



Solicitation Information

16 May 2012

RFP # 7449736

TITLE: Women's Substance Abuse Treatment Services

Submission Deadline: 27 June 2012 @ 11:00 AM (EDT)

PRE-BID/ PROPOSAL CONFERENCE: Yes Date: 4 June 2012 Time: 1:30 PM (EDT) Mandatory : No Location: Department of Administration, Division of Purchases (2nd floor Bid Room), One Capitol Hill, Providence, RI

Questions concerning this solicitation may also be e-mailed to the Division of Purchases at questions@purchasing.ri.gov no later than 31 May 2012 @ 12:00 Noon (EDT) .Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP / LOI # on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

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Vendors must register on-line at the State Purchasing Website at www.purchasing.ri.gov.

NOTE TO VENDORS:

Offers received without the entire completed three-page RIVP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

Women's Substance Abuse Treatment Services

SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Office of Purchases, on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), hereinafter referred to as the Department, Division of Behavioral Healthcare Services (DBH) is soliciting proposals from qualified firms to provide Women's Substance Abuse Treatment Services as described elsewhere herein, and in accordance with the terms of the Request and the State's General Conditions of Purchase (available at www.purchasing.ri.gov).

This is a Request for Proposals, not an Invitation for Bid: responses will be evaluated on the basis of the relative merits of the proposal; there will be no public opening and reading of responses received by the Office of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

SECTION 2: INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

- Potential offerors are advised to review all sections of this Request carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
- Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this Request will be rejected as being nonresponsive.
- All costs associated with developing or submitting a proposal in response to this Request, or to provide oral or written clarification of its content shall be borne by the offeror. The State assumes no responsibility for these costs.
- Proposals are considered to be irrevocable for a period of not less than sixty (60) days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
- All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
- Proposals misdirected to other State locations or which are otherwise not present in the Office of Purchases at the time of opening for any cause will be determined to be late and will not be considered. The official time clock is located in the reception area of the Division of Purchases (Dept. of Administration), One Capitol Hill, Providence, RI
- Joint ventures and cooperative proposals will be considered, subcontracts are permitted, provided that their use is clearly indicated in the offeror's proposal, and the subcontractor(s) proposed to be used are identified in the proposal.

- Interested parties are instructed to peruse the Division of Purchases web site on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP / LOI
- The offeror should be aware of the State's MBE requirements, which addresses the State's goal of ten per cent (10%) participation by MBE's in all State procurements. For further information, contact the MBE Administrator, at (401) 574-8253 or visit the website <http://www.mbe.ri.gov>
- Interested parties are instructed to peruse the Division of Purchases web site on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP / LOI
- We are interested in considering innovative ideas that we have not mentioned in this RFP
- Vendors must comply with BHDDH Regulation 8.5.4A. The Department requires appropriate justification to be maintained in the employee's record as to why an individual who has been convicted of child abuse or of felony for sexual assault, physical assault, sexual exploitation or any criminal activity and/or disposition is deemed appropriate for service provision in Women's Treatment. Any non-licensed vendor who employs contracts or has someone volunteer with the above stated criminal activity must submit justification to the Department.

SECTION 3: BACKGROUND AND PURPOSE

Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, (BHDDH) has always offered substance abuse treatment services that focus specifically on the needs of women. However, for the most part, women's services have been integrated into a co-ed system of care. This RFP is intended to change the way that services to women are delivered by asking providers to look at the distinct needs of women and proposing ways to provide these services.

In addition to a new way of delivering women's substance abuse treatment services, the State is also anticipating the advent of the Affordable Healthcare Act. It is expected that the general service landscape will continue to change dramatically and challenge the treatment system to adapt to new ways of thinking and doing business. It is the Department's overarching goal to see that the system identifies the needs of the community and to ensure that the system of care is client centered utilizing a full continuum of treatment and recovery support services.

The goal of this RFP is to improve access to a full continuum of treatment and recovery services for women statewide. This RFP presents with two new levels of residential treatment services. The first being an acute stabilization service (ASAM Level III.2D) for up to 14 days intended to meet the need of the clients awaiting placement into a traditional short or long term residential program. This level of care is offered to the client who has either completed or does not need detoxification services but is in crisis with risk of imminent relapse. The other new level of care is a transitional program (ASAM Level III.I) with a less than 30 day length of stay geared to the

needs of individuals who need to stabilize before full community re-integration. This may be a re-entry client from a recent incarceration or someone who needs short term stabilization, post relapse, in a lower level of care that does not require a full 90 days. This RFP will also allow for the integration of both the short term halfway houses and the contracting and utilization of recovery housing within certain parameters.

Successful applicants will be expected to establish connections with other agencies that provide natural supports to their clients, including linkages to the variety of recovery supports and primary care providers. In addition, successful applicants will be expected to demonstrate the ability to transition individuals through the various ASAM PPC levels of care and demonstrate tools for documenting these transitions, policies and procedures for admissions and discharges. Staff development and training around the importance of transitioning clients using the American Society of Addiction Medicine (ASAM) criteria will also be expected. Adherence to use of ASAM criteria to establish appropriateness for admission and continued justification of treatment will be a focus of monitoring by the department. The expectation is that all providers will respond effectively to the needs and differences of all clients, and will participate in ongoing self assessment and development of their cultural competence.

SECTION 4: GENERAL INFORMATION

In the past three years there were 546 state-funded admissions of women to residential substance abuse treatment for an average of 182 admissions per year. About half of the women in residential treatment had a follow-up episode of care after discharge. They received outpatient services (17%), another residential episode (10%), inpatient detoxification (7%) or narcotic detoxification or maintenance (2%). Another 14 percent were admitted to a mental health program. Most (64%) of admissions were 26 to 45 years old. A significant number of clients present at residential treatment as homeless. A little under a third of the women were court ordered to treatment. The most common primary substance of use for women was cocaine (33%) followed by alcohol (25%), heroin (19%), marijuana (12%) and opiates (6%).

Women with substance use disorders face numerous and sometimes overwhelming obstacles. Women who have children may function as single parents with little or no financial support. They may lack child care and therefore be unable to enroll in treatment. They may live in unstable or unsafe environments, including households where others use alcohol or other drugs. They may be victims of physical and/or sexual abuse and suffer from Post-Traumatic Stress Disorder, anxiety and depression, all of which complicate the recovery process.

This application solicitation is designed to address the multiple needs of women and their families to access family-centered services for their substance use disorders. These services must be gender, culturally and linguistically relevant. These services also must include, where appropriate, mental health, trauma responsive approaches, childcare and parenting assistance, transportation, natural and recovery supports and/or other services that are necessary to provide wraparound care to women and their families.

Family-centered treatment offers a solution to an intergenerational cycle of substance use and related consequences by helping families reduce substance use and improve family functioning, child health and safety.

This application solicitation will provide an opportunity to focus on the specific needs women, as well as achieve and identify improved outcomes for evaluation. For women with children this solicitation will provide an opportunity to focus on therapeutic childcare and other services as necessary for treatment and for a woman's meaningful recovery.

Target Population

Women and their families included in the program must be in need of services for substance use disorders.

The eligible population for this initiative includes all medically uninsured (which includes uninsured for service), legal Rhode Island residents with incomes up to 200% of the federal poverty level who are determined to be in need of IOP, PHP, and all Level III treatment and recovery support services. Level of care determination requires the use of the most recent version of the ASAM PPC. If the client has insurance that covers residential for a period of time and the benefit is exhausted, as long as the client demonstrates clinical need for that level of care and other eligibility criteria are met, then the client may be eligible for funding through this contract.

Over the past several years BHDDH established a priority, in collaboration with the Department of Corrections, to meet the needs of individuals with substance use disorders as they transition from prison to community. Both BHDDH and Corrections have aggressively obtained and allocated additional funds to serve this population. In addition to enhancing the integration of recovery support services into the service milieu, these grants targeted individuals involved with the criminal justice system. It is expected that this contract will build upon the strengths and experiences of these grant funded programs

Funding under this initiative shall not be utilized to treat individuals who are insured for service through private health insurance or other public programs, including Title 19, RIte Care, health care benefits available to veterans, or for individuals who have the ability to pay for service. Admission into state funded treatment will be prioritized in the following descending order from 1-5 but the other populations are targeted to receive treatment services:

1. Women who are pregnant;
2. Women who are IV users;
3. Women who are HIV antibody positive or have HIV disease;
4. Women who are homeless or at risk of being homeless;
5. Women in state-funded detoxification, inpatient psychiatric hospitalization and diversion/step-down units;

It is expected that successful applicants will adopt and incorporate SAMHSA's National Behavioral Health Quality Framework into the service continuum The Department is also seeking proposals that address the unique needs of the following populations:

- Women with co-occurring disorders;
- Women involved with the criminal justice system;
- Women involved with DCYF/child welfare;
- Women who are Sex Trafficked/Commercially Sexually Exploited ;
- Women who are in domestic violent relationships;

- Women who are 18-28 years of age;
- Women with physical or other disabilities or medical conditions;
- Racial and ethnic minorities;
- LGBQ populations;
- Any other specialized populations proposed (applicants must demonstrate need for specialized services for such populations).

SECTION 5: PROGRAM GOALS

The primary goal of this RFP is to create and maintain a statewide holistic recovery oriented system of care which will utilize gender responsive family-centered approaches in an integrated behavioral health setting driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for women, children and families across the life span.

