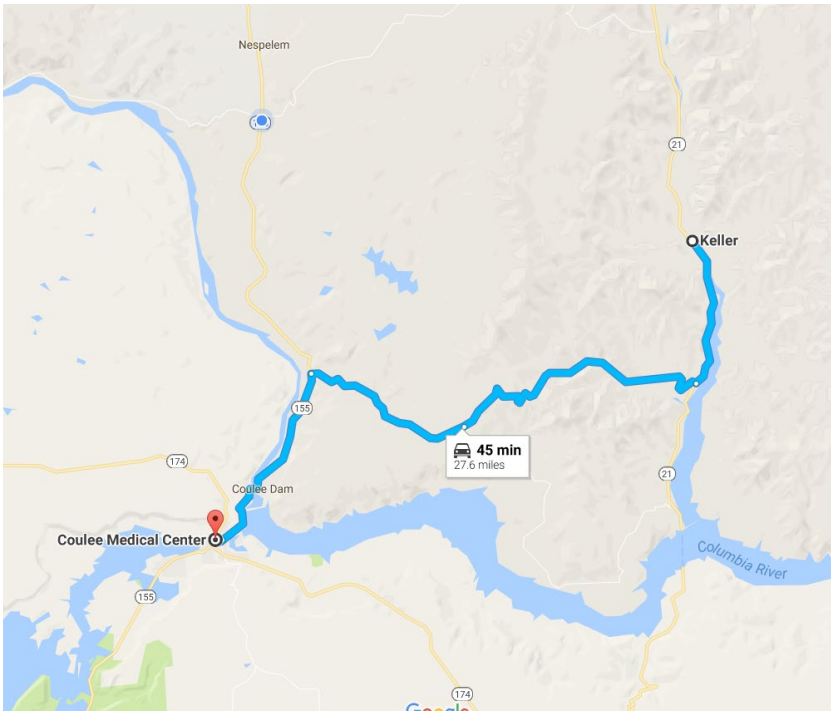
*Figure 23. Diagram of the proposed structure for residential treatment and recovery centers.*



1. **Proximity to medical services:** Residential substance abuse treatment facilities should be located within close proximity to medical facilities for the purpose of both routine medical treatment and Emergency Medical Services. Due to the significant medial needs that clients typically have and the benefit of not requiring a full medical staff as part of the Residential Substance Abuse Treatment Facility, proximity to a medical services facility capable of meeting routine medical treatment needs is ideally within a 15 minute drive. The map shows 5-10 minute radii from existing medical clinics on the Colville Reservation.

2. **Proximity to emergency medical services:** Proximity to 24-hour, seven days a week Emergency Medical Services capable of treating a wide range of urgent injuries and other medical conditions from clients served by a Residential Substance Abuse Treatment Facility is another criteria to consider. The map shows 45-60 minute radii from existing medical facilities with an Emergency Room.

*Figure 24. Keller Community to Coulee Medical Center*

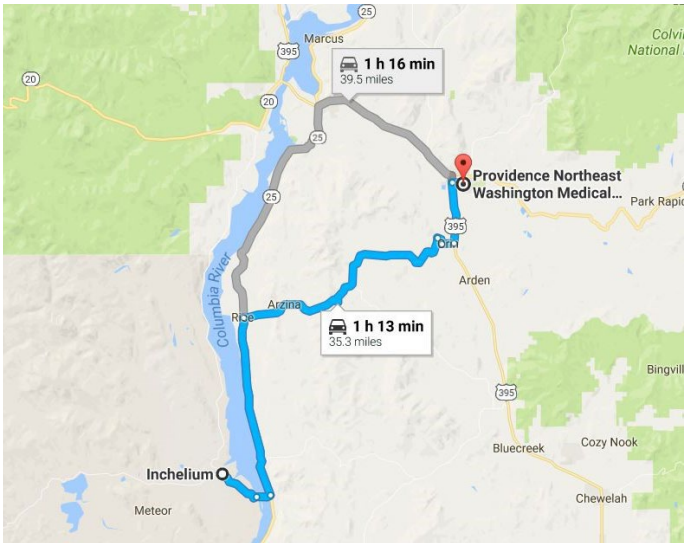



3. **Proximity to housing for staff:** A key consideration will be to locate the facility within a reasonable distance from population centers where the staff will be able to obtain housing and schools. This was identified by the team as a potentially significant issue for the tribe, as there is very limited housing stock for professionals on the reservation or in the nearby areas.

4. **Availability of infrastructure:** The capital costs of the facility will be significantly higher if the selected location requires significant new roadway, water, sewer and electrical lines for development of the site. Access to existing infrastructure will therefore be an important consideration for the site selection.

