AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Rural Mental Health Integration Initiative

REQUEST FOR APPLICATIONS (RFA)

Eligible organizations: Primary care clinics in rural Washington and Alaska
Funding available: Up to $245,000
Timeframe: November 2020 through January 2022
RFA Release date: January 21, 2020
Webinar for Potential Applicants: June 18, 2020 at 3:30 PM Pacific Time
Application due date: July 31, 2020 (11:59 PM Pacific Time)
Award notification: September/October 2020
Activities start: November 2020

SECTION 1: OVERVIEW

1.A PURPOSE

Premera Blue Cross is committed to healthy communities by making health care work better. Rural communities and residents of those communities face significant social and health disparities as compared with urban and suburban residents. Rural residents are older,[1] poorer,[1] have lower educational attainment and income,[2] are more likely to be unemployed,[1,2] and are more likely to have experienced adverse childhood events (ACEs), including household mental illness.[3]

Rural residents face similar health disparities. They are more likely to have chronic health conditions, are less likely to receive healthcare of any kind, and are less likely to receive evidence-based treatments when they do access care.[4,5,6] Geographic maldistribution of mental health specialists from all disciplines and education levels (e.g., psychology, social work, psychiatry) creates significant access challenges.[7] Rural areas also experience primary care workforce shortages. Given primary care settings are where most rural mental health treatment occurs, this further exacerbates access barriers.[8,9]

Furthermore, behavioral health conditions are expected to increase and worsen as a result of COVID-19. According to a survey conducted by the American Psychiatric Association, 36% of respondents said COVID-19 is “seriously affecting their mental health, and most (59%) said it’s having a serious impact on their daily life.”[10] Primary care is likely to see many of these patients.

Collaborative Care (CoCM) is a type of integrated behavioral health with a strong evidence base for treating common mental health conditions like depression and anxiety in primary care settings.[11] CoCM has been proven to be effective when delivered via telehealth, either in part or wholly.[12]

1.B INTEGRATED CARE

Integrating evidence-based mental health services into primary care settings is particularly important in rural areas where workforce shortages for both primary care and mental health are most acute. The most effective approaches apply the principles underlying effective management of chronic medical illnesses to depression, anxiety, and other behavioral health conditions commonly treated in primary care.[11,13-14] The core principles, which can be achieved in a variety of ways,[15] are:

<u>Population-Based Care</u>
Primary care practices routinely screen for mental health conditions that commonly occur in primary care (e.g., depression, anxiety). The care team (comprised of the primary care provider, a behavioral health care manager, and psychiatric consultant) shares a defined group of patients. The behavioral health care manager enrolls and tracks patients who screen positive in a registry designed to drive measurement-based treatment to target by proactively prompting treatment changes for patients who are not improving or are only partially improving after an adequate treatment trial, typically 10-12 weeks per treatment change. The psychiatric consultant (e.g., psychiatrist, psychiatric nurse practitioner, psychiatric physician’s assistant) provides regularly scheduled caseload-focused consultation rather than ad-hoc advice.

<u>Patient-Centered Team Care</u>
Primary care and behavioral health providers collaborate together using a shared care plan that incorporates patient goals. Primary care providers (PCPs) remain the locus of care, prescribing

medication if that is part of the treatment plan. The PCP is augmented by a behavioral health care manager, typically a social worker, counselor, or nurse. The behavioral health care manager performs the initial assessment, completes the treatment plan with input from the PCP and psychiatric consultant, assists with differential diagnosis, routinely measures symptoms, proactively follows up with patients, prompts the treatment team to make a change in the treatment plan if patients are not adequately improved, and delivers evidence-based behavioral interventions and psychotherapy. In rural areas, where workforce shortages can make it difficult to recruit behavioral health providers and nurses, the behavioral health care manager role can be shared by a licensed provider (e.g., nurse, social worker) and non-licensed staff (e.g., medical assistant, community health worker). Non-licensed staff perform key behavioral health care manager functions that do not require a license, e.g., symptom measurement with PHQ-9 or GAD-7, proactive patient check-ins, entering information into the registry, assisting with pleasant events scheduling, and other interventions appropriate to their scope of practice.

