# MIDD Briefing Paper

**BP 123 Outreach for Older Adults in Psychiatric Crisis**

**Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)**
**New Concept X (Attach New Concept Form)**
**Type of category:** New Concept

**SUMMARY:** This proposed concept is an outreach program targeting older adults in psychiatric crisis who are at risk for hospitalization or re-hospitalization as a result of their mental health crisis. The program will consist of a team made up of Geriatric Mental Health Specialists (GMHSs), a Director and a consulting Psychiatric Nurse Practitioner. This team will provide outreach visits to older adults experiencing a psychiatric crisis to help coordinate and solidify outpatient services thereby diverting them away from emergency services. With the consultation of the team, the individual's primary care provider can make needed adjustments to medications until psychiatric services can be accessed. Potential participants will be referred by the King County Designated Mental Health Professionals (DMHPs) or the Geriatric Regional Assessment Team (GRAT). The team will be able to provide up to six crisis support visits in order to stabilize the individual. This concept aims to address an individual's mental health needs in a population specific manner that prioritizes using available resources in a cost effective manner. The goal of this proposed concept is to reduce inpatient psychiatric hospitalizations.

**Collaborators:**

| **Name** | **Department** |
|---|---|
| Piruz Huda | Solstice Behavioral Health at Full Life Care |

**Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.**

| **Name** | **Role** | **Organization** |
|---|---|---|
| Margy Kotick | Chemical Dependency Professional; Geriatric Specialist | EvergreenHealth |
| Dick Crabb | Care Authorizer/Mental Health Contract Monitor | King County |

***The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.***

**A. Description**

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This proposed concept is an outreach program targeting older adults in psychiatric crisis who are at risk for hospitalization or re-hospitalization as a result of their mental health crisis. The program will consist of a team made up of Geriatric Mental Health Specialists (GMHSs), a Director and a consulting Psychiatric Nurse Practitioner. This team will provide outreach visits to older adults experiencing a psychiatric crisis to help coordinate and solidify outpatient services thereby diverting them away from emergency services. With the consultation of the team, the individual's primary care provider can make needed adjustments to medications until psychiatric services can be accessed. Potential participants will be referred by the King County Designated Mental Health Professionals (DMHPs) or the Geriatric Regional Assessment Team (GRAT). The team will be able to provide up to six crisis support visits in order to stabilize the individual. This concept aims to address an individual's mental health needs in a population specific manner that prioritizes using available resources in a cost effective manner. The goal of this proposed concept is to reduce inpatient psychiatric hospitalizations.

This new concept relates to existing Strategy 1h, Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults, in that the GRAT team, consisting of GMHS's, provide outreach and assessments to older adults experiencing a crisis that relates to mental illness and substance abuse and linking them up with ongoing services in their community. This proposal is different from Strategy 1h in that there are no eligibility criteria, so this concept could serve those individuals that do not qualify for Strategy 1h. This concept also relates to Briefing Paper (BP) 33, Coordinated Care for High Risk Older Adults and Adults with Disabilities, with the exception of BP 33 revolving around providing care for up to 12 months, not just crisis care, and the team composition, because BP 33's team consists of Registered Nurses and Social Workers.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☐ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   **Please describe the basis for the determination(s).**

The primary strategy area this concept fits is Crisis Diversion in that its overall goal is to reduce inpatient psychiatric hospitalizations. Secondary and tertiary strategy areas are System Improvements and Recovery and Re-entry. The system improvements this concept would provide is an intermedium that will ensure consumer stability once the crisis situation has ended. By doing this, the outreach team will also be assisting consumers in transitioning back into their communities safely and with the necessary supports they need to remain stable.

**B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes**

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

The overall prevalence of psychiatric disorders for older adults in the United States is estimated at 20-25 percent.[1] Psychiatric related emergency department visits have increased nationwide with the highest increase occurring in the elderly. Between 14 percent and 20 percent of older adults have one or more mental health and substance use conditions. Depressive disorders are one of the most prevalent but substance use disorders are also a significant problem.[2] While comprising about 13.75 percent of the population, 16.37 percent of all suicide deaths occur in older adults (age 65+). Depression, often undiagnosed and untreated, is a leading cause of suicide in older adults.[3]

Older adults in psychiatric crisis are at risk for hospitalization due to greater difficulty in accessing mental health services. Many older adults have difficulty finding reliable and safe transportation to appointments, or have functional limitations, and there is a lack of available outpatient mental health services that specialize in serving this population. Often, after discharge from inpatient psychiatric hospitalization, appointments with outpatient treatment providers are weeks out, or are not fully solidified, leading to a repeat psychiatric crisis. When discharging from the hospital, a well-developed discharge plan often will fall apart due to lack of follow through by the individual due to inability to follow a goal directed plan.