5. **Level of Community Readiness:** Public acceptance of the risks associated with a facility of this nature is detrimental to both the success of the facility. There has been community agreement from all Districts that there is need for enhanced community development, which would help stimulate their local economy. According to staff, the identification of land parcels within the Keller Community suggests a level of community readiness to benefit supportive of project success.

*Figure 25. Inchelium Community to Providence Northeast Medical Center, Colville WA*



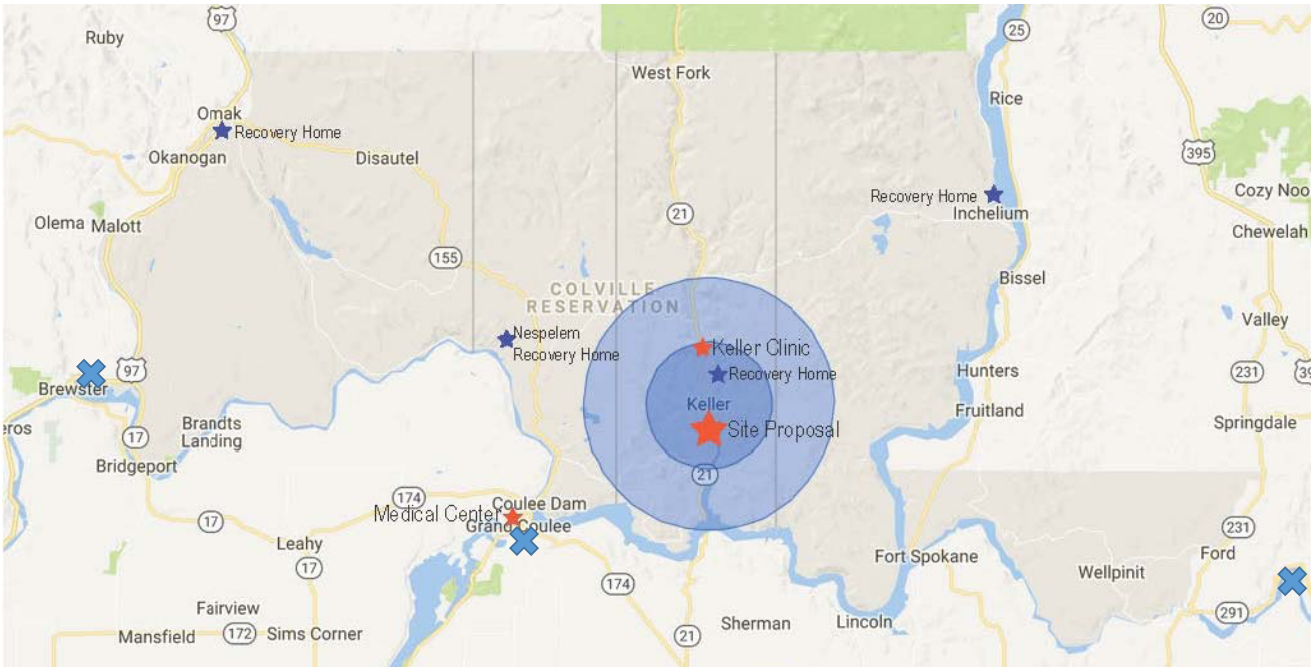

6. **Proximity to Triggers to Relapse:** Treatment Facility considerations that include the proximity of taverns, liquor stores and other high-risk places need to be evaluated as well. Remoteness can assist in type of treatment (i.e. Wilderness Therapy Programs) as well as deterring clients from walking out of treatment. Interviews with chemically dependent persons support the concept of remoteness as a deterrent to simply walking out of treatment due to an environment that triggers relapse

7. **Treatment Program Type(s):** The type of treatment may be an important factor for the location. If, for example, the program includes equine therapy, access to pasture land and trails will be important. If the program requires relative isolation in a tranquil pastoral setting, then a more rural or more mountainous location may be desired vs. a more community-based location.

The Recovery Group Homes are recommended to be located within the population centers of each district, with access to jobs and services.

*Figure 26. Proposed Keller Facility Location with a recovery home in each district.*

*Keller Site: Proximity to a 24 hour health care facility with an Emergency Room.* ✖ *Liquor stores, Taverns & Restaurants*
*Only Keller does not have a tavern or liquor store serving as a trigger to relapse.*



## Staffing Patterns and Operating Budgets

Based on insight from Diana Yazzie Devine, CEO of Native American Connections; the workforce analysis from the convalescent hospital; national healthcare employment data; pay sales from the human resources department, and regulations, staffing patterns and budgets have been estimated for a 24-bed and a 48-bed facility. Below are very preliminary budgets to illustrate the potential costs and revenue streams for the facility.