Measurement-Based Treatment to Target

Each patient's treatment plan clearly articulates personal goals and clinical targets. The behavioral health care manager measures progress toward achieving these targets by routine use of evidence-based screening and assessment tools, like the PHQ-9 depression scale and GAD-7 anxiety scale. These tools are used in conjunction with clinical assessment and judgment of the treating providers. Symptom severity is measured at treatment initiation and at each subsequent contact, similar to taking blood pressure readings for patients being treated for hypertension, and this information is used to adjust treatment. Treatments are proactively changed if patients are not improving or only partial symptom improvement occurs.

Evidence-Based Care

Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. Treatment may include medications, psychotherapy and other behavioral interventions, or both. Evidence-based psychotherapies proven to work in primary care include Cognitive Behavioral Therapy, Behavioral Activation, and Problem-Solving Treatment.

Accountable Care

Clinics are accountable to their patients, providers, and the communities they serve. This accountability includes increasing access to services as well as the effectiveness of those services.

SECTION 2: ELIGIBILITY REQUIREMENTS

Eligible organizations must be a primary care clinic or a healthcare organization with at least one primary care clinic located in a rural area of Washington or Alaska that provided primary care services to at least 1,500 unique patients age 18 or older in the most recent reporting year. This minimum patient count applies to each individual applicant clinic and refers to all patients treated in the clinic, regardless of whether they were/are treated for behavioral health issues or have a behavioral health diagnosis. This minimum patient population should **not** include patients who only utilize a clinic's specialty services without also being primary care patients.

See Appendix A for details regarding ineligible geographic areas. Clinics federally designated as rural health clinics (RHCs) are eligible to apply, regardless of zip code.

Applying organizations do **not** need to have patients served by Premera. Organizations that have worked with the AIMS Center in the past are also welcome to apply.

Healthcare organizations with more than one clinic location are eligible to apply for participation of more than one site if those sites are at least 20 miles apart and are both located in a rural area. **Organizations applying on behalf of multiple sites should submit separate applications for each site. Applications can repeat certain sections when they apply to all clinics (e.g., organization overview) but should otherwise reflect the characteristics, personnel, strengths/challenges, and workflows of each separate clinic.** Preference in issuing awards will be given to separate clinics/healthcare organizations. However, depending on the number of applications received, consideration will be given to applications from organizations with multiple sites.

Many primary care clinics have experience of some kind integrating behavioral health services in a variety of different ways. This can look like primary care providers independently providing care, sometimes supported by a clinic nurse, medical assistant, community health worker, or other support staff; co-located behavioral health services; or fully integrated, team-based care. **Regardless of current approaches to behavioral health delivery, including no current provision of any services, all clinics are welcome to apply**. All applicants should clearly articulate what their goals for participation will be in relation to their current level of integration. For clinics with an existing integrated care program, please describe how participation would strengthen and/or expand some aspect of the existing program (e.g., would participation support the clinic in serving more individuals or expanding existing services to another patient population?). Please also articulate how participation in this initiative will make a significant difference in services available in the clinic's community.

SECTION 3: TRAINING, IMPLEMENTATION SUPPORT, AND IMPACT EVALUATION

Premera is partnering with the University of Washington AIMS Center to provide training and practice support for clinics participating in this rural mental health integration initiative. The AIMS Center will lead clinic selection, training, technical assistance, and practice coaching for participating clinics. The AIMS Center has 15 years' experience supporting integrated care implementation, including experience supporting rural and frontier primary care clinics in Texas, Montana, Washington, Alaska, and Wyoming.