The primary objective of the family-centered treatment services is to improve outcomes for women with substance use disorders, their children, and other members of their families. To accomplish this objective, a program must have a strong core that includes approaches, interventions, and services that are effective in reaching and retaining women. Gender-responsive programs consider the needs of women in all aspects of program design and delivery, including location, staffing, program development, program content, and program materials (United Nations Office on Drugs and Crime, 2004). Gender-responsive programs offer more than a set of relevant services for women; they provide safe and comfortable environments in which women develop supportive relationships that allow them to address their recovery needs (Covington, 2006). In addition, gender-responsive programs strive to achieve the following goals:

- A. To achieve improved outcomes by meeting the special needs of women and their families who experience problems resulting from substance use disorders by providing intervention, treatment, and support services that are gender, culturally and linguistically responsive.
- B. To target women and their families who are involved in several systems in order to develop better ways to coordinate services from multiple service systems.
- C. To ensure the provision of wraparound services including, but not limited to, parent education, vocational and housing assistance, coordination with other community programs, and treatment under intensive care.
- D. To develop a system that reinforces the empowerment of consumers and their involvement in the planning, design, implementation, and evaluation of the program, as well as their care plan.
- E. To identify best practices and provide knowledge dissemination activities and cross training and education to professionals who work with women and their families and are from different systems in order to achieve positive client/family outcomes.
- F. To provide screening and information for Fetal Alcohol Spectrum Disorders (FASD), Fetal Alcohol Syndrome (FAS).
- G. To provide relapse prevention for at-risk clients.

- H. To ensure that all aspects of the program reflect the core values identified elsewhere in this document.
- I. To provide family-centered-improved outcomes for women, children, and other family members; better parenting and family functioning.

SECTION 6: BHDDH WOMEN'S TREATMENT FUNDAMENTAL PRINCIPLES

The Department of BHDDH is requiring the following eight core fundamental principles as the foundation of integrating women-specific substance abuse treatment services and wraparound/integrated services, while focusing on effective and comprehensive treatment of women and their families.

- 1) Women's recovery is significantly based on relationships, a "relational model."
 - a) A relational model emphasizes the central importance of relationships in women's lives. Since women in this culture have been the caretakers of certain aspects of the total human experience, specifically carrying responsibility for the care and maintenance of their children and/or other relationships, this model attempts to address the strengths as well as the problems arising for women from this relational orientation.
 - b) The primary motivation for women throughout life is toward establishing a basic sense of connection to others.
 - c) Women feel a sense of self and self-worth when their actions arise out of a connection with others. The experience of psychological connection is based on empathy and mutuality in relationships. Applications must describe how peers will be incorporated into the treatment milieu if proposed.
- 2) Treatment revolves around the role women have in society, therefore treatment services need to be gender specific.
 - a) Gender-responsive programs are not simply "female only" programs that were designed for males.
 - b) A woman's sense of self develops differently in women-specific groups as opposed to co-ed groups.
 - c) Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.
 - d) The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, sexual exploitation, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
 - e) Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.
- 3) The wraparound philosophy is driven by a person-centered approach.
 - a) Utilization of the wraparound philosophy through inter-systems collaboration and involvement of informal supports is expected.

- b) Although there are many agencies and systems involved the life of the woman, her needs determine the connections with those agencies and systems that impact her life or her family's life.
- c) Each woman will have a single coordinated care plan or that is used for service coordination.
- d) The care coordinator should remain the same as the woman progresses in recovery.

4) The model is one of empowerment.

- a) The participant is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
- b) This experiential learning process is initially taught by appropriate staff, and is woven into recovery.
- c) This tapestry of recovery focuses on empowerment as a learned skill that is taught by all service providers working with the woman and her family.
- d) The ultimate goal for the service system is to weave the woman so well into the fabric of informal support systems that the role of formal services is very small or not needed at all.

5) Education and employment are important components of recovery and serve as vital therapeutic tools.

- a) The structure of employment is a benefit to recovery, and treatment providers must help clients to connect with available resources to assist them in this realm. Waiting for a client's substance abuse problems to completely resolve before addressing their vocational concerns is often an inappropriate strategy. Women in treatment may be engaging in education, work and/or work-related activities, therefore, treatment providers must clearly integrate education, work and/or work-related activities into the overall treatment plan and services provided to clients, or must document why these are not being addressed in their plan.

6) The use of a multi-system approach that is culturally cognizant. Gender specificity and cultural competence go hand in hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community. This concept was developed by Sue, Arredondo, and McDavis, (1991) who suggests five broad categories:

- 1) Awareness of one's own assumptions, values, and biases;
- 2) Understanding the worldview of the (gender) and culturally different client; and
- 3) The ability to develop appropriate strategies and techniques.
- 4) People who are skilled in these competencies possess the following beliefs and attitudes:
 - a) They are aware of their own (gender) and cultural history and value and respect the differences of others.
 - b) They are aware of how their own gender and cultural backgrounds, experiences, attitudes, values and biases influence the psychological process and relationships with others.
 - c) They are able to recognize the limits of their competencies and expertise.
 - d) They are comfortable with gender and cultural differences.

5) Also, if an agency is providing services to a multi-linguistic population, there should be multi-linguistic resources, including use of skilled bilingual, bicultural translators, and interpreters

whenever a significant percentage of the target community is more comfortable with a language other than English or spoken language.

- a) Preference will be given to programs that offer women-specific, self-help programs to current and former clients (including but not limited to women-specific NA and AA) as alternatives to traditional male-based NA and AA models.

SECTION 7: STANDARDS, REGULATIONS AND CORE VALUES

Standards

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes women's development in terms of the range of relationships in which women can engage. This is very different from the theories of emotional growth which have been the basis of substance abuse treatment and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as a source of strength to be built upon, rather than see this as "treatment resistance." When a program operates from this theoretical point of view, the characteristics of the clinical treatment program and its objectives and measures of success are defined very differently from those of traditional treatment programs. Programs that are designed to meet women's needs tend to be more successful in retaining women clients. For an agency to be able to offer women-specific treatment, its programs must include the following criteria:

I. Accessibility

Many barriers exist that may critically inhibit attendance and follow-through for women with children, including child care, transportation, hours of operation and co-occurring mental health issues.

Standard: Agencies/programs shall demonstrate a process to reduce barriers to treatment by providing those ancillary services or ensuring that appropriate referrals to other community agencies are made. Agency policies should be updated to reflect this focus.

II. Assessment

Women with children need to be assessed and treated as a unit. Women often enter and leave treatment because of their children's needs.

Standard: Assessment shall be a continuous process that assesses the client's psychosocial needs and strengths within the family context and through which progress is measured in terms of increased stabilization/function of the individual/family. In addition, all assessments shall be strength-based, trauma informed and conducted through motivational interviewing.

III. Psychological Development

Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness, and "learned helplessness," particularly as they operate in relationships with their children and men.

Standard: Agencies/programs shall demonstrate acknowledgement of the specific stages of psychological development and modify therapeutic techniques according to client needs, especially to promote independence/autonomy.

IV. Abuse/Violence/Trauma

A history of abuse, violence, trauma and sexual exploitation often contributes to the behavior of substance abusing and dependent women.

Standard: Agencies/programs must develop a process to identify and address past and current abuse/violence/trauma/exploitation issues. Services will be delivered in a trauma-informed, trauma-sensitive setting and provide safety from abuse and exploitation, stalking by partners, family, other participants, visitors, and staff.

V. Family Orientation

Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and developmental problems. Early identification and intervention for the children's problems is essential.

Standard: Agencies/programs must identify and address the needs of family members through direct service, referral, and/or other processes. Families are a family of choice defined by the clients themselves and agencies will include informal and natural supports in the treatment process when it is in the best interest of the client.

VI. Mental Health Issues

Women with substance abuse problems often present with concurrent mood, personality disorders, and other mental health problems.

Standard: Agencies/programs must demonstrate the ability to identify concurrent mental health disorders and develop a process to have the treatment for these disorders take place in an integrated fashion with substance abuse treatment and other health care services. All programs are expected to be either Co-occurring Capable or Co-occurring Enhanced, and must identify themselves as such in their applications.

VII. Physical Health Issues

Substance abusing women and their children are at high risk for significant health problems. They are at greater risk than the general population for substance abuse and violence related injuries, communicable diseases such as HIV, TB, Hepatitis, and sexually transmitted diseases. Prenatal care for substance abusing women is especially important as their babies are at risk for serious physical, neurological, and behavioral problems. Equally as important is to provide screening and information for Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD). Early identification and intervention for children's physical and emotional growth and development and for other health issues in a family is essential.

Standard: Agencies/programs shall:

1. Inquire about health care needs of the client and her children;
2. Provide appropriate referrals, coordination of services, and case management services
3. Document client and family health needs, referrals, and outcomes.
4. Assess, treat or refer for Eating Disorders

VIII. Legal Issues

Women entering treatment may be experiencing legal problems, including custody issues, civil actions, criminal charges, and probation and parole. Interaction with the legal system may further complicate a woman's sense of victimization and her trauma related issues.

Standard: Agencies/programs shall document an individual's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will reduce barriers to individual compliance with legal authorities. Program staff shall remain cognizant of and provide trauma informed services according to the woman's clinical needs.

IX. Sexuality/Intimacy/Exploitation

A high rate of treatment non-compliance among female substance abusers with a history of sexual abuse has been documented. The frequent incidence of sexual abuse among women substance abusers necessitates the inclusion of problem specific questions during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

Standard: Agencies/programs shall:

1. Conduct an assessment that is sensitive to sexual abuse issues and sexual exploitation;
2. Demonstrate training and competence to address these issues;
3. Make appropriate referrals and ensure coordination of services;
4. Acknowledge and incorporate these issues into the treatment and discharge plans;
5. Assure that the client will not be exposed to exploitive situations that continue abuse patterns within the treatment process (co-ed groups are not appropriate early in treatment, physical separation of sexes is required in inpatient/residential treatment setting except as specified elsewhere in this RFP.)

Sexual Exploitation is legally defined as: A commercial sex act induced by force, fraud or coercion, or in which the person performing the act is under age 18.