Actual staffing plans and budgets will need to be developed once the project is under development and several factors are determined. For example, the facility may function as a self-contained unit, share centralized administrative support, or as a hybrid. Capacity of other service departments such as payroll, budgeting and finance, HR, and medical oversight must be considered. Depending on the service and capacity some services may eventually be able to be delivered onsite. Otherwise, referrals to a nearby facility are necessary as discussed above. Other decisions that will affect the budget and staffing plans are facility location, capital and operating costs, debt service for the building, type of treatment services offered, availability of skilled labor, and greater clarification on revenue streams, types of accounting procedures, and several other factors.

Some of the key unknowns are the potential debt service for the building, which is estimated at $125,000/year for the 24 bed facility and $250,000 for a 48 bed facility. Actual costs for this could significantly affect the total net income for the project and will need to be elaborated in the development phase of the project.

Based on the proposed staffing model and estimated operating costs, revenue streams, the following budgets demonstrate that a 24 bed facility is possible. Any smaller facility is not likely to be financially viable as the staff ratios and the expected income sources will likely not be viable with a smaller facility.

*Figure 27. Staffing Arrangement for Colville's 24-bed Residential Substance Abuse Treatment Center.*

| Residential Substance Abuse Treatment Staffing Pattern - 24 Bed Facility | | | |
|---|---|---|---|
| | FTE | Total | Per Position |
| Director | 1 | $83,000 | |
| Assistant Director/ Program Manager (1) | 1 | $72,000 | |
| Office Manager | 1 | $95,000 | |
| Clinical Supervisor | 1 | $72,000 | |
| Counselor/Therapist | 2 | 117,000 | $58,000 |
| Registered Nurse | 0.5 | $35,000 | |
| Case Manager | 2 | $70,000 | $35,000 |
| Recovery Coach | 5 | $155,000 | $31,000 |
| Case Aids | 4 | $100,000 | $25,000 |
| Traditional Counselor | 1 | $40,000 | |
| LPM or Med Assistant | 1 | $103,000 | |
| Intake Assessment | 1 | $45,000 | |
| Phychiatric Nurse Practitioner | 1 | $72,000 | |
| Food Service Workers | 3 | $90,000 | $30,000 |
| Maintenance | 1 | $40,000 | |
| Payroll Accountant | 1 | $40,000 | |
| Accounts Payable | 1 | $40,000 | |
| Contracts & Compliance | 1 | $65,000 | |
| Janitorial | 1.5 | $13,000 | |
| Driver | 1 | $30,000 | |
| Human Resources - Hiring/ Benefits | 0.5 | $28,000 | |
| IT | 0.25 | $12,000 | |

## Revenue

A broad range of revenue sources should be sought out. Some funding streams will take significantly more time to set up compared to others. We provide a detailed example of encounter rate revenue below. However, the reader should also refer to the Challenges, Opportunities, and Keys to Success section for a fuller understanding of the complexities involved with revenue. The ratio of patients with higher reimbursement rates (or self-pay) versus patients lower paying reimbursement rates is a particularly salient consideration in order for a break even budget for the facility to occur.

One higher paying rate is the IHS encounter rate available to IHS and 638 facilities. An IHS encounter is a face-to-face contact between a health care provider and a federal program beneficiary for the provision of medically necessary services from a IHS or 638 facility within a 24-hour period ending at midnight. The encounter is documented in the patient's record. The payment of the rate is in accordance with a memorandum of agreement. The reimbursement rate for CY 2017 for Medicaid beneficiaries is $391 per encounter and the rate for Medicare beneficiaries is $349.

Below are conceptual operating budgets based on preliminary proposed staffing.  These budgets are very preliminary and will need to developed further as part of the development of a business plan for the center in the Next Steps.  The operating budgets are for both a 24 bed and 48 bed facility.

Below is the proposed staffing pattern for a 48 bed facility.