Participating clinics will convene the follow teams:

Clinic Implementation Team (CIT)

- Each practice will identify a clinic implementation leader (required). This role is typically filled by a Clinic Manager, CEO, CMO, CNO, Behavioral Health Director, or similar. This person will convene a clinic implementation team (CIT).
- Each practice will identify a Primary Care Provider Champion (required) who will represent the clinic's primary care providers. This person will participate in the CIT, attend the in-person training, and champion practice changes with their peers.
- Potential other CIT members: Clinic leadership, psychiatric consultant, care manager, finance and quality team members.
- The CIT from each organization meets monthly with an AIMS Center implementation coach to tailor implementation of the integrated care core principles to their clinic, develop a sustainable financing strategy and processes, and develop/implement a comprehensive, evidence-based suicide prevention protocol.
- The CIT participates in the Pre-Launch Training and Virtual Learning Community (VLC) described below.

Clinical Team

The clinical team at each healthcare organization is comprised of the primary care providers, behavioral health care manager(s), and psychiatric consultant.

The University of Washington cannot provide psychiatric consultation services for participating clinics. In addition, psychiatric consultation services provided as part of evidence-based integrated care cannot be ad-hoc. The AIMS Center can provide resources and guidance for clinics who need to identify a psychiatric consultant. Psychiatric nurse practitioners are eligible to serve as psychiatric consultants.

Training and implementation support for these teams will include:

Pre- and Post-Program Launch Reading and Online Didactic Training

Pre-launch reading assignments will come from *Integrated Care: Creating Effective Mental and Primary Health Care Teams.* Two copies of this book will be provided to participating clinics free of charge.

All online trainings utilize existing AIMS Center training content delivered through a Learning Management System (LMS) and/or the American Psychiatric Association (APA)'s online training offerings. The purpose of this initial online training is to focus on knowledge transfer so the in-person training can focus on applying knowledge and skill development.

In addition to the required training outlined below, the AIMS Center will offer comprehensive suicide prevention training free of charge, dependent upon a provider's licensure/credentials and their prior completion of similar training.

- ***Primary Care Provider Champion:*** The PCP champion will complete approximately five hours of combined reading and online training prior to program launch. Core content focuses on the importance of the PCP role and key components of evidence-based integrated care. Additional content will focus on workflow development and implementation.

- ***Other Primary Care Providers:*** These providers will complete approximately five hours of combined reading and online training prior to program launch. Core content focuses on the importance of the PCP role and key components of evidence-based integrated care.

- ***Behavioral Health Care Manager(s):*** BH care managers will complete approximately 10 hours of combined reading and online training prior to program launch, with topics and required time varying based on the clinician's credentials (e.g., Master's or Bachelor's level) and/or if the role is being shared between Master's and non-Master's level staff. Core content focuses on key activities associated with the behavioral health care manager role and training in evidence-based behavioral interventions appropriate for primary care (e.g., Behavioral Activation skills).

- ***Psychiatric Consultant:*** Psychiatric consultants will participate in approximately five hours of combined reading and online training through the American Psychiatric Association prior to program launch, with an additional two hours of APA online training post program launch. The APA training will be required unless the clinician serving in this role has already completed it or attended an in-person workshop hosted by the APA. Core content focuses on the consultant role, especially regular caseload consultation with the behavioral health care manager.

- ***Clinic Leadership and Staff:*** CIT Leaders will complete approximately two hours of combined reading and online training prior to program launch. Core content will include an overview of integrated care principles and key components as well as workflow development and implementation. CIT Leaders and other staff are welcome to participate in any of the aforementioned training as desired.

In-Person Training

The AIMS Center will provide a full-day in-person training in Seattle. This training will build upon the online training and will emphasize adapting and applying the principles to each clinic's local context. Clinicians will also practice skills relevant to integrated behavioral health. The training will include caseload management using a registry.

In-person training attendees must include the Clinic Implementation Leader, PCP Champion, all behavioral health care managers, and the psychiatric consultant. Other staff are welcome to attend the in-person training upon mutual agreement of the clinic and AIMS Center.