- *Victims can be found working in massage parlors (spas), brothels, strip clubs, escort services, street prostitution, domestic brothels and pornography, phone sex lines, private parties, gang-based prostitution, interfamilial pimping and forms of internet-based exploitation.*

X. Survival Skills

Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process.

Standard: Agencies/programs must identify and address the client's needs in the following areas, including but not limited to:

1. Education and Literacy (Including Technology)
2. Job Readiness and Job Search (Including Non-Traditional Jobs for Women)
3. Parenting Skills
4. Housing
5. Language and Cultural Issues
6. Basic Living Skills
7. Criminogenic Risk Factors, and Criminal Thinking and Behaviors
8. Core beliefs leading to continuation in role of victim
9. Eating Disorders

The agency/program shall refer to appropriate services and document both the referrals and outcomes.

XI. Transitional Case Management

In order for a woman to remain in recovery after treatment, she needs to be able to retain a connection to the treatment staff and to receive support from appropriate services in the community.

Standard: Agencies/programs shall:

1. Conduct an assessment prior to discharge to address and plan for the client's continuing care needs;
2. Design a written plan with the client to meet those needs;
3. Make and document appropriate referrals as part of the continuing care plan;
4. Remain available to the client as a resource for support and encouragement for at least one year following discharge.

All levels of care must provide trauma- informed gender -specific services. Each must have a plan to engage state-wide referral sources, and provide them with eligibility criteria and program information. Each provider must maintain a list of community resources and document referrals for clients' children to ensure they have access to services including pediatric care, early childhood intervention services, and interventions that address issues of abuse or neglect. Providers must be able to demonstrate that all direct care staff have knowledge how and where to refer for pregnancy related complications, and community resources that serve women and their children, including Medicaid, TANF, and Rite Care, and Domestic Violence shelters. All new direct care staff must complete and document completion within 60 days of employment the online Fetal Alcohol Syndrome Center of Excellence course on Fetal Alcohol Spectrum Disorders (<http://www.fascenter.samhsa.gov>). Existing direct care staff must complete and document completion of this training within 60 days of the start of this contract. Treatment Programs must use a trauma-informed curriculum, such as Seeking Safety or a similar model with Departmental approval. They must provide counseling and education to all female parents and women of child-bearing age on the effects of their substance use on the fetus, their children and on their parenting issues.

Each provider must maintain a waiting list and documented system to track all eligible women who have been screened but cannot be admitted because of insufficient capacity. Assessments must take place within 72 hours of referral; the expectation is that clinical treatment occurs within two weeks of the assessment and according to BHDDH Priority Population Guidelines. The provider must make and document referrals to services for women on their waiting lists such as testing, counseling and treatment for HIV, TB and STDs, prenatal care, domestic violence, and services for their children. Providers must immediately notify BHDDH of any pregnant woman who is unable to be admitted or referred into treatment within the specified time frame and advise the Department of the interim services provided, and the outcome of referrals they have made for her.

SECTION 8: BLOCK GRANT REGULATIONS

All programs must comply with regulations from one of the major funding sources for this solicitation which is the Substance Abuse Prevention and Treatment (SAPT) Block Grant for treatment of pregnant women and women with dependent children. All programs providing such services will treat the family as a unit and therefore will include both women and their children into treatment services, if appropriate. The state shall ensure that, at a minimum, treatment programs receiving funding for such services also provide or arrange for the provision of the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:

1. Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
2. Primary pediatric care, including immunization, for their children;
3. Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;
4. Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse and neglect; and
5. Sufficient case management and transportation to ensure that women and their children have access to services provided.

Required Core Values to be Incorporated into Program Implementation

1. **Family-Centered:** A family-centered approach means that families are a family of choice defined by the consumers themselves. Families are responsible for their children and are respected and listened to as they are supported in meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single client represented in systems, to a focus on the functioning, safety, and well-being of the family as a whole. A primary focus of a family-centered approach is unconditional care. Unconditional care means that the agency will care for the family, not that they will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family - not of the family to adapt to the needs of a program. If difficulties arise, the individualized services and supports change to meet the family's needs.

2. **Consumer Involvement:** The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision making process affecting their lives including decisions made about their service plans.

3. **Builds on Natural and Community Supports:** Recognizes and utilizes all resources in communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the families' relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.

4. **Strengths-Based:** Strengths-based planning builds on the woman's unique qualities and identified strengths that can then be used to support strategies to meet her needs. Strengths

should also be found in the family's environment through their informal support networks as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge with strategies discussed and implemented.

5. Collaboration across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance abuse, mental health, child welfare, Human Services and other identified systems collaborate and coordinate a single system of care for clients involved with their services.

6. Team Approach across Agencies: Planning, decision-making, and strategies rely on the strengths, skills, mutual respect, creative, and flexible resources of a diversified, committed team. Team member strengths, skills, experience, and resources are utilized to select strategies that will support the family in meeting their needs. All clients, formal, and informal team members share responsibility, accountability, authority, and understand and respect each other's strengths, roles, and limitations.

7. Ensuring Safety: In any service environment funded through this grant where children are present, priority and focus must be placed on the safety of the children. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible, and whether the safety services in place are effectively controlling those threats. When safety concerns are present, a primary goal of the family team is the protection of clients from crime and the fear of crime. The presence of individuals who are potentially dangerous requires that protection and supervision be sufficiently effective to dispel the fears of the public.

8. Gender/Age/Culturally Responsive Treatment: Services will reflect an understanding of the issues specific to gender, age, disability, race, ethnicity, sexual orientation, military service, and reflect support, acceptance, and understanding of cultural and lifestyle diversity.

9. Self-sufficiency: Clients will be supported, resources shared, and team members held responsible for assisting clients to move toward self-sufficiency in essential life domains. (Domains include but are not limited to, safety, housing, and employment, financial, educational, psychological, emotional, and spiritual.)

10. Education and Employment Focus: Dedication to positive, immediate, and consistent education, employment, and/or employment-related activities which results in resiliency and self-sufficiency, improved quality of life for self, family, and the community. Referrals for participation in vocational programs through Network Rhode Island and the Office of Rehabilitation Services (ORS) are expected based on the needs and goals of participants

11. Belief in Growth, Learning and Recovery: Clients' improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals

with compassion, dignity, and respect. Team members operate from belief that every client desires change and can take steps toward attaining a productive and self-sufficient life.

12. **Outcome-oriented:** From the onset of the client and family team meetings, clients' formal and informal supports are discussed, agreed-upon, and maintained. All team members should identify their roles and levels of personal responsibility and accountability in the clients' recovery process. Identified outcomes are understood and agreed upon by all team members. Legal, education, employment, child-safety, and other applicable mandates are considered in developing outcomes, progress is monitored and each team member participates in assisting the client to identify her meaning of success. Selected outcomes are standardized, measurable, based on the life of the family and its individual members.

SECTION 9: WOMEN'S RESIDENTIAL SERVICES

The contractor will be responsible for the development and implementation or access to a full continuum of treatment as described within ASAM PPC for Level III.I, III.2D, III.3 or III.5, Recovery Housing and services for pregnant, post-partum women and women with children.

Applicants must demonstrate ability to refer, provide or arrange for the level of care omitted if the need arises. The service continuum may be provided collaboratively with other providers or through contract with recovery housing as **approved by the Department of BHDDH**. Priority will be given to applicants who can demonstrate the ability to provide "one stop shopping" within single settings to facilitate access to needed service. Proposals will be expected to address issues of access, retention in treatment, risk reduction, linkages to recovery support services, and patient choice (including options for referral to medication assisted treatment, if appropriate). Proposals are expected to address recognized evidence and research-based principles of addiction treatment as described by the Institute of Medicine and the National Institute of Drug Addiction Treatment.

Mandatory *minimal* program components include:

Descriptions of ASAM Levels of Residential/Housing Programs

Residential Distribution of Funds: The continuum of level III residential services shall be designed to ensure service accessibility by diverse populations throughout the state and tailored to meet the needs of specific communities or populations. Preference will be given to applicants who are able to move clients fluidly from level to another based on their individual needs. Admissions criteria based on ASAM should be submitted for each service you are applying to provide.

It is expected that clients be admitted and treated in the least restrictive environment and level of care possible based on ASAM criteria. Clients should be transitioned into a lower level of services when clinically indicated.

This initiative will not limit access to service based on a client's city or town of residence. However, funding will be allocated to level of housing as described in this proposal. Adjustments to these allotments may be made in upcoming contract cycles, subject to utilization, emerging needs and funding availability. For the purposes of this initiative, levels are described as follows:

Levels of Care	Description	Minimum Desired Beds to be Awarded	Length of Stay	Daily/Weekly Rate
ASAM Level III.2D	<p><u>Respite/Transitional Crisis sites:</u> Provide residential social non-medical care and sobriety maintenance services designed for an individual awaiting a assigned treatment bed in a level III setting. Could be done with monitoring of vitals, Nurse/Dr involvement, and emergency services back-up with hospital. Use of Motivational Interviewing skills, Contingency Management, and other Evidence Based practices should be used in order to maintain the client in this level of care until a bed becomes available. For pregnant women, arrangements must be made for prenatal care when indicated.. Client <u>must not</u> be in need of medical detoxification Vendors should provide education, referral and treatment for post-partum depression and other issues that impact new mothers._ Respite services may be allowed to be coed but vendors must identify how gender specific services will be provided. Pregnant and Post-Partum women must be written into applications for the below levels of care.</p>	8	Maximum of 14 days.	For IMD Facilities, \$105.00 per day. For non-IMD facilities, a daily rate of \$30.00 plus clinical services billed through HP.
ASAM Level III.1	<p><u>Adult Residential (Short Term) Women or Women and Children:</u> Alcohol and/or drug services; Clinically managed Low-Intensity offers level III-1 professional addiction treatment services at least 5 hours a week. Treatment is directed toward applying recovery skills, promoting personal responsibility and integrating the world of work, education and family into the treatment milieu. This structured environment needs to be staffed 24 hours a day, and is not intended to include sober house, boarding houses or group homes where professional addiction treatment services are not provided. Emphasis on employment requires a strong collaboration with Vocational Resources and other employment services. Vendors must provide or assist with arranging recovery support services to increase clients' chances of</p>	24	Maximum of 90 days	For NON IMD facilities a daily rate of \$30 per day for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.00