*Figure28. Proposed Preliminary Staffing Pattern for a 48 Bed Residential Treatment Center*

| Residential Substance Abuse Treatment Staffing Pattern - 48 Bed Facility | | | | | | | |
|---|---|---|---|---|---|---|---|
| | FTE | Total | Per Position | Tribe In-Kind | | Total Offices | Work Stations |
| Director | 1 | $80,000 | | | 1 office | 1 | |
| Office Manager | 1 | $45,000 | | | front desk area | | 1 |
| Clinical Supervisor | 1 | $75,000 | | | 1 office | 1 | |
| Counselor/Therapist | 4 | 180,000 | $45,000 | | 1 office | 1 | |
| Traditional/Cultural Counselor | 4 | $140,000 | $35,000 | | 1 shared office with cultural counselor | 1 | |
| Case Manager | 4 | $100,000 | $25,000 | | 2 offices (shared) | 2 | |
| Recovery Coach | 6 | $150,000 | $25,000 | | 4 work stations | | 4 |
| Case Aid (24/7 coverage) | 1 | $70,000 | | | desk area by dorm rooms | | 2 |
| Registered Nurse | 2 | $70,000 | $35,000 | | 1 office - window for self administration of meds | 1 | |
| LPN or Med Assistance | 1 | $45,000 | $45,000 | | shared office with RN | | |
| Billing Specialist | 1 | | | $40,000 | 1 office | 1 | |
| Eligibility Specialist | 2 | $90,000 | $45,000 | | 1 work station | | 1 |
| Intake/Assessment | 1 | $45,000 | | | 1 office | | |
| Food Service Chef | 3 | $90,000 | $30,000 | | Kitchen with 1 office | 1 | |
| Food Service Workers | 1 | $40,000 | | | Commercial Kitchen | | |
| Art/Trauma/ Family Therapist | 1 | $50,000 | | | 1 shared office with cultural counselor | | |
| Maintenance | 1 | $40,000 | | | Maintenance storage area - work station | | 1 |
| Payroll Accountant | 1 | | | $45,000 | 1 shared office with accounts payable | 1 | |
| Accountant - Payables | 1 | $45,000 | | | 1 shared office with payroll | | |
| Human Resources - Hiring/Benefits | 2 | | $50,000 | $100,000 | 1 office - window for self administration of meds | 1 | |
| Janitorial | 1 | $25,000 | | | Storage room for supplies | | |
| Contacts & Compliance Manager | 1 | $65,000 | | | 1 office | 1 | |
| | | | | | 1 group room 48 people | | |
| | 41 | $1,445,000 | | | 1 group room 24 people | 12 | 9 |
| | | | | | dining room for 48 people | | |
| | | | | | 2 dorm wings - 24 women & 24 men - total 48 beds | | |
| | | | | | 1- 24 bed women's dorm - 4 rooms with 4 beds; 4 rooms with 2 beds | | |
| | | | | | 1- 24 bed men's dorm - 4 rooms with 4 beds; 4 rooms with 2 beds | | |
| | | | | | laundry room | | |
| | | | | | Talking Circle group room | | |
| | | | | | Computer lab; library | | |
| | | | | | Conference room | | |
| | | | | | staff lounge | | |
| | | | | | each dorm room has shared bathrooms | | |
| | | | | | common space M/W bathroom | | |
| | | | | | staff M/W bathroom | | |

*Figure 29. Conceptual Operating Budget for 24 and 48 Bed Residential Treatment Center*

| *Residential Substance Abuse Treatment Budget - 48 Beds* | | | | *24 Bed Capacity* |
|---|---|---|---|---|
| **REVENUE** | $2,903,575 | 48 bed capacity x 90% occupancy (43 beds) | Rate $185 bed per day | $1,485,550 |
| | | | Tribal In-Kind | |
| **EXPENSE** | TOTAL | Description | | |
| Payroll | $1,445,000 | Payroll | | $850,000 |
| ERE & Benefits | $361,250 | ERE @ 25% of Payroll | | $200,000 |
| Audit & Accounting | $15,000 | | $15,000 | $10,000 |
| License & Certifications | $10,000 | | | $5,000 |
| Office Supplies | $15,000 | | | $7,500 |
| Program Supplies | $20,000 | Personal Items for Clients | | $10,000 |
| Food & Related Expenses | $150,000 | | | $80,000 |
| Medical Supplies | $10,000 | | | $5,000 |
| Insurance | $40,000 | Professional Liability, Auto, Workers Comp | | $20,000 |
| Equipment | $0 | Computers, Telephone System, Copier | $200,000 | |
| Furniture | $0 | One Time Capital Expense | $150,000 | |
| Equipment Leases | $20,000 | Copiers, Washer/Dryer/ Etc | | $10,000 |
| Utilities | $90,000 | Water, Gas, Electric | | $50,000 |
| Waste & Trash | | | $10,000 | |
| Building Maintenance | $25,000 | Supplies & Repairs | | $10,000 |
| Linens & Towels | $5,000 | | | $2,500 |
| Cell Phones & Contracts | $10,000 | | | |
| Vehicle | | One Time Capital Expense | $35,000 | |
| Vehicle Maintenance/Gas | $10,000 | | | $5,000 |
| Mileage Employees | $10,000 | | | $5,000 |
| Employee Education | $10,000 | | | $2,500 |
| | | | | |
| | | | | |
| Debt Service | $250,000 | | | $125,000 |
| | $2,496,250 | | | $1,397,500 |