If this concept is not implemented, eligible older adults will continue receiving crisis care and care coordination through GRAT and the DMHPs. Without having a support team at the ready upon crisis or discharge from a crisis service, the individual may not have the tools and resources necessary to follow through on aftercare, resulting in increased morbidity and mortality in this population, as well as continued use of emergency, high-cost services.[4]

**2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

Upon referral, a GMHS will connect with the individual on the next business day. The GMHS will provide up to six one-hour visits to solidify with the individual and their immediate support team their relapse prevention plan, ensure adherence to a prior discharge plan, or to develop a crisis stabilization plan utilizing available private and public resources such as community behavioral health organizations, coordinating care with the individual's primary care provider, or arranging transportation needs. The GMHS will function as a 'problem solver', providing immediate short-term case management and crisis stabilization support until outpatient services can take care of the

[1] Patrick G. Walsh, B.S., Glenn Currier, M.D., Manish N. Shah, M.D., Jeffrey M. Lyness, M.D., and Bruce Friedman, Ph.D. **Psychiatric Emergency Services for the U.S. Elderly: 2008 and Beyond.** Am J Geriatr Psychiatry. 2008 Sep; 16(9): 706–717.

[2] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.

[3] American Association of Suicidology. Elderly Suicide Fact Sheet Based on 2012 Data. http://www.suicidology.org. Accessed December 13, 2015.

[4] Janice F. Bell PhD MPH, David Mancuso PhD , Toni Krupski PhD, Jutta M. Joesch PhD, David C. Atkins PhD, Beverly Court, MHA PhD, Imara I. West MPH, Peter P. Roy-Byrne MD. Care Management for Medicaid Clients with High Health Care Costs: Evaluation of One-Year Health and Social Outcomes. http://www.agingkingcounty.org/docs/KCCP_Abstract_Bell3-15-11.pdf.

individual's psychiatric needs. Consultation with a Psychiatric Nurse Practitioner will allow for the individual's medication regimen to be adjusted during the support period.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Being that this proposal is so similar to Strategy 1h, data from the MIDD Annual Reports was used to show evidence. In the MIDD Seventh Annual Report, data shows that Strategy 1h resulted in decreased psychiatric hospitalizations and emergency department admissions proving that crisis intervention and support for ongoing services works.[5]

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Again, since this proposal is so similar to Strategy 1h, information on the GRAT program is included here. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) credited the GRAT program as a Promising Practice in the "Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems" guidebook. The article that featured the GRAT program attributed the success of the program to, "…free service [to clients]; flexibility; strong, experienced clinicians; quick response to those making referrals; and a creative approach to initial encounters".[6]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

A study funded by the Center for Health Care Strategies on the King County Care Partners Program, a similar program that provided coordinated care to older adults for one year, found that multidisciplinary care management of high-cost Medicaid beneficiaries resulted in reduced psychiatric inpatient costs, reduced criminal justice involvement, and improved access to drug and alcohol treatment. This model also "shows promise of reducing costs and improving quality and outcomes for high-cost Medicaid patients, particularly those with alcohol and chemical dependency problems".[7] Another study of older adults still living in the community found that integrated care

[5] King County Mental Illness and Drug Dependency (MIDD) Oversight Committee. MIDD Seventh Annual Report: Implementation and Evaluation Summary for Year Six October 1, 2013—September 30, 2014. February 2015.
[6] Substance Abuse and Mental Health Services Administration, *Promoting Older Adult Health: Aging Network Partnerships to Address Medications, Alcohol, and Mental Health Problems, pg. 44*. www.samhsa.gov.
[7] Harris Meyer. Improving Medicaid High-Risk Care Management Overview: King County Care Partners. Center for Healthcare Strategies, Inc. November, 2012.

management was a cost-effective approach to reduce admissions to hospitals and individual functional decline.[8]

**C. Populations, Geography, and Collaborations & Partnerships**

**1. What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☐ **Transition age youth 18-25**
- ☐ **Adults**
- ☒ **Older Adults**
- ☐ **Families**
- ☐ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☒ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☐ **Immigrant/Refugee**
- ☐ **Veteran/US Military**
- ☐ **Homeless**
- ☐ **GLBT**
- ☐ **Women**

**Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.**

Underserved individuals, generally older adults who have limited transportation options to attend outpatient treatment programs, would be well served by this program.

**2. Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

The services are mobile; the services would be available to all residents living in King County. The GMHSs will be driving out to meet individuals in their residences.

**3. What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Necessary partnerships include, but are not limited to:

- Inpatient hospitals such as Northwest Geropsych hospital in Seattle.
- Coordination with GRAT team for potential referrals.