	<p>success. This may include, but is not limited to childcare, transportation, job and recovery coaching, and parenting supports.</p> <p>The vendor must provide or refer to gender-specific, trauma-informed services that address complex issues such as domestic violence, sexual abuse, sexual exploitation and mental health issues, and must understand that substance abuse may be a client’s way to cope with her trauma history.</p>			
<p>ASAM Level III.3</p>	<p><u>Extended Assessment/Transitional Care. Adult Residential (Short Term) Women or Women and Children:</u></p> <p>Alcohol and/or drug services; non-medical, non-acute care in residential treatment program where stay is no longer than 30 days. This level provides a structured recovery environment for individuals in need of rehabilitation and relapse prevention services. Case management activities are directed toward returning home or networking residents into community-based ancillary or “wrap around” services such as housing, vocational services or transportation services to attend mutual self-help meetings and/or follow-up aftercare services post discharge. The vendor must provide or refer to gender-specific, trauma-informed services that address complex issues such as domestic violence, sexual abuse, sexual exploitation and mental health issues, and must understand that substance abuse may be a client’s way to cope with her trauma history.</p>	24	Maximum of 30 days	For NON IMD facilities a daily rate of \$30 per day for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.
<p>ASAM Level III.3</p>	<p><u>Adult Residential (Medium Extended Term) Women or Women and Children:</u></p> <p>Alcohol and/or drug services; Clinically-Managed Medium-Intensity level of a residential treatment program where the stay is no longer than 90 days. This level provides a structured recovery environment for individuals in need of rehabilitation, and treatment of such patients is directed toward overcoming their denial of the presence and effects of addiction in their lives. The goal is to prevent relapse and promote reintegration of the individual into the community. The</p>	30	Maximum of 90 days	For NON IMD facilities a daily rate of \$30 per day for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.

	Provider must provide trauma informed services that address complex issues such as domestic violence, sexual abuse, sexual exploitation and mental health issues, and must understand that substance abuse may be a clients way to cope with her trauma history			
ASAM Level III.5	<p><u>Adult Residential (High Intensity Long Term):</u> Example: Therapeutic Community. This level could possibly be provided in a co-ed setting, but the application must clearly specify how gender specific services will be provided Alcohol and/or drug services program where the stay is longer than 90 days. Level III.5 programs are characterized by their reliance on the treatment community as a therapeutic agent that introduces and enforces social values and behaviors. Treatment is specific to maintaining abstinence and preventing relapse but also vigorously promotes personal responsibilities and positive character changes for those with chronic substance use disorders. The Provider must provide trauma informed services that address complex issues such as domestic violence, sexual abuse, sexual exploitation and mental health issues, and must understand that substance abuse may be a clients way to cope with her trauma history.</p>	25	Maximum of 180 days	For NON IMD facilities a daily rate of \$30 per day for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.
Recovery Housing	<p><u>Adult Residential Working/Recovery House:</u> No direct alcohol and/or drug services; a recovery house is a dwelling for a group of individuals in recovery that is drug and alcohol free. Supportive services to maintain sobriety and vocational, educational, and employment focus are expected. Memorandums of Understanding (MOUs) with licensed Behavioral Healthcare Organizations are minimally required. For the purposes of this grant, recovery houses must only allow women, or women with children, adhere to the National Association of Recovery Residences Standards for Recovery Residences, and be active members in good standing of the Ocean State Coalition of Recovery Housing.</p>	16	Maximum of 180 days (through contract funding)	Daily of rate of \$20 for the first 90 days. Daily rate of \$10 for last 90 days of funding through contract.

SECTION 10: Standards of Care to be Incorporated into the Entire Treatment Continuum

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD) screening and brief intervention: Preference will be given to applications that maintain a certified FASD educator.

Outreach and Referral: Intervention services include timely access to services through outreach, screening and organized referrals.

Transportation: Transportation and childcare must be provided or arranged for in order to reduce barriers to treatment.

Medical Treatment: Regular medical care must be assured for both the clients and their minor children, especially prenatal and postpartum care. The vendor need not be responsible for any medical costs incurred by the clients and their children. A vendor's responsibility is limited to arranging for the clients and their minor children to access these services and providing transportation for them. Applications must include the agency's policies regarding storage and dispensing of medications for the clients and their children.

Education/Job Skills: The vendor will assist the client to arrange for attendance at GED classes, literacy activities, receive job-training skills, or actively seek employment. The vendor should provide or access support to clients in finding a job and continued support as needed to retain employment. Other education to be provided will include, but not be limited to, the topics of HIV/AIDS, STD (sexually transmitted disease), sexual abuse, domestic violence, and should all be in context of developing and maintaining healthy relationships and intimacy. Federal and state funding is available for vocational/educational services and must be expended prior to use of these grant monies.

Parenting Skills: The vendor will assure that clients with children receive training and support regarding early childhood development, proper nutrition and medical care for children, and other parenting issues and skills. These services may be provided on the premises, provided in the client's home, or the clients may be transported to other locations. The vendor will also connect the parent with maternal support networks in the community that provide ongoing support and education to the parent and children.

Family Education and Support: The vendor will establish a family counseling program for clients. Family members should receive basic substance use prevention information and support skills, especially in relapse prevention, family dynamics and communication. The vendor should link these families to community support networks, the faith community, and natural supports for on-going assistance in family education and support.

Mental Health Services: The vendor will provide or arrange for mental health education and will assure that clients are screened for mental health problems. The program should assure appropriate mental health services and care are provided. In addition, for persons with co-occurring mental health issues, AODA and mental health services must be provided in an

integrated manner and may be paid for with grant funds after exhausting all other funding sources.

Care Coordination: The vendor must ensure that all of the listed services are provided to the clients. This must be accomplished by employing a care coordinator whose duties must include the following:

1. Assessing client and family strengths and needs and developing a comprehensive plan with each client and family, natural supports, and other service providers,
1. Develop a plan of care, or single coordinated care plan, for all women and their families.
2. Arranging and facilitating the provision of all services.
3. Holding regular, and as needed, meetings with the client to monitor and re-evaluate the individualized plan of care.
4. Holding regular, and as needed meetings with the client/family, provider staff and others involved in the delivery of services to the client to monitor and evaluate progress/success.
5. Maintaining records or other documentation of all services delivered to the client.
6. Developing a continuing care plan with the client prior to discharge,
7. Developing peer support and connections with natural support systems and community support agencies including volunteer agencies, faith communities, or others identified in the community.
8. Provide documentation of contacts and services according to the Department.
9. Provide documentation of Department approved training in Confidentiality (42CFR Part II) and substance abuse treatment-specific Ethics

Recovery Coaching: Preference will be given to vendors that propose to use recovery coaches and peer-supported models to support clients in their treatment and recovery. Recovery Coaches must provide documentation of contacts and services according to the Department. and must provide documentation of Department approved training in Recovery Coaching, Confidentiality (42CFR Part II) and substance abuse treatment-specific Ethics

Basic Living Skills: The vendor will provide or arrange for training and on-going support in Life Skills such as nutrition, proper hygiene, consumer awareness, banking, and budgeting. to clients when indicated

Trauma Resolution/Identification: The vendor will demonstrate an understanding of the effects of traumatic experiences and the unique vulnerabilities of trauma survivors so that revictimization and misdiagnosis of the client does not occur. Trauma-informed services and organizations create safe, supportive environments that improve treatment retention and proactively assist clients and their families in developing healthy coping strategies. Trauma-informed services require staff members who are trained to understand the multiple and complex links among violence, trauma and addiction; trauma related symptoms as attempts to cope; that violence and victimization play large and complex roles in the lives of most of our consumers. Staff should receive training in trauma-informed care to reduce the chances of them triggering trauma symptoms by their mannerisms and behaviors. Women and their families should receive trauma-informed as well as trauma-specific services; clients should not have to fully disclose their trauma history to receive trauma-specific services.

Child Care: Vendor's providing IOP or PHP must ensure clients have adequate access to childcare and transportation so that they are not barriers to treatment and recovery.

Education/Treatment: Funds may be used to implement evidence-based strategies as determined by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence Based Practices.

Staff Development and Training: Funds may be used for staff development training of evidence based strategies, including design, delivery, quality assurance, and evaluation of the women's AODA program being proposed. These trainings could cover topics such as co-occurring disorders, family—centered treatment, women's specific curriculum, core values, public health, care coordination, domestic violence, Dialectical Behavioral Therapy, eating disorders, culturally competent assessment and treatment, neuroscience of addiction.

Other evidence-based practices: Funds may be used to implement other effective strategies as supported through appropriate evidence. The applicant must submit documentation to support such evidence.

- Some clinical services under the residential continuum will billed through HP for Medicaid and CNOM eligible populations. Providers eligible for this billing function will use appropriate codes approved by The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and the Department of Human Services. Claims will be reviewed on a quarterly basis by BHDDH to determine if the ASAM criterion is being adhered to.

Reimbursement:

Reimbursement methodology for awarded contracts will be determined by the Department and depend on whether or not the awarded contract is a CNOM (Cost Not Otherwise Matchable) or not.