## *Figure 30. Preliminary Conceptual Building Program and Capital Budget*

**COLVILLE TREATMENT CENTER PRELIMINARY PROGRAM / BUDGET**

| PHASE 1: 24-Bed | 30 days - 6 months | | | | |
|---|---|---|---|---|---|
| BUILDING | QUANTITES | SIZE | SQUARE FOOTAGES | SF TOTALS | NOTES |
| ***Treatment Center*** | | | | | |
| Lobby | 1 | 12x15 | 180 | 180 | |
| Reception | 1 | 8x12 | 96 | 96 | |
| Restroom | 1 | 8x8 | 80 | 80 | |
| Therapy Counseling Rooms | 2 | 10x12 | 120 | 240 | |
| Conference Meeting Room | 1 | 12x14 | 168 | 168 | |
| Copy / Mail Room | 1 | 9x10 | 90 | 90 | |
| Program Manager Office (1) | 1 | 8x12 | 96 | 96 | |
| Director (1) Office | 1 | 8X10 | 80 | 80 | |
| Clinical Site Supervisor Office (1) | 1 | 8x10 | 80 | 80 | |
| Medical Dependency Professional & Assistant Office | 1 | 8x12 | 96 | 96 | |
| Case Manager Office (2) | 2 | 8x10 | 80 | 160 | |
| Case Aids Office (4) | 2 | 8X12 | 96 | 192 | |
| Counselor/ Therapist (2) | 2 | 8X12 | 96 | 192 | |
| Art/ Trauma Family Therapist | 1 | 8X10 | 80 | 80 | |
| Recovery Coach (2) | 1 | 8X10 | 80 | 80 | |
| Traditional Counselor (1) | 1 | 8X10 | 80 | 80 | |
| Registered Nurse (2) Pod | 1 | 5X12 | 60 | 60 | |
| LPM or Med Assistant (2) | 1 | 8X10 | 80 | 80 | |
| Intake Assessment Space | 1 | 5X10 | 50 | 50 | |
| Billing Office: Accounts Payable (1)/ Payroll Accountant (1) | 1 | 8X12 | 96 | 96 | |
| Eligibility Specialist (1) | 1 | 8X10 | 80 | 80 | |
| Human Resources Hiring/ Benefits (2) | 1 | 8X12 | 96 | 96 | |
| Contracts & Compliance Office | 1 | 8X10 | 80 | 80 | |
| Patient Records / Data Room | 1 | 8x10 | 80 | 80 | |
| Staff Break Room/ Lounge | 1 | 10x12 | 120 | 120 | |
| Clinic Rooms | 8 | 10X12 | 120 | 960 | |
| Storage Closet | 2 | 7x7 | 49 | 98 | |
| Janitor Closet/ Maintenance (1) | 1 | 9X10 | 90 | 90 | |
| Electrical Rm | 1 | 12X14 | 168 | 198 | Size determined by Bldg SF |
| Mechanical Rm | 1 | 14X16 | 224 | 224 | Size determined by Bldg SF |
| Riser Room (Sprinkler Syst) | 1 | 10X12 | 120 | 120 | Size determined by Bldg SF |
| Circulation/ Gross Factor | | 30% | | 1327 | 4422 |
| UNIT TOTALS | 24 | | SF TOTALS | 5,749 | |
| ***Residence*** | | | | | |
| Single Bedroom | 4 (4 people) | 8x10 | 80 | 320 | |
| Double Bedroom | 8 (16 people) | 10x12 | 120 | 960 | |
| Quad Bedroom | 1 (4 people) | 14X14 | 196 | 196 | |
| Shared Bathrooms | 3 | 8x8 | 64 | 192 | |
| Community Living Room | 1 | 24x20 | 480 | 480 | |
| Kitchen (3 Chefs, 1 Food Service worker) | 1 | 10x15 | 150 | 150 | |
| Shared Dining | 1 | 20x20 | 400 | 400 | |
| Laundry | 1 | 10x15 | 150 | 100 | |
| Circulation/ Gross Factor | | 30% | | 839 | 2798 |
| UNIT TOTALS | 14 | | SF TOTALS | 3,637 | |
| | | | 24-BED TOTAL SF | 9,386 | Estimated Cost |
| | | | $ 250 | 9,386 | $ 2,346,500 |