[8] Roberto Bernabei, Francesco Landi, Giovanni Gambassi, Antonio Sgadari, Giuseppe Zuccala, Vincent Mor, Laurence Z Rubenstein, PierUgo Carbonin. Randomised trial of impact of model of integrated care and case management for older people living in the community. BMJ 1998;316:1348

- Community behavioral health providers.
- Access to referral services by Senior Services.
- King County DMHPs.

**D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches**

**1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Almost 18 percent of the King County population is 60 years of age or older and two of ten people have a disability. The fastest growing segment of the population is the 85 and older age group. There was a 42 percent increase in the older adult population in King County between the years 2000 - 2013 and increased life expectancies will only strengthen this demonstrated wave of aging boomers and those who need these services.[9]

**2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

There are a couple of foreseen barriers to implementing this proposal. First, as the number of older adults in the community continues to grow, community resources will be challenged by the escalating dependency ratio for older persons. Second, as there is already an older adult crisis intervention and linkage to ongoing services program, there may be confusion between the two, and, as stated in the first example, two separate programs seeking identical, limited community resources.

**3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

One potential consequence could be the possibility of services being duplicated by different programs. It might be necessary to develop a system that tracks all older adult services throughout King County to avoid this type of situation.

**4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Those individuals not eligible for GRAT may not have the tools and resources necessary to follow through on aftercare, resulting in increased morbidity and mortality in this population as well as continued use of emergency, high-cost services.[10]

[9] Aging in King County. Profile of the Older Population. http://www.agingkingcounty.org/.

[10] Janice F. Bell PhD MPH, David Mancuso PhD , Toni Krupski PhD, Jutta M. Joesch PhD, David C. Atkins PhD, Beverly Court, MHA PhD, Imara I. West MPH, Peter P. Roy-Byrne MD. Care Management for Medicaid Clients with High Health Care Costs: Evaluation of One-Year Health and Social Outcomes. http://www.agingkingcounty.org/docs/KCCP_Abstract_Bell3-15-11.pdf.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

As previously stated, Strategy 1h provides similar services to older adults (60+) who are deemed eligible for the program. Evaluation of this program shows successful outcomes in decreased emergency and hospital admissions, and criminal justice issues. This concept could be merged with Strategy 1h to fill the gap for individuals not eligible for GRAT for reasons such as being enrolled in the King County Behavioral Health Organization, in residential treatment, or residing in a nursing home. The pro of merging these two concepts would be that any older adult experiencing a psychiatric crisis could receive the support and care that has been proven to be beneficial for improving overall health and reducing system costs.

**E. Countywide Policies and Priorities**

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This new concept fits within the continuum of care in that the outreach team will work side by side with the individual to ensure that s/he follows through on recommended referrals to care and is stabilized before ending services. Together with the individual, the team will identify the individual's needs and coordinate care, including mental health and chemical dependency treatment, making it a fit with Behavioral Health Integration. This model also fits perfectly with the Health and Human Services Transformation initiative in that it diverts the use of crisis-oriented services to focus on prevention and eliminates disparities by providing the unique care that is necessary for this population to thrive in their communities.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Experiencing a psychiatric crisis can be trauma-inducing, especially when a crisis is complicated by compounding factors such as a medical condition, and the individual lacks natural supports. This concept aims to minimize or potentially avoid the crisis for the individual while seeking out services identified as necessary. The concept is rooted in the principles of recovery and resiliency in that the team will connect the individual with holistic services and act as the individual's community as they transition into ongoing aftercare.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

Older adults have special needs that are unlike other populations. They face extreme barriers such as inability to transport themselves and limited public transportation options, chronic disabilities that many times cause immobility, and significant cognitive dysfunction, to name a few, that prevent them from being able to navigate the health system and seek the care they need without

assistance. Social justice is addressed by addressing an individual's unique needs and not requiring the county to usurp their civil rights with an involuntary hospitalization. Implementing a crisis support model that is designed to meet the specific needs of this special population will result in fewer crisis services and overall better individual health.

**F. Implementation Factors**

**1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

A minimum of four staff will be necessary to implement this concept; at least two GMHS's, one Director, and one consulting Psychiatric Nurse Practitioner. Other resources needed are unknown.

**2. Estimated ANNUAL COST. $100,001-500,000 Provide unit or other specific costs if known.**

It is estimated to cost $110,000 to serve up to 240 older adults a year. Specific costs are unknown.

**3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

Considering that this concept is similar to MIDD Strategy 1h, it can be assumed that there are no other revenue sources that could fund this work.

**4. TIME to implementation: 6 months to a year from award**

- **a. What are the factors in the time to implementation assessment?**
- **b. What are the steps needed for implementation?**
- **c. Does this need an RFP?**

Time to implementation will depend on whether this becomes an enhancement of existing strategy 1h or another existing MIDD strategy. If it is not blended as a contract amendment to 1h, an RFP would likely be needed.