Virtual Learning Communities (VLC):

- ***Clinic Implementation Teams (CIT):*** Project ECHO serves as the model for these videoconference-based virtual learning communities. The CIT leader from each clinic

participates. The PCP Champion will represent all PCPs in the clinic and will be responsible for bringing content back to other PCPs in their clinic via in-service or similar venues, according to the culture of each clinic. Video conferences will occur monthly. During the planning and pre-training phase, topics will include creating a program vision, preparing workflows, identifying staff to fill roles or hiring new staff, developing a financing plan, etc. After launch, the conferences will focus on quality metrics and problem-solving implementation challenges. Participants learn from each other as they continue to make adaptations to maintain core components of integrated care and hit quality targets. This is in addition to the monthly organization-specific meetings each CIT participates in with an AIMS Center coach (described on page 4 under CIT description).

- ***Behavioral Health Care Managers:*** Prior to program launch, training for behavioral health care managers focuses on knowledge and skills necessary to fulfill their role immediately following the in-person training. Thereafter, behavioral health care managers will participate in a monthly VLC designed to expand and hone their skills. This training will focus on specific behavioral health topics, including relapse prevention, working with patients with challenging or complex conditions, and using a registry to drive clinical decisions with the care team.

- ***Psychiatric Consultants:*** Training for psychiatric consultants focuses on how their role differs from traditional consultative models, including best practices for the weekly caseload review. An experienced psychiatric consultant from the AIMS Center will join a caseload review between the psychiatric consultant and care manager(s) within about 10 weeks of the in-person training. This expert will give verbal feedback at the end of the review as well as a written summary for the psychiatric consultant and CIT. Over the following 11 months, this caseload review consultation with an AIMS Center expert will occur twice more. In addition, psychiatric consultants from all participating clinics will meet together for a one-hour conference call with an experienced psychiatric consultant from the AIMS Center every two months. These calls will focus on the consultant role, monitoring quality measures, and strategies the psychiatric consultant can use to reinforce the training topics covered with the behavioral health care managers.

Onsite Technical Assistance
When needed, AIMS Center integrated care experts will provide onsite coaching and assistance to diagnose implementation challenges and develop strategies for overcoming them.

Caseload Tracker/Registry
The AIMS Center will provide a simple caseload tracker to each participating clinic. The care team uses this simple yet powerful registry tool in conjunction with the electronic health record to drive measurement-based treatment to target. It tracks all patients engaged in treatment, identifies patients not improving as expected or ready for discharge from active treatment, and prompts providers to act upon this information.

Use of the caseload tracker is required unless the clinic is already using the Mental Health Integrated Tracking System (MHITS) through the Washington State Mental Health Integration Program (MHIP) OR another version of the Care Management Tracking System (CMTS).

Impact Evaluation

The AIMS Center will conduct an impact evaluation for this initiative. The Clinic Implementation Team leader will complete surveys prior to the planning phase and after implementation about the clinic's experiences with practice change. Clinical staff (primary care providers, behavioral health providers, and psychiatric consultants) will also complete surveys about their experience implementing integrated care.

SECTION 4: AWARD INFORMATION

4.A. Amount

Clinics are eligible to receive up to $245,000 for participation in this initiative. The award will be made in two payments directly from Premera. The first payment will be $160,000, and the second payment will be $85,000. Receipt of the second payment will be contingent upon meeting participation requirements.

4.B. Award Notification

The AIMS Center will notify clinics about the outcome of the application process **by late September or early October 2020**. Applicants that do not receive an award will receive written feedback about what they can do to strengthen their application for the final funding cycle. If a healthcare organization applied for participation of more than one clinic site, it is possible some but not all sites will be selected to receive funding.

4.C. Award Start

Grants will be awarded in **October 2020** and work with the AIMS Center will start in **November 2020**. Each organization's participation in the initiative will last 15 months. There will be one future round of funding beginning in **August 2021**.