Below is a proposed preliminary conceptual spatial requirements program for a 24 bed and a 48 bed residential treatment center and potential construction costs for these facilties. These are very preliminary figures, intended for illustration only. Actual numbers will need to be developed in the Next Steps after a site is selected and the building program is finalized based on an input process with tribal staff and available information.

| PHASE 2: Additional 24 beds = 48-bed | | | | | |
|---|---|---|---|---|---|
| BUILDING | QUANTITES | SIZE | SQUARE FOOTAGES | SF TOTALS | NOTES |
| *Treatment Center* | | | | | |
| Restroom | 1 | 8x8 | 80 | 80 | |
| Counselor Therapist (+2) | 1 | 8x10 | 80 | 80 | |
| Case Managers (+2) | 1 | 8x12 | 96 | 96 | |
| Recovery Coach (+3) | 1 | 8x12 | 96 | 96 | |
| Case Aids 27/7 Coverage (+1) | 1 | 8x12 | 96 | 96 | |
| Therapy Counseling Rooms | 2 | 10x12 | 120 | 240 | |
| Office Space | 1 | 8x10 | 80 | 80 | |
| Eligibility Specialist (1) | 1 | 8x10 | 80 | 80 | |
| Medical Dependency Professional & Assistant Office | 1 | 8x12 | 96 | 96 | |
| Case Manager Office | 1 | 8x10 | 80 | 80 | |
| Storage Closet | 1 | 7x7 | 49 | 49 | |
| Circulation/ Gross Factor | | 30% | | 298 | 1073 |
| UNIT TOTALS | 18 | | SF TOTALS | 1,371 | |
| *Residence* | | | | | |
| Single Bedroom | 4 (4 people) | 8x10 | 80 | 320 | |
| Double Bedroom | 8 (16 people) | 10x12 | 120 | 960 | |
| Quad Bedroom | 1 (4 people) | 14x14 | 196 | 196 | |
| Shared Bathrooms | 3 | 8x8 | 64 | 192 | |
| Circulation/ Gross Factor | | 30% | | 500 | 1668 |
| SF TOTALS | 24 | | | 1,668 | Estimated Cost |
| ADD ON TOTAL | | | | 3,637 | $ 909,350 |
| 48-BED TOTAL SF | | | | 13,023 | |
| | | | $ 250 | 13,023 | $ 3,255,850 |
| **Local Recovery Supportive Housing** | **6 months - 2 yrs** | | | | |
| Recovery Group Home | QUANTITES | SIZE | SQUARE FOOTAGES | SF TOTALS | NOTES |
| *Group Townhome - 1 in Ea. District* | | | | | |
| Porch | 1 | 10x30 | 300 | 300 | |
| Entrance Hall | 1 | 10x10 | 100 | 100 | |
| Kitchen | 1 | 10x15 | 150 | 150 | |
| Pantry | 1 | 8x10 | 80 | 80 | |
| Dining Room | 1 | 15 x 15 | 225 | 225 | |
| Living Room | 1 | 15x20 | 300 | 300 | |
| Bedroom | 6 | 10x12 | 120 | 720 | |
| Bedroom Closet | 6 | 2x6 | 12 | 72 | |
| Bathroom | 4 | 6x9 | 54 | 216 | |
| Linen Closet | 1 | 4x6 | 24 | 24 | |
| Entry Closet | 1 | 4x7 | 24 | 24 | |
| Laundry | 1 | 8x10 | 80 | 80 | |
| Storage | 1 | 6x10 | 60 | 60 | |
| Management Office | 1 | 8x10 | 80 | 80 | 2431 |
| Circulation/ Gross Factor | 1 | 30% | | 729 | |
| UNIT TOTALS | 1 | | SF TOTALS | 3,160 | Estimated Cost |
| COST | 1 | | $ 200 | 3,160 | $ 632,060 |
| TOTAL COST | 4 | | $ 200 | 12,641 | $ 2,528,240 |
| TOTAL BUILDING COST | 5 | | | | $ 5,784,090 |
| TOTAL SITE / INFRASTRUCTURE COST | 5 | 40% | | ESTIMATED | $ 2,313,636 |
| TOTAL PROJECT CONSTRUCTION COSTS | | | | | $ 8,097,726.00 |
| TOTAL PROJECT SOFT COSTS | | 20% | | ESTIMATED | $ 1,619,545.20 |
| TOTAL DEVELOPMENT COSTS | | | | | $ 9,717,271.20 |

Assumptions about the cost of the facility are based on $250/SF construction budget. This amount may vary substantially depending on actual site conditions, building type, design requirements and many other factors. Site costs and soft costs are included as percentages of the building costs. Actual site costs and soft costs will need to be determined during the Next Steps.