**G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?**

Just before submitting this paper for review, this writer was notified by the proposer that he is leaving Full Life Care, the organization that would have been interested in implementing this concept had it been approved. Initially it was thought that Navos would take over responsibility, but they also have since backed out so at this time this paper is not tied to any responsible organization.

**New Concept Submission Form**

## #123

## Working Title of Concept: Crisis Outreach for older adults in psychiatric crisis.

**Name of Person Submitting Concept: Piruz Huda**
**Organization(s), if any: Solstice Behavioral Health at Full Life Care**
**Phone: 206-224-3779**
**Email: huda@fulllifecare.org**
**Mailing Address: 2600 South Walker Street, Seattle WA, 98144**

***Please note that county staff may contact the person shown on this form if additional information or clarification is needed.***

*Please share whatever you know, to the best of your ability.*
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by* ***October 31, 2015****.*

**1. Describe the concept.**
**Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.**

**An outreach program targeting older adults in psychiatric crisis who are at risk for hospitalization or re-hospitalization The outreach team will consiste of Geriatric mental health specialists, a program director and a consulting psychiatric nurse practitioner who will provide outreach visits to older adults to help cooridate and solidfy outindividualservices and to provide no more than 6 crisis suppor visits. With the consulation of the team, the indivdiuals primary care provider can make medication needed medication adjustments until psychiatric specialty services can be utilized. Potential participants will be referred by king county CDMHP services, GRAT team, or designated county referral specialists. Services will be funded by the county, with a goal of reducing inindividualpsychiatric hospitalzations.**

**2. What community need, problem, or opportunity does your concept address?**
**Please be specific, and describe how the need relates to mental health or substance abuse.**

**Older adults in psychiatric crisis are at risk for hospitalization for a variety of reasons; greater difficutly in accessing mental health services (transportation, functional limitations and lack of available outindividualmental health services). Often after discharge from inindividualpsychiatric hospitalization, appointments with outindividualtreatment providers are weeks out, or not fully solidified, leading to a repeat psychiatic crisis (suicidal ideation, inability to care for self). When discharging from the hospital, a well developed discharge plan often will fall apart due to lack of follow through by the individual due to inability to follow a goal directed plan.**

**3. How would your concept address the need?**
**Please be specific.**

**Upon referral, a geriatric mental health specialist (GMHS) will connect with the client on the next business day. The GMHS will provide up to 6 one hour visits to solidify with the individual and their immediate support team their relapse prevention plan, ensure adherence with prior arranged discharge plan, or develop a crisis stabilization plan utilizing available private and public resources such as community mental health, coordination of care with the clients primary care provider or , arranging transportation needs. The GMHS will function as a 'problem solver', providing immediate short term case management and crisis stabilization support until outindividualservies can take care of the clients psychiatric needs.**

**Consultation with a psychiatric nurse practitioner will allow for the individual's medication regimen to be adjusted during the treatment period.**
**The Roads to CommunityLiving by Aging and Disability Services is a similar project that targets older adults in risk of losing their housing.**

**4. Who would benefit? Please describe potential program participants.**

**-the individual who will be prevented from the emotional trauma of a psychiatric hospitalization, and will get their needs met while preserving their independence .**
**-the county will reduce preventable and unnecessary scarce and costly hospital treatment beds.**
**-Outindividualmental health service providers will benefit from improved coordination of care; accurate information regarding the individual's status will be communicated to those attempting to provide continuity of care.**

**5. What would be the results of successful implementation of program?**
**Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.**

**The key result will be crisis diversion; getting older adults population specific services by experienced geriatric mental health speciliasts using already available though diffiuclt to access services. This would be measured by county data indicating a decrease in requested older adult-specific psychiatric hospitalizations, and report from the CDMHP office of a reduction in ITA (involuntary treatments) of older adults.**

**6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)**

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

**7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?**

**This concept strives to address the county's already strained resoures in addressing older adults in psychiatric crisis. Social justice is addressed by addressing an individuals unique needs and not requiring the county to upsurp their civil rights with an involuntary hospitalization. This concept aims to address an indivdual's mental health needs in a populations specific manner that prioritizes using available resources in a cost effective manner.**

**8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.**

**Necessary partnerships include but are not limited to:**
**-inindividualhospitals such as Northwest Geropsych hospital in Seattle.**
**-Coordination with GRAT team for potential referrals.**
**-Community mental health providers such as Full Life Care or Navos**
**Access to referral services by Senior Services.**

**King county CDMHPs**
**-**

**9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?**

**Pilot/Small-Scale Implementation:** **$ 110,000 per year, serving 240 people per year**
**Partial Implementation:** **$** # of dollars here **per year, serving** # of people here **people per year**
**Full Implementation:** **$** # of dollars here **per year, serving** # of people here **people per year**

**Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.**

**If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.**