4.D. Allowable Use of Funds

Funding is intended to offset the cost of clinic staff time to participate in planning, training, and coaching activities described in Section 3. Clinics may use funds to pay "locum" providers to cover for providers to participate in these activities, so long as these providers treat patients in the same manner (i.e., the clinic will bill the patient and their payer in the exact same way as they would if the provider who is participating in this initiative was seeing the patient).

Funds are also intended to pay for clinic staff to travel to Seattle to participate in the in-person training.

Grant funds MAY NOT be used for

- Clinical care delivery (i.e., clinics must bill patients and payers for services rendered as they normally would)
- Hiring new staff (with the exception of locum providers to cover clinical responsibilities for providers participating in training)
- Medications, lab tests, imaging, or similar costs related to clinical care delivery
- Technology infrastructure (EHR costs, computers, etc.)
- Fundraising
- Facility acquisition or renovation
- Deficit reduction or debt payment
- Lobbying activities
- Displacement of existing funding sources

Neither the AIMS Center nor Premera will require any budgets or financial reporting from participating clinics over the course of the initiative. However, participating clinics should keep records that would support their correct use of the funds in the event of an audit from Premera.

SECTION 5: APPLICATION PROCESS

5.A. Web Address for Information, including application materials
https://aims.uw.edu/premera-rural-mental-health-initiative
If you have questions about completing the application, please email ruralmh@uw.edu.

5.B. Applicant Webinar
The AIMS Center will host a webinar for potential applicants on **June 18 at 3:30pm Pacific**. Connection information is provided below. This webinar will summarize this opportunity and applicant questions received to date as well as offer the opportunity for live questions.

Join Zoom Meeting
https://uw-phi.zoom.us/j/526912592
Dial by your location
+1 669 900 6833 US (San Jose)
Meeting ID: 526 912 592

5.C. Application Submission
Applications must be received by the due date and time below. The AIMS Center will not consider late submissions.
Due Date/Time: **July 31, 2020, 11:59pm Pacific**
Submit applications by email to: ruralmh@uw.edu

5.D. Written Application Review
Two integrated care experts from the AIMS Center will review and score written applications. Finalists will be invited to participate in a selection site visit (see below). Applicants not selected for a site visit will receive feedback about their application and concrete suggestions for submitting a successful application for the final round of funding. Applicants will receive a determination about the outcome of the written application review in **August 2020**.

5.E. Selection Site Visits
At least one member of the AIMS Center will travel to the finalist clinics; **if circumstances require it, site visits will be conducted virtually instead of in-person**. A representative from Premera may participate in some site visits. The purpose of this visit will be to address questions that arose from review of the written application and to give applicants the opportunity to expand on their written application, if necessary. Applicants will receive an agenda for the visit and questions to address at least one week prior to the visit to ensure they have time to prepare their answers. If questions arise during the selection site visit that cannot be answered at the time of the visit, clinics will be given one week to submit a brief written response to ruralmh@uw.edu. If a healthcare organization applied for more than one clinical site, it is possible some sites but not others will be selected to participate in a selection site visit. Selection site visits will occur between **August 24 and September 25, 2020**. Key members of clinic leadership (e.g., CMO, clinic manager) and clinical providers already on staff (e.g., primary care provider champion, behavioral health staff) must be available to participate in the visit.

SECTION 6. APPLICATION

6.A Application Format

Applications must be submitted in pdf format. Font must be Calibri point 11. Tables may use Calibri point 10. Margins must be 1 inch. Header must include clinic name. The application narrative is limited to five (5) single-spaced pages and a required one-page appendix. **We will not consider any materials beyond the required components and five (5)-page narrative application.**

6.B Application Components

- Cover Page
  - This must be completed, signed, and dated by an authorized representative as well as key stakeholders.
- Behavioral Health – Primary Care Integration Assessment
- Clinic Implementation Team (CIT) Appendix
  - Applicants will submit a one-page appendix describing the leadership, providers, and other staff members who will comprise the CIT. This description will include these individuals' roles within the CIT, their credentials, length of tenure at the organization, and any other information that will illustrate your plan for the CIT.
- Application Narrative
  - The narrative should be clear, concise and address each of the items below. Applicants will provide the narrative and all required attachments as a combined pdf: 1) Cover Sheet, 2) Application Narrative, 3) Integrated Care Assessment, 4) CIT Appendix

6.C Application Narrative Components

1) Organization overview: Applicant should describe their organization, including a brief history, mission, organizational and governance structure, and payer mix.