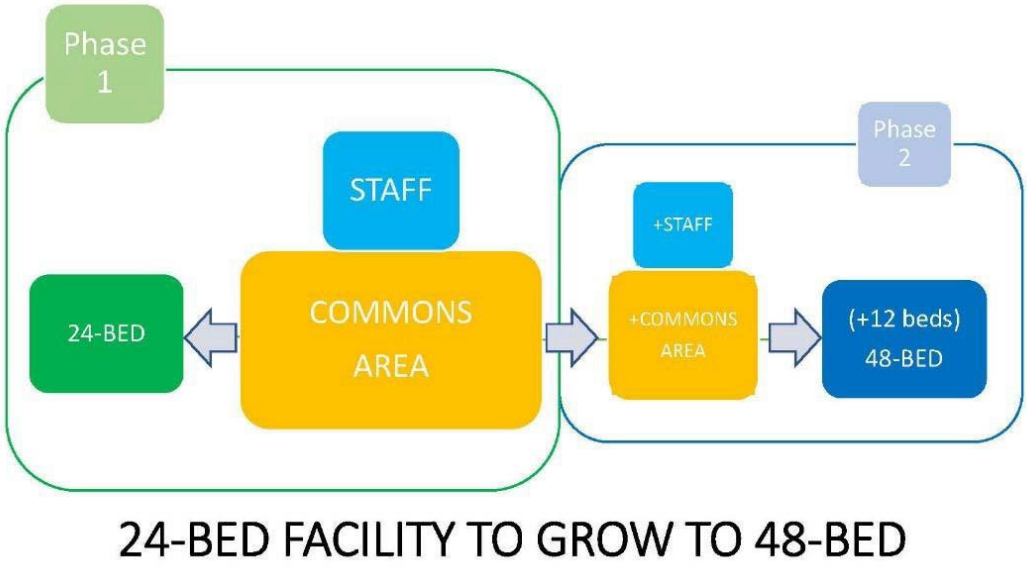
*Figure 31. Diagram of Community Wide Investment in Patient Recovery*


# *Next Steps*

This Feasibility Study provides the information necessary for the Colville Business Council to determine whether to proceed with the development of a new Residential Substance Abuse Treatment Center. As the study indicates, need for a facility is well established. The need both on the Colville Reservation and in the larger region for additional options for treatment for drug and alcohol dependency is profound. There are many challenges with developing a successfully run, professional facility, and we have laid out some of these challenges in this report, including funding availability for construction and operations of the facility, and the challenge of attracting and retaining qualified staff for the facility in a relatively remote, largely rural community. However, despite these challenges, the Colville Business Council has indicated their strong interest in the development of this facility.

To meet the needs of the community while addressing some of the challenges, we recommend starting with a 24-bed facility that can expand to a larger, 48 bed facility. In addition, we suggest that the tribe invest in continuum of care services to include a Transitional/ Recovery Group Home in each district. We recommend 6 to 8 beds in each of these housing units. With this approach, the Tribes will be able to serve up to 56 people from the outset, with an additional 24 individuals to be served in the future as the staffing and experience is further established at the central facility.

*Figure 32. Diagram of 24 Bed and 48 Bed Residential Treatment Center*




The Council will need to make the final determination on proceeding with this recommendation. If the Council decides to move forward, the following Next Steps are outlined towards the implementation of these recommendations:

1) **Determine funding** options for the following:

    a. Design and construction of the facilities.

    b. Maintenance and operation of the facilities.

    c. Staffing

2) **Determine the location** of the central residential substance abuse treatment center and the transitional /recovery group homes.

3) **Develop the treatment model for the facilities:** The design, location, staffing and operation of the facilities will be affected by the treatment model and programs desired for the facilities.

4) **Develop the building space program:** This study provides initial spatial programming based on other facilities. These will need to be further developed and designed around the treatment models and staffing for the facilities.

5) **Develop a Business Plan** for the building and operation of the facilities: As a new business on the Colville Reservation, a business plan is necessary to determine the overall funding for construction, operation and marketing of the facility.