- If the awardee is a CNOM then billing for all clinical services will occur through HP and be paid on the cycles used by Medicaid. These awardees will also be paid a daily bed rate of \$30 per day to cover expenses not funded by Medicaid/CNOMs. All clients must have Medicaid applications completed to determine whether clinical services are billed through the CNOM Program or through Medicaid. Medicaid is the first option before CNOMs. Clinical services billed through HP are subject to the same regulations and standards as described by Medicaid.
- If the awardee is not a CNOM then payment will occur monthly by calculating beds days used entered into BHOLD.

WOMEN'S GENERAL OUTPATIENT, PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT

The following services must be included in proposals responding to this RFP although they will not be funded through these dollars—they will be reimbursed through CNOMs/ATR. If your primary treatment and recovery support model cannot meet these needs, you must demonstrate your ability to network with other agencies to do so.

Alcohol and Other Drug Abuse Treatment: Treatment services may include Residential Treatment, Partial Hospitalization, Intensive Outpatient and Outpatient services, non-hospital inpatient services, and continuing care. (Funds under this grant may not be used to pay for hospital-based inpatient treatment or detoxification.) Treatment services may include referrals to programs in other areas of the State for unmet clinical needs. The treatment model should be able to address appropriate level of care. Because the funds provided for this program includes block grant funds, first priority for treatment services must be given to pregnant women.

Women's Intensive Outpatient, Partial Hospital and Continuing Care programs are expected to adhere to the Fundamental Principles and Core Values and Standards described in Sections 6 and 7 of this RFP. Applications must describe the Program's use of Trauma Informed Services and evidence based interventions, and includes the program's staffing pattern, days and hours of services, and curricula to be used. Please describe the ability of administration to treat staff and clients with a recovery focus, reinforcing a culture and environment of acceptance, and ensuring a holistic approach.

The expectation is that all providers will respond effectively to the needs and differences of all clients, and will participate in ongoing self assessment and development of cultural competency. Please include steps the agency takes to foster promotion of a recovery oriented service system of care with attention to enrichment of cultural competency.

Contract Terms:

The State of Rhode Island intends to award a contract for a period of two years beginning on July 1, 2012, with a state option for annual renewals of up to five additional years, for a total period of seven years, subject to annual assessment of performance and availability of funds. Cost of living adjustments (COLAs) will be based on any enacted provider COLA contained in the State's Annual Appropriation Act, but are not guaranteed. Volume or case mix adjustments will be at the State's discretion. Any other changes will be performance based and will be instituted by contract amendment. The State reserves the right to renegotiate programmatic and contractual requirements on an annual basis with the selected vendor, based on Departmental priorities. The State further reserves the right to reject any and all proposals submitted as a result of the Request, and pursue other options.

Applicant Criteria:

In order to be eligible to receive funding under this initiative, applicants must:

- Be a non-profit (including faith-based) corporation incorporated in the State of Rhode Island, and be licensed by the Department of Behavioral Healthcare Services, Developmental Disabilities and Hospitals to provide behavioral health treatment services.

--AND--

- Either directly, or through Department-approved subcontracts with specialty providers, demonstrates the ability to provide a range of ASAM Level III residential services as described under Section 3, "Scope of Work," and ASAM-based admissions criteria for each Level III service for which they are applying,
- Services must be provided within the state boundaries of Rhode Island.
- Applicants proposing to utilize facilities that are not approved by BHDDH licensing at the

time of application submission must provide appropriate documentation that the facility(ies) to be used has the physical capacity to provide the proposed services, and meet all relevant life/safety standards required by BHDDH Licensing.

- A copy of the Licensing application must be included in the response to this request.
- The vendor must demonstrate the capacity to implement services beginning July 1, 2012.
- The vendor must meet and accept the terms and conditions of programmatic criteria as well as reimbursement rates.
- Applicants who are applying for Recovery Housing must have a standing Maintenance of Understanding with a BHDDH Licensed and Contracted Treatment Agency.
- Recovery Housing MOU standards and requirements are described in Appendix II
- Recovery Houses need to meet the standards as described in Appendix I.

Preference will be given to applicants and participating subcontractors who:

- Demonstrate experience in and ability to provide a continuum of services under ASAM PPC, Levels III to target population(s) described above;
- Demonstrate experience and capacity to provide specific services in a cost-effective and client-centered manner;
- Offer services which are accessible to a wide range of consumers, including varied client populations, and offer days and hours of admission which enhance access to treatment during non-traditional hours.
- Demonstrate experience and/or capacity to provide complementary revenues and/or services to enhance or expand program services or capacity (such as through third party reimbursements, including Rite Care, in-kind contributions, complementary grant funds, provision of free care etc.).
- Have a record of satisfactory utilization of funded slots from the Department of BHDDH; Have a record of compliance with licensing and contract monitoring requirements, including timely response to Departmental corrective action plans.
- Ability to work with Specialized Populations as described above.
- Having proper staffing to work with Specialized Populations which would be evidenced by having staff credentialed in CCDP, CCJP, FASD and other relevant credentials.
- Agree to participate in trainings provided or recommended by the Department of BHDDH.
- Ability to provide outcomes as dictated from The Department using evidence based practices.

Proposals must address client rights, including mechanisms for soliciting client input into satisfaction with service and recommendations for improvement. Programs must also have a client grievance process, with evidence that clients are aware of their rights while engaged in service.

SECTION 11: OUTCOMES AND EVALUATION

On a program level, establishing outcomes and then measuring program effectiveness for meeting these outcomes help ensure that clients receive a good standard of care. Use of quality assurance and quality improvement measures allows programs, funders, and evaluators to examine whether the program is offering a consistent and competent practice for all families, enables programs to examine where service delivery can be improved, and identifies strategies to improve these services.

Note: As part of contract negotiations, BHDDH will work collaboratively with each vendor to identify outcomes and process indicators appropriate to the vendor’s program.

Grant recipients receiving funds shall report data on federally required National Outcome Measures (NOMS) in accordance with guidelines provided through the Human Services Reporting System (HSRS), or other comparable reporting system. NOMS reporting is required in order to receive the full allocation of funds. All agencies receiving grant funds through this RFP are required to have in place the mechanisms to report timely, accurate, and complete NOMS data through the RIBHOLD, or other comparable reporting system. Data on all program participants in the project must be entered into RIBOLD, or other comparable reporting system utilizing a unique identifier provided by the Department, even if public funding is not utilized to provide treatment services. Federal NOMS outcome measures include:

- a) Reduced Alcohol/Drug Use
- b) Improved Employment/Education
- c) Reduced Crime and Criminal Justice
- d) Reduced Homelessness
- e) Improved Social Supports for Recovery
- f) Retention in or Completion of Treatment

Process indicators and outcomes shall address the following areas:

- 1. Units of service provided (such as hours in treatment) and cost per unit of service.
- 2. Unduplicated number of individuals served with grant funds.
- 3. Percentage of individuals and/or family members expressing a high level of satisfaction with services funded.
- 4. Number of individuals maintained on a waiting list for state slots and average time of wait to get into slots.
- 5. Requested funds are justified based on number of individuals served and cost per unit of service provided.

SECTION 12: PROPOSAL QUESTIONS / SUBMISSION

Consult page one of this solicitation for information regarding the opportunity for interested parties to ask questions prior to the deadline for proposal submission.

Individuals requiring other special accommodations for the pre-proposal meeting must call 462-4680 no later than 48 hours prior.

Responses (**an original plus 5 copies**) should be mailed or hand-delivered in a sealed envelope marked “**RFP # 7449736 Women’s Substance Abuse Treatment Services**” to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered.

Proposals misdirected to other State locations or which are otherwise not presented in the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed or emailed to the Division of Purchases will not be considered. The official time clock is located in the reception area of the Division of Purchases

NOTE: In addition to the original, one of the ten copies must be submitted unbound to facilitate copying by the Department, if needed.

The Proposal must be typed, one sided, on 8 ½ by 11 inch paper in 12 point print or larger, and in English. The technical proposal (which includes the Executive Summary, Previous Experience and Background, Work plan/Approach Proposed, and Offeror's Organization) may not exceed a total of 45 pages. **The Table of Contents, List of Sites to be Used, Staffing and Cost Proposal, and Appendixes are not included in the 45-page limit.** All proposals must be numbered sequentially (including appendixes), with the Executive Summary page number one. Divisions of Purchases cover sheets and certifications should not be included in the page numbering.

Proposals must include the following:

- 1) A completed and signed three page RIVIP Bidder Certification Cover Form, available at www.purchasing.ri.gov
- 2) A separate Technical Proposal describing the background, qualifications, and experience with and for similar programs, as well as the Work plan or approach proposed for this requirement.

The Technical Proposal must contain the following sections:

Executive Summary (Not to Exceed Two Pages)

The Executive Summary is intended to highlight the contents of the Technical Proposal and to provide State evaluators with a broad understanding of the offeror's technical approach and ability. At a minimum the Executive Summary should identify the **applicant agency**, the **region** to be served, list **partnering/subcontractor** behavioral health agencies, if necessary, and identify any **specialized populations** to be targeted.

Table of Contents

The table of contents shall be broken down by primary proposal components, including appendixes and MOU's, with corresponding page numbers.

Previous Experience and Background

This section shall include the following information:

- 1) For the applicant agency and each subcontracting Behavioral Health agency, a brief paragraph describing similar projects undertaken or client populations served, including

length of time the program has provided services.

Example: X agency has provided general substance abuse residential treatment services to adults since _____. Also provide narcotic treatment services, and specialized domestic violence services since _____. More recently have provided onsite psychiatric services through contract with _____ since _____.

- 2) A description of the business background of the offeror (and all proposed behavioral health subcontractors). A copy of the most recent independent certified audit(s) and any accompanying management letters issued as part of the audit must be appended.
- 3) Copies of the agency's (including subcontracted behavioral health agencies') most recent BHDDH licensing review report, as well as the past two BHDDH Contract Monitoring reports (if the agency is under contract with BHDDH), including copies of any resulting Corrective Action Plans must be appended.
- 4) The offeror's status as a Minority Business Enterprise (MBE), certified by the Rhode Island Department of Administration, and/or a subcontracting plan which addresses the State's goal of ten per cent (10%) participation by MBE's in all State procurement.