2) Goals: Applicant should describe their interest in this integrated care initiative and what they hope to achieve through participation.

3) Organizational strengths, challenges: Applicant should describe organization strengths and anticipated challenges associated with integrating behavioral health services into primary care according to the principles described in Section 1.B. When describing challenges, applicants should describe potential solutions or mitigating factors and/or why previous attempts at overcoming challenges have not succeeded.

4) Screening for behavioral health conditions: Applicant should describe current screening practices for common behavioral health conditions including depression, anxiety, and substance use. Applicants must report the proportion of the clinic population screened for each condition as well as the source and timeframe for that data, or clearly address why such information is unavailable.

5) Current behavioral health services: Applicant should describe current behavioral health services, if applicable. Please describe: a) the physical location of these services in relation to primary

care service area, b) the types of psychotherapy available and number of providers trained to deliver each, and c) the range of behavioral health services provided. Applicants should base these descriptions on services offered in the clinic applying to participate, rather than the health care organization as a whole.

6) Staffing: All information below should refer to the applicant clinic rather than the healthcare organization as a whole.
   - Applicant should describe total FTE primary care providers, total FTE behavioral health staff, and total FTE leadership.
   - Please provide information about the length of tenure of personnel in key organizational leadership roles (e.g., CEO, CMO, CNO, Behavioral Health Director)
   - Please provide the FTE of primary care providers who are non-permanent (e.g., locum tenens).
   - Applicants should describe in detail how they plan to fill the behavioral health care manager and psychiatric consultant roles. Specifically, will applicant redeploy existing staff or hire new staff? If the former, how will existing responsibilities be managed? If the latter, applicant should describe available workforce in their area, whether psychiatric consultant will work onsite or remotely, and prior experience recruiting behavioral health workforce if applicable. Applicants should describe their previous experience recruiting behavioral health providers, if any
   - Applicant should describe their planned approach to the behavioral health care manager role. For example, will only licensed behavioral health staff serve in this role, or do applicants intend to share care management duties with non-licensed staff? If the latter, please describe the type of non-licensed staff to be used, whether staff will be hired or redeployed and, if redeployed, how existing responsibilities will be managed.

7) Implementation leadership plan: Applicant should describe their plan for designating an implementation leader and that person's experience with prior quality improvement initiatives.

8) Financing: Applicant should describe their current financing strategies for behavioral health services, if applicable, and current or anticipated challenges associated with financing. Applicants using CMS (Centers for Medicare and Medicaid Services) Psychiatric Collaborative Care (CoCM) billing codes should describe how they are using the codes.

9) Applicants should describe their plan to sustain the integrated care program after completing participation in the initiative.

6.D Required CIT Appendix
Applicants must submit a one-page appendix describing the leadership, providers, and other staff members who will comprise the Clinic Implementation Team (CIT). This description should include these individuals' roles within the CIT, their credentials, length of tenure at the organization, and any other

information that will illustrate your plan for the CIT. See section 6.A for formatting specifications. **Any materials beyond this one-page appendix will not be considered during the application review.**

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Appendix A – *Ineligible* Zip Codes

To determine if your clinic is eligible to apply for this initiative, please locate the zip code for your clinical service delivery location, which may be different from your business office location. If you have multiple clinic locations, some may be eligible and others may not.

Clinics in the zip codes listed below are NOT eligible unless they are federally designated rural health clinics (RHCs).