6) **Project Design:** The building design process is estimated to take approximately one year for programming, design and preparation of construction documents. This process can be fast tracked if necessary and reduced to 68 months if necessary for funding or operations requirements. Below are the proposed steps for project design:

a. Engagement Process and Concept Design: We recommend an inclusive process that includes input from tribal leadership, staff, and tribal members to ensure that the vision for the facilities resonate with the tribal community and meet the goals and culture of the Colville Tribes. This time for this process depends on the level of engagement and input desired. (23 months)

b. Schematic Design: Once the overall vision and goals are established by the input process, the buildings can be designed. This stage includes development of the site plan, schematic level building plans and 3D modeling, and schematic level cost estimate. (23 months)

c. Design Development: The designs are further developed to including electrical, mechanical and structural engineering, as well as site civil and landscape design, and establishment of building materials, energy and waste water systems, and details (23 months)

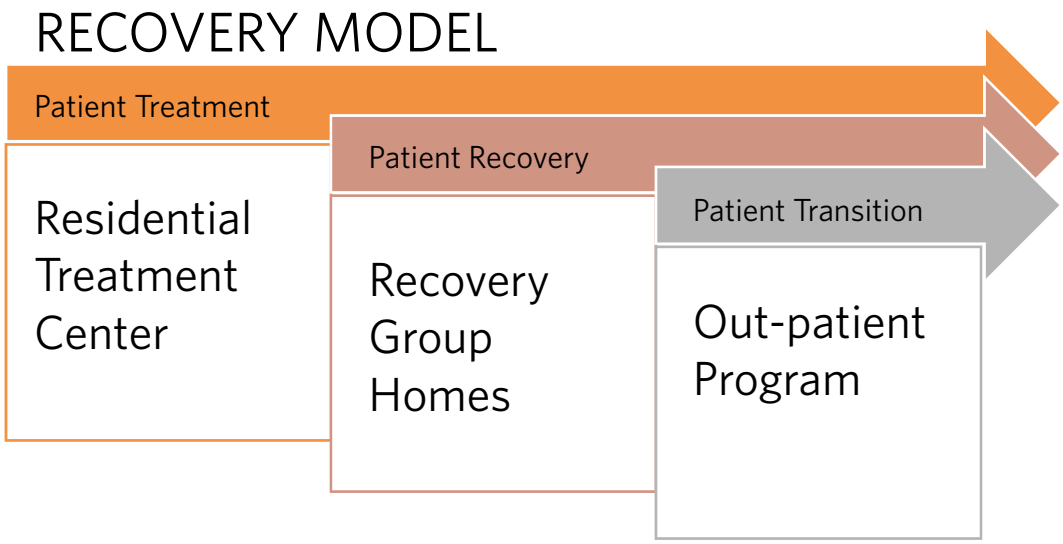
d. Construction Documents: The final design is developed into construction documents, including specifications, final engineering, and complete architectural drawings for bidding. (46 months).

7) **Building Construction:** The building construction phase for this project will likely take up to a year for site and building construction, depending on the site and level of development needed in the area selected for the site.

8) **Staffing and Marketing:** The development of the staff needed for these facilities will require a substantial effort to attract and retain qualified and experienced staff for the successful operation of the facility. A key part of this will include determining housing options and relocation needs for the staff. Marketing the new facility and determining the process for attracting and selecting the clientele will also be a significant effort.

9) **Operations and Maintenance:** Once the building is completed and ready to open, an operations and maintenance plan will need to be in place. A key part of the design will be to create a highly energy efficient and low maintenance, durable facility.

*Figure 33. Recovery Model Diagram*



# Project Schedule / Process

**Pre- Planning** *(3 Months)*

**Community Engagement/ Design** *(3 Months)*

**Design and Construction Documents** *(6 Months)*

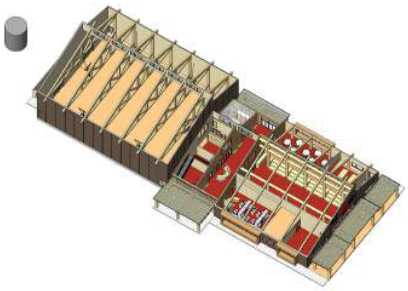
**Pre-Planning**
1. Determine Funding
2. Determine the Location
3. Develop the Treatment model for the facility.

**Programming: Site / Building Uses**
4. Develop the building space program
5. Develop a Business Plan

**Concept Design Workshop**
6. Project Design
a. Community Engagement
Concept Design

**Schematic Design Workshop**
b. Development and Building Plans





## CONFEDERATED TRIBES OF THE PROJECT SCHEDULE

**Bidding** *(1 Month)*

**Construction** *(1 Year)*

**Move In !!**

**Design Development & Construction Documents**

**Development**
**7. Building Construction**
**8. Staffing & Marketing**
**9. Operations & Maintenance**

**Cost Estimating**

**Implementation Plan**

Level 1 Floor Plan Option 2

# COLVILLE RESERVATION

HERRERA

7 DIRECTIONS architects / planners

The West Studio evidence-based design for supportive environments

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