(Further questions regarding MBE should be directed to the MBE Administrator, at (401) 574-8253

- 5) In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in electronic format (CD / flash drive). Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested. This CD or flashdrive should be included in the proposal marked "original". This electronic file is non-returnable

Work Plan/Approach Proposed

This section shall describe the agency's understanding of the State's requirement, including the results intended and desired, the approach and/or methodology to be employed, and a work plan for accomplishing the results proposed. The work plan should address all the core program components described under Scope of Work, as well as any technical issues that will or may be confronted in implementing the initiative.

- 1) The work plan must include:
 - a) Letters of agreement mutually signed by the lead agency and each Behavioral Health subcontractor must be appended.
 - b) Information regarding any new proposed sites which are not currently approved for use by the BHDDH licensing office must be provided within the application. Such information shall include address of the facility, a drawing of the layout, including dimensions of the space to be used, a description of how the space is to be used, and evidence of site control. A request for site approval must be submitted to the BHDDH Licensing Office at the time of submission of the response to this Request.

For each of the required sections below, if the approach or methodology is identical for all sites to be utilized or populations served, the applicant shall clearly state that this is the case. In such

cases, only one response for each program area is required.

In cases where the approach or methodology differs by site or population, the applicant shall clearly describe each response separately.

Example A.

Screening and Assessment: The Agency shall utilize the ___ screening instrument for initial determination of eligibility for program services and ___ assessment instrument for conducting a biopsychosocial assessment of treatment needs. Screening may be conducted by telephone or in person between the hours of ___ by calling a central intake number at ____.

Exception: Agency/site ___ will utilize the ___ assessment instrument for assessing needs of the ___ population.

- 2) The applicant will describe how it will provide each residential continuum (ASAM PPC Level III) within the identified region for populations described within this request (as well as any additional targeted populations). This description should clearly describe a program design that is tightly structured and organized into definable and measurable stages/phases that describe the specific services clients will receive at each stage. Progress to the next stage should be based upon achievement of **measurable benchmarks** that have been spelled out in the client's treatment plan. The description must include:
 - a) **Admission and discharge criteria and procedures by population to be served and service type.** This section must address eligibility for service and criteria for both satisfactory and unsatisfactory discharge, as well as protocols for referral of individuals being discharged for cause. Note: Relapse shall not be used as a reason for discharge. This section shall clearly describe any population that cannot be served by the program, including mechanisms for referral of these populations for appropriate care. The program shall make provisions for referral to Medication Assisted Treatment Programs, as appropriate.
 - b) The program's **screening, assessment and admission process**, including days and hours of admission mechanisms. (*Copies of standardized, normed and reliable screening and assessment tools must be appended*). The description shall also include a rationale for the choice of assessment instrument proposed.
 - c) *How **services and coordination of care will be developed** to serve clinically and financially eligible populations described under Scope of Work, including:*
 1. Women who are pregnant;
 2. Women who are IV users;
 3. Women who are HIV antibody positive or have HIV disease;
 4. Women who are homeless or at risk of being homeless;
 5. Women in state-funded detoxification, inpatient psychiatric hospitalization and diversion/step-down units.

The Department is also seeking proposals that address the unique needs of the following populations:

- Women with co-occurring disorders;
 - Women involved with the criminal justice system;
 - Women involved with DCYF/child welfare;
 - Women who are Sex Trafficked/Commercially Exploited;
 - Women who are in domestic violent relationships;
 - Women who are 18-28 years of age;
 - Women with physical or other disabilities or medical conditions;
 - Racial and ethnic minorities;
 - LGBTQ populations;
 - Any other specialized populations proposed (applicants must demonstrate need for specialized services for such populations).
- d) For each ASAM level of service, a typical weekly **schedule**, including an explanation of the expected number of hours per week the average client will spend at each stage of the program, and the length of time that the average client will take to complete the program.
- e) **Evidence based practices** to be provided at each level within the residential continuum. Each area must be thoroughly described, including differences in approach *for various populations served, including gender specific issues.*
- f) Mechanisms for **accessing other related services** during treatment, such as:
- Tuberculosis, Hepatitis C, HIV, and STD services,
 - Primary care.
- g) How the project intends to **address issues** of:
- Rapid access to treatment
 - Retention in treatment
 - Risk reduction
 - Patient choice (including client rights, measuring satisfaction with treatment, mechanisms for appealing issues, and options for referral to medication support treatment, if appropriate.)
- 3) Thoroughly describe, and provide examples of how the Recovery Oriented System of Care will be integrated into the delivery of services, including how the program will help clients' access recovery support services, 12 step, self help or other approaches to enhance treatment services provided under this contract.
- 4) Demonstrate knowledge of other appropriate community-based substance abuse and mental health treatment, as well as other human service or support resources which may be needed by the client population for referral of clients upon residential discharge.
- 5) Describe any additional services to be provided by the agency, beyond the scope of work described within this Request, and resources to be used for these services.

- 6) Provide a complete timeline for projected program implementation
- 7) Describe any requirements that cannot be met and justification for their exclusion in the proposed plan.

Organization and Staffing

In this section, offerors shall include identification of the clinical staffing pattern, by lead and subcontractor agencies, proposed to provide the required program services. The staffing pattern must indicate whether the position is full or part time; if part time, it must indicate the number of hours per week. This section must also include a brief synopsis of job responsibilities and educational, experiential and credentialing requirements for each staff position *by site and level of service*, and shall include a brief biography of all clinical staff proposed, including their credentials.

BHDDH is also looking to see the plan of action designed by the Agency to have all clinical supervisors with the now RCS credential moved to the new CDCS requirements by ICRC effective 2014.

This section must also describe any specialized staff training proposed for clinical and support staff proposed to ensure the delivery of quality services to clients.

Applications shall include TWO types of **organizational charts**:

- For **each proposed site**, an organizational chart describing how the residential continuum fits in the overall organization/agency structure, AND
- The applicant must describe its mechanisms for communication between/among primary project participants.

Cost Proposal:

Provide a discussion of other existing funding sources and/or in-kind contributions provided by the agency to enhance program services.

This section shall also include a discussion of existing agreements with third party payors for coverage of services described within this Request.

Funding from this initiative may not be utilized for purchase or renovation of any facility to be used for service delivery. There is a cap of 15% for indirect administrative costs.

Appendixes

This section shall, at a minimum include:

- A completed List of Behavioral Healthcare Sites to be Utilized for the project
- Copies of the most recent independent certified audit(s) and any accompanying management letters issued as part of the audit for the applicant agency and any proposed behavioral health subcontractors
- Proposed screening and assessment instruments
- Information regarding any proposed sites which are not currently approved for use by the BHDDH licensing office. Such information shall include address of the facility, a

drawing of the layout, including dimensions of the space to be used, a description of how the space is to be used, and evidence of site control. A request for site approval must be submitted to the BHDDH Licensing Office at the time of submission of the response to this Request.

- Copies of licensing application(s) for any proposed facilities to be used which are not licensed at the time of application to this Request.
- The offeror's status as a Minority Business Enterprise (MBE), certified by the RI Department of Administration, and or a subcontracting plan which addresses the State's goal of ten per cent (10%) participation by MBE's in all State procurements. For further information, contact the MBE Administrator at 222-6253 or visit the website at <http://www.rimbe.org>
- Rhode Island Equal Employment Opportunity Compliance Certificate and Agreement. For further information call 222-3090.
- Other materials which support the criteria described within this Request.

SECTION 12: EVALUATION AND SELECTION

The State will commission a Technical Review Sub-Committee that will evaluate and score all proposals based on the extent to which proposals address the needs of women's treatment services within a continuum of care.

PART I

Awarding Funds Information, Evaluation Criteria, Potential Points to be Awarded and Procedures

All applications received will be reviewed by an evaluation committee and ranked accordingly. The evaluation committee will evaluate all applications against stated criteria. Applications from eligible applicants will be scored according to the following competitive criterion that is described under Part Two Technical Specifications. Maximum Points (100 Total)

- Organizational Experience including Staffing and Qualifications: 5 points
- Problem/Need Statement: 10 points
- Goals and Performance Expectations: 10 points
- Target Population(s): 5 points
- Work Plan: 15 points
- Care Coordination Service Delivery: 15 points
- Data Collection and Evaluation: 5 points
- Program Design: 15 points
- Adherence to Core Values and Women's Treatment Standards: 15 points
- Cultural and Linguistic Competence: 5 points

TOTAL 100 POINTS

ORGANIZATIONAL EXPERIENCE INCLUDING STAFFING AND QUALIFICATIONS (5 Points):

The applicant has fully documented experience in providing community-based substance use disorder treatment services for the target population and is qualified to carry out the proposed program in a cost effective manner.