Alaska

99501	99506	99511	99517	99522	99540	99695	99707	99712	99790
99502	99507	99513	99518	99523	99567	99701	99708	99714	
99503	99508	99514	99519	99524	99577	99703	99709	99716	
99504	99509	99515	99520	99529	99587	99705	99710	99725	
99505	99510	99516	99521	99530	99599	99706	99711	99775	

Washington

98001	98027	98053	98093	98125	98166	98208	98255	98294	98342
98002	98028	98055	98101	98126	98168	98213	98256	98295	98344
98003	98029	98056	98102	98127	98170	98220	98257	98296	98345
98004	98030	98057	98103	98129	98174	98223	98258	98303	98346
98005	98031	98058	98104	98131	98175	98224	98259	98304	98348
98006	98032	98059	98105	98132	98177	98225	98262	98310	98349
98007	98033	98061	98106	98133	98178	98226	98263	98311	98351
98008	98034	98062	98107	98134	98181	98227	98266	98312	98352
98009	98035	98063	98108	98136	98185	98228	98270	98314	98353
98010	98036	98064	98109	98138	98188	98229	98271	98315	98354
98011	98037	98065	98110	98139	98189	98232	98272	98321	98359
98012	98038	98070	98111	98141	98190	98233	98273	98322	98360
98013	98039	98071	98112	98144	98191	98235	98274	98323	98364
98014	98040	98072	98113	98145	98194	98236	98275	98327	98366
98015	98041	98073	98114	98146	98195	98238	98276	98328	98367
98019	98042	98074	98115	98148	98198	98241	98282	98329	98370
98020	98043	98075	98116	98154	98199	98244	98284	98330	98371
98021	98045	98077	98117	98155	98201	98247	98287	98332	98372
98022	98046	98082	98118	98158	98203	98248	98288	98333	98373
98023	98047	98083	98119	98160	98204	98249	98290	98335	98374
98024	98050	98087	98121	98161	98205	98251	98291	98337	98375
98025	98051	98089	98122	98164	98206	98252	98292	98338	98378
98026	98052	98092	98124	98165	98207	98253	98293	98340	98380

98383	98412	98467	98530	98616	98684	98923	99023	99208	99329
98384	98413	98471	98540	98622	98685	98933	99025	99209	99330
98385	98415	98481	98546	98625	98686	98936	99026	99210	99336
98386	98416	98490	98548	98626	98687	98937	99027	99211	99337
98387	98417	98493	98555	98629	98801	98939	99029	99212	99338
98388	98418	98496	98556	98632	98802	98942	99030	99213	99348
98390	98419	98497	98557	98639	98807	98947	99031	99214	99352
98391	98421	98498	98558	98642	98811	98951	99034	99215	99353
98392	98422	98499	98568	98645	98815	99001	99036	99216	99354
98393	98424	98501	98576	98648	98821	99003	99037	99217	99360
98394	98430	98502	98580	98649	98822	99004	99039	99218	99361
98395	98431	98503	98581	98660	98828	99005	99110	99219	99362
98396	98433	98504	98588	98661	98836	99006	99122	99220	99363
98397	98438	98505	98589	98662	98847	99009	99148	99223	99401
98401	98439	98506	98597	98663	98850	99011	99156	99224	99402
98402	98443	98507	98599	98664	98852	99012	99173	99228	99403
98403	98444	98508	98601	98665	98901	99013	99181	99251	
98404	98445	98509	98603	98666	98902	99014	99201	99252	
98405	98446	98511	98604	98668	98903	99016	99202	99258	
98406	98447	98512	98606	98671	98904	99018	99203	99301	
98407	98448	98513	98607	98674	98907	99019	99204	99302	
98408	98464	98516	98609	98675	98908	99020	99205	99320	
98409	98465	98524	98610	98682	98909	99021	99206	99323	
98411	98466	98528	98611	98683	98920	99022	99207	99324	