The narrative should include at a minimum:

- 1) A documented discussion of the organization's ability to provide community-based alcohol and other drug abuse intervention/treatment services to women and families; experience, and ability to coordinate and collaborate with key organizations, and to carry out other provisions of the grant.
- 2) The proposed budget is clearly targeted to achieving the project outcomes. The budget should be accurate and appropriate for the scope of the project, other agency's involvement, and the financial contribution is well defined.
- 3) A clear description of outcomes that will be used to measure the successes of the organization in providing services to women and families.
- 4) If a subcontractor is to be used, documentation of the subcontractor's qualifications and experience.
- 5) A clear description of the criteria used to measure the successes of the organization in providing family-centered treatment.
- 6) The applicant agency (or subcontractor, if applicable) either has existing qualified personnel or has proposed a functional staffing or volunteer pattern that is capable of supporting program activities.
- 7) Staff costs that will be charged to the grant have been fully justified and are reasonable and necessary for carrying out the program.
- 8) For those programs with significant minority populations within the service area, the agency has made or will make an effort to recruit, hire, and train minority staff/volunteers and provide in-service sensitivity training about gender responsive treatment, cultural competence, language and sexual orientation for all staff/volunteers.
- 9) For those programs that have Native American Tribes within the service area, the agency has made or will make regular and meaningful efforts to coordinate with identified Tribal leadership in order to provide culturally competent treatment and referrals.
- 10) Attach the agency's organizational chart that indicates current and proposed positions that will implement this program.
- 11) Attach the agency's current and proposed staffing pattern and organizational structure.
- 12) Attach copies of job descriptions, staff orientation outline and staff supervision and a list of required competencies for working with women and their families.
- 13) Description of the agencies' staff development plan.
- 14) Description of how your agency has or will implement trauma informed, recovery oriented system of care and integrated services into your women's treatment programs.

PROBLEM/NEED STATEMENT (10 Points)

The applicant's response shows that they have an excellent understanding of the programs and unmet needs in their community or region related to providing community-based AODA treatment for women and families. The proposal fully documents with statistical data, where available, the extent of the problem and fully demonstrates the inadequacy of existing programs in the program area to deal with the problem. If an agency has an existing program, documentation is provided that an expanded program is needed.

The narrative should include at a minimum:

- 1) A clear discussion of whether this is a new program or whether it will be an expansion of an existing program.

- 2) A full discussion of the exact unmet needs the program will address.
- 3) Any data available to document the problems or unmet needs the program tends to address.
- 4) A full discussion of how grant funds would expand/enhance service delivery and not supplant state and federal funds currently in use, if this is not a new program.
- 5) The applicant's response shows that they have an excellent understanding of the programs and unmet needs in their community related to providing services to women and their families.
- 6) The application fully documents with statistical data, where available, the extent of the problem and fully demonstrates the inadequacy of existing programs in the program area to deal with the problem. This may include inadequate resources and other unmet assessment, treatment or other needs.

GOALS AND PERFORMANCE EXPECTATIONS (10 Points):

The goals and objectives are clearly stated and consistent with the goals and performance expectations of the RFP as reflected in this RFP. The goals are stated for clients as well as the service delivery and system goals. The applicant has made it very clear how these grant funds will be utilized in the development of a new program or to strengthen the current program so that it meets these goals. The strategies described are logical and appropriate responses to the description of the problems and unmet needs. The discussion indicates an excellent understanding of how this program will impact target populations and/or enhance current service delivery with clear timelines, identified outcomes and effective strategies to achieve these outcomes.

The narrative should, at a minimum, include:

- 1) A statement of goals and objectives for the organization's proposed program regarding specific women/family outcomes and service systems outcomes (e.g. Reduced Alcohol/Drug Use; Improved Employment/Education; achieving healthy relationships, Reduced Crime and Criminal Justice; Reduced Homelessness; Improved Social Supports for Recovery; Retention in or Completion of Treatment) and how grant funds will be used to measure the stated outcomes.
- 2) Statement on the organization's ability to meet the process indicators and outcomes listed in Scope of Work of this RFP.
- 3) A discussion of strategies the program will use to achieve outcomes and performance expectations, and address the problems and unmet needs identified; state why these strategies will be effective; discuss how the agency plans to overcome obstacles or barriers to service delivery; and state what the agency you anticipate as the overall impact of their program.
- 4) Statement of the organization's ability to meet the integrated service provision philosophy of care in all aspects of its program service delivery, design, and treatment and its plan to measure progress in this practice in day-to-day operations.
- 5) Statement of the organization's ability to meet the Women's treatment standards, core values and Women's treatment philosophy of care in all aspects of its program delivery, design and treatment.

TARGET POPULATION (5 Points):

The target populations described in the application must be consistent with the stated goals of the RFP. If the application is for funds to develop a new program or expand or enhance the scope of

existing programs, the application must identify the program's new target population. The applicant will identify a reasonable number of new individuals to be served by the program. The applicant will provide specific demographic information about the target population. In general, the composition of the target group should reflect the demographics of the community including adequate representation of urban/rural, racial/ethnic minorities and LGBQ populations. The location of the target population should be fully described including the geographic boundaries and special characteristics of the area. In general, the composition of the target population should reflect the needs of the demographic community; however, the adequate inclusion of racial/ethnic minorities and LGBQ populations should be clearly demonstrated in the target population where feasible and appropriate.

The narrative should, at a minimum, include:

- 1) A description of the target population(s) that the program will serve.
- 2) An estimated number of participants that will be served annually with the grant funds and how they will be referred to the program.
- 3) If expanding and/or enhancing an existing program, clearly specify the increase in participants who will be served through these grant funds.
- 4) If appropriate, a description of how participant eligibility will be determined.
- 5) A description of the geographic boundaries in which the target population is located and special characteristics of the group.
- 6) A description of the criteria to be used for inclusion or exclusion of participants and rationale used in making these clients recruitment and selection determinations.
- 7) Describe situations under which participants will be sought and who will be responsible for these activities.
- 8) Documentation to support identification and engagement into services of the clients and their families to be served.
- 9) Identification of the number clients to be served with grant funds.

WORK PLAN (15 Points):

The work plan described in the application is related to the goals of the program listed in Section 1.4, will facilitate the program accomplishing what has been proposed, and includes a reasonable timetable for implementation. Activities in the work plan are clearly assigned to personnel. The work plan is consistent with the objectives and can be accomplished given the time frames, staffing, and the budget proposed. Time frames for all tasks and activities in the work plan are appropriate to ensure that sufficient effort is planned.

The narrative for this section should, at a minimum, include:

- 1) The work plan must detail all tasks, activities and procedures in a logical progression that will be used to achieve the goals.
- 2) The work plan includes the assignment of responsibility to specific personnel and the timetable for each task or activity to be started and to be completed.

CARE COORDINATION SERVICE DELIVERY (15 Points):

The applicant demonstrates that necessary community and/or regional agencies have been or will be involved in the planning and execution of the program to achieve a coordinated approach to meet the needs of women and their families involved in various service systems. The application includes a description of how the applicant will work with appropriate local, county, tribal and/or

regional agencies and child welfare, law enforcement agencies, court system, treatment agencies and providers, probation/parole agents and others to achieve multi-system coordination at the direct service worker level, and a detailed explanation as to how these coordination efforts will relate to the application. The application must include letters of cooperation, memorandums of understanding or inter-agency agreements from all agencies whose involvement is essential for the success of the program; these should be included in the attachments.

The narrative should, at a minimum, include:

- 1) A description of how the agency and direct service staff will work with appropriate community agencies (e.g., court system, treatment providers, law enforcement, technical colleges, corrections, mental health services, medical facilities, child welfare, etc.).
- 2) A detailed explanation as to how these community support systems will assist in achieving the proposed goals for the women and her family and service system including discussion of how joint service plans are developed and how various fiscal resources are shared or assigned to this project.

DATA COLLECTION AND EVALUATION (5 Points):

The applicant will evaluate the grant program by use of outcome measurements that the Department approves. The applicant's evaluation plan should follow the Goals and Work Plan. The applicant will discuss criteria of measurement that will demonstrate if the intended results have or have not been achieved. The applicant will be required to enter additional data fields into RIBOLD, or comparable reporting system to identify clients receiving new or enhanced services. The agency's evaluation plan should follow the WORK PLAN. The applicant will discuss criteria of measurement that will demonstrate if the intended results have or have not been achieved.

The applicant is responsible for collecting and reporting on the outcomes measures with data collection methods and format to be determined in conjunction with DBH and other contract awardees. The applicant shall be responsible for the collection and reporting of any additional performance measures and/or outcome data that may be required by BHDDH during the contract period.

The narrative should, at a minimum, include:

- 1) How the NOMS data will be collected.
- 2) Who will be responsible for collecting and analyzing these data?
- 3) Who will be responsible for supervising the data collection and for taking corrective actions based on the results of the evaluation?
- 4) Preparation, distribution, and use of reports summarizing program results.
- 5) Procedures to be implemented to ensure privacy and confidentiality.

PROGRAM DESIGN (15 Points):

The applicant thoroughly describes the program design by demonstrating all aspects described in section 1.5 with emphasis on evidence-based strategies, women's specific and family-centered treatment that ensure effective services to women and their families.

CORE VALUES AND WOMEN'S TREATMENT STANDARDS (15 points)

- 1) The narrative should describe in this RFP how the Core values will be implemented in the agency's policies, procedures and quality improvement program.
- 2) The narrative should describe the implementation the BHDDH Women's Treatment Standards, philosophy, and the relation/cultural model referring the treatment standards in the program design and coordination of the service delivery systems.

CULTURAL/LINGUISTIC COMPETENCE (5 Points)

Organizations that provide services to diverse groups must understand the culture of the group that they are serving and must design and manage cultural and linguistic competent programs to address those groups.

- 1) Evaluation: Program evaluation methods and instruments should be appropriate to the population/community being served. There should be a rationale for the use of the evaluation instruments that are chosen, including a discussion of the validity of the instruments in terms of the gender/age/culture of the group or groups targeted. The evaluators should be sensitized to the culture and familiar with the gender/age/culture/communication style whenever possible and practical.
- 2) Implementation: There should be objective evidence/indicators that the organization understands the cultural/linguistic aspects of the community that will contribute to the program's success and knows how to recognize and avoid pitfalls.

APPLICANT RESPONSES

Applications submitted in reply to this RFP shall respond to the specifications stated herein. Failure to respond to the specifications may be a basis for an application being eliminated from consideration during the selection process. In the event of an award, the contents of this RFP (including all attachments), RFP addenda and revision and the application from the successful applicant(s) will become contractual obligations. BHDDH reserves the right to negotiate the award amount, the programmatic goals, and the budget items with the selected applicant(s) prior to entering into an agreement. Justifiable modification may be made in the course of the agreement only through prior consultation with and written approval of BHDDH. Failure of the successful applicant to accept these obligations may result in cancellation of the award.

WITHDRAWAL OF APPLICATIONS

Applications may be withdrawn by written notice. Applications may be withdrawn in person by the applicant or his/her authorized representative, providing his/her identity is made known and he/she signs a receipt for the application.

AWARD PROCEDURES

The Evaluation Committee's scoring will be tabulated and applications will be ranked according to the numerical score received. The evaluation committee has the option to conduct interviews and/or on-site inspections of the top ranked applications to include those results in the consideration of the evaluation points. BHDDH reserves the right to reject any or all applications and to negotiate the award amount, authorized budget items, and specific programmatic goals with the selected applicant(s) prior to entering into an agreement.

PART II

Technical Specifications (Application Instructions)

GENERAL INSTRUCTIONS

Please read this section carefully. Applicants are cautioned that in completing the following Technical Specifications they are to provide complete information as possible. The only information evaluators will be given about a program is that which is contained within the application. For that reason, each copy must be a duplicate of the entire original, including any attachments.

The focus of the funding is for counties, tribal governing body and private non-profits agencies to address the multiple needs of women and their families to access family-centered services for their substance use/misuse (alcohol and/or drug abuse) problems. These services must be gender, culturally and linguistically relevant and include, where appropriate, mental health, trauma responsive, therapeutic child care, transportation and community natural and recovery supports and other services and systems that are necessary to provide wraparound care to women and their families. Through best practices and evidence-based strategies women and their families reduce substance use and improve family functioning, child health and safety. In order to determine the potential for a proposed program to achieve this aim, applications must fully address the program requirements and specifications that follow.

Applications must include the following items submitted in the order listed.

I. Outline and Table of Contents (checklist form)

II. Application Summary

III. Abstract

IV. Narrative

Section A - Administration

Section B - Program

V. Detailed Budget Request

VI. Assurance

VII. Attachments

Proposals found to be technically or substantially non-responsive at any point, or proposals scoring less than sixty (60) points in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The Technical Review Sub-Committee will present written findings, including the results of all evaluations, and will make a recommendation to the State Purchasing Agent, or his designee, who will make the final selection for this requirement.

REQUIREMENTS/ASSURANCES:

(Unless otherwise stated within the response, submission of an application shall indicate a commitment to compliance with the following requirements/assurances).

The contractor will give priority to:

- Individuals who are HIV antibody positive or have HIV disease;
 - Individuals who are homeless or at risk of being homeless.
 - Referrals from state-funded detoxification, inpatient psychiatric hospitalization and diversion/step-down units.
- 1) Make available tuberculosis (TB), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and sexually transmitted disease (STD) services directly or through arrangements with other public or nonprofit entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB and/or Hepatitis for appropriate medical evaluation and treatment.
 - 2) Awardess will report on waiting lists to the Department on a weekly basis in a format to be determined by The Department.

Appendix #1- Standards for Recovery Houses

Policies and Procedures

Each house shall have a mission statement which promotes a group approach to recovery

Each house shall publish admission criteria, which may include the right of the Program to determine a target population for admission.

A Recovery House must have someone available 24/7 to address emergencies in the house.

House rules and regulations must be reviewed with all residents, signed by each resident and include provisions on:

1. Attendance at three Recovery based meetings per week, and attendance at the weekly house meeting.
2. Immediate response for relapse, stealing, violence and/or overtly disruptive behavior as determined by program.
3. Curfew hours and rules.
4. Guests, including a policy on children
5. Overnight visits
6. Employment or daytime activities
7. Smoking

8. Medication storage and restrictions
9. Explanation of management structure and contact information
10. A grievance procedure
11. A procedure for how and/or where to contact residents in the event of an emergency if residents are not home
12. Emergency contact information for each resident
13. Drug and alcohol testing
14. Disclosure, at time of admission to the house, of fees and any additional costs or charges

Minimum standards for each dwelling unit shall include:

All living space must be finished and furnished.

Every dwelling unit must have:

- A fully functional kitchen, including a stove, sink and refrigerator
- Fully functional bathrooms, including a toilet, sink, and bathtub or shower, with no more than (8) people sharing a bathroom.
- Central heat
- Each bedroom must allow a reasonable amount of living space including a bed and storage of clothing and other belongings.

Furniture must be:

- Complete, clean, and in good repair
- The outside appearance of each house must be neat and clean.
- Each house must have a maintenance policy to address routine and emergency repairs and maintenance in a timely fashion.
- A Recovery House shall offer shared common areas such as kitchens, living rooms, and dining rooms.
- A Recovery House shall not place more than 4 people in one bedroom.
- A Recovery House shall not exceed a reasonable occupancy for a Recovery Housing setting.
- If a Recovery House is located in a multi-family residence, it shall occupy all units in that residence unless there is 24 hour manager.
- Carbon monoxide and smoke detectors on each floor.
- Fire extinguishers in each kitchen.

Ethical Standards:

- House owners and house managers shall under no circumstances engage in sexual activities or sexual contact with current, or with former, residents.
- House owners and house managers assume the full burden for setting clear, appropriate, and culturally sensitive boundaries in all encounters with residents, including appropriate physical contact with residents, and members of their immediate families.
- House owners and house managers shall not provide any services to individuals with whom they have had a prior sexual relationship.
- House owners and house managers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate and culturally sensitive boundaries that govern such physical contact.
- House owners and house managers shall not sexually harass residents.
- House owners and house managers shall not use derogatory language in their written or verbal communications to or about residents; rather, they shall use accurate and respectful language in all communications to and about residents.
- Owners and House Managers shall not engage in the financial exploitation of Residents.

Governance

The ombudsman, or designee, shall be the primary investigator of resident complaints.

The ombudsman shall, as much as possible, have no direct connection with, or interest in, any housing program, or personnel.

The parameters of the duties of the ombudsman shall be determined by a Executive Committee.

Investigation

- All complaints from residents living in residences shall be directed to the ombudsman
- The Prime Contractor shall be notified that a complaint has been received
- The investigator shall communicate directly with the primary complainant
- Information shall be gathered from other persons associated with the complainant, as necessary
- After the complaint is received, the investigator shall contact the representative of the house or program about which the complaint has been received.
- If the complainant has not gone through the grievance procedure at their house, they will be encouraged to do so. The House Manager or Owner will be informed of the issue by the Ombudsman. The Ombudsmen will follow up with complainant and House Manager or Owner within two weeks after the initial complaint to see if it has been resolved through the grievance procedure of the house. If not, the contracting agency will open an investigation and determine if said house has remained faithful to Memorandum of Understanding.

- The specifics of the complaint will be discussed with the house/program representative
- All relevant staff and house residents shall be made available for interview by the investigator
- The investigator shall prepare a written report that shall be submitted to the Contractor and the Owner or Operator.
- The report shall be an objective summation of the complaint, of the statements collected by interview, and the result of any site viewing
- The raw data (e.g., investigator notes, written statements) shall remain with the investigation..
- The decision to take action shall be based upon whether the complaint poses a continuing risk to residents and/or exposes the contractor to disrepute.
- Failure to remedy the cause(s) leading to a finding that a member’s house does not meet minimum standards, within an applicable remediation time period, shall be cause for the Department of BHDDH to take action.

Appendix II:

RFP Criteria for Affiliation: Recovery Residence and Behavioral Health Provider Organizations.

Purpose of these affiliation criteria

The proposed criteria listed below address the requirement that affiliates and BHO’s work as effective organizations, with defined agreements and administrative policies, and are able to implement and enforce the safest recovery support systems possible.

Rhode Island recovery residence and provider organizations are expected to establish affiliation agreements to meet these following criteria:

1. Organizational structure

1.1. The affiliate must have a formal organizational and leadership structure.

1.2. The affiliate must have and effectively administer a formal process for all client applications, including a listing of any fees and/or items that the client may be responsible for prior to admission, along with any required participation, such as types of meetings or lectures.

2. Standards

- 2.1. The affiliate must maintain a set of existing standards for its provider members including how they will address relapse behavior. The BHO reserves the right to review these standards as part of the application process.
- 2.2. The affiliate's existing standards must include a code of ethics or provisions in its standards which are equivalent to a code of ethics.
- 2.3. The affiliate must have and effectively administer a defined process for ensuring adherence to its standards.
- 2.4. The affiliate has an established and publicized process for resolving disputes and complaints from residents, former residents and from the general public. It must require members to notify the BHO who will in turn notify BHDDH about all deaths, serious injuries, abuse, serious misconduct or neglect at member residences. A BHO must require its affiliates to report to them any disciplinary or equivalent actions taken against them.
- 2.5. Affiliates agree to cooperate with the BHO and BHDDH in any efforts to resolve complaints received by the affiliate or about its individual members.
- 2.6. The affiliate must require notification to the BHO in the event of material changes in ownership or management of member organizations.
- 2.7. The affiliate must be clear in its communication with the public that they are independent organizations and that the BHO does not manage the operations of its members or of their residences.

3. Records management

- 3.1. The affiliate must maintain adequate records of resident's applications and standards of compliance.
- 3.2. The affiliate must maintain clear, accurate and complete financial records and make them available to the BHO upon request.
- 3.3. Toxicology procedures and expectations must be clearly written, signed and reviewed by all new members prior to admission and kept within their record.

Terms and conditions

The affiliate relationship is severable by either party with a 30 day notice period. Affiliation is valid for one year from the date of agreement being signed by the BHO and affiliate agencies. The agreement can be terminated for any level of non-compliance with standards listed above. The BHO will notify BHDDH of any changes in terms or conditions.