



Solicitation Information

16 May 2012

RFP # 7449738

TITLE: Residential Substance Abuse Treatment Services for Adult Males

Submission Deadline: 27 June 2012 @ 11:30 PM (EDT)

<p>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</p>
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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.

<p>SURETY REQUIRED: No</p>

<p>BOND REQUIRED: No</p>

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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

Substance Abuse Adult Residential 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 Substance Abuse Male Adult Residential 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). It is expected that successful applicants will adopt and incorporate SAMHSA's National Behavioral Health Quality Framework into the service continuum. Up to eight with no more than 16 contracts will be awarded to ensure that services are available Statewide.

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.

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

SECTION 2 BACKGROUND AND PURPOSE

Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals has not re-contracted its substance use adult residential services for over 15 years. Since that time the landscape of providing treatment and the financial ability to support long term treatment has changed. Anticipating the advent of the Affordable Healthcare Act, it is expected that this 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. In times past treatment options most often consisted of detoxification followed by a clinically managed short or long term residential treatment program. Short and long term residential programs were inconsistently defined with anticipated lengths of stay ranging from ninety to three hundred sixty-five days. An analysis of BHDDH data revealed that the average length of stay in residential treatment in 2011 was 96 days.

The current system funds 147 adult residential male or co-ed beds in long or short term residential treatment. Most male and female admission were in the 26 to 45 year age range. Of those clients 12.3% are African American, 7.4% Hispanic, 2.1% Native American and 77.8% are white. This is a predominately unemployed population the majority of whom resides in Providence County. Data shows that 75% are unemployed and 13% are out of the labor force due to disability or coming from corrections. There is remarkable consistency across men and women with regard to employment status. A larger percent of percentage of clients coming from Providence or Newport counties are listed as homeless at admission. The older the client the more likely they are to be homeless. Most clients were court referred (40%), followed by referral by a Substance Abuse provider (24%) and then a self referral (22%). Clients under 25 were more likely to be referred from courts (>50%), in comparison to those over 25 who are more likely to be self or other Substance Abuse provider referrals (<50%). The most common primary substance of abuse for women is cocaine (33%) while for men it is alcohol (41%). Opioids peak as primary substance of abuse in 18-25 year olds while heroin peaks for 25-36 and

cocaine for 35 to 45 year olds. Alcohol is overwhelmingly the primary substance of abuse for clients over 56 years old (73%). The data referenced in this paragraph was taken from the state's BHOLD client information system and was provided by the current Substance Abuse residential contracted agencies.

In redefining a system of care, BHDDH has established a clear emphasis on decisions that are outcome driven using performance based measures. This is a departure from the previous business model of continuing to fund a system without clear evidence of the effectiveness of the intervention, use of evidence-based practices, or desirable outcomes. Providers have not been asked to prove that the services they offer produce the desired outcome. Review of the data that has been collected indicates that there is much room for improvement.

- 30% of clients were discharged with treatment complete.
- 25% discharged to another provider or with referral.
- 25% were listed as “client terminated.”
- 20% left due to non compliance.
 - The percent for non compliance decreases as age increases and peaks with 26 to 35 year olds at 28%.
- 34% of male discharges become re-incarcerated.
 - The average time of re-incarceration post residential treatment is 144 days.

The first priority to inform this RFP is BHDDH's focus on expanding levels of care to meet the needs of the client appropriate for residential treatment. The goal of this RFP is to improve access to a full continuum of treatment and recovery services statewide. This RFP presents with two new levels of residential treatment services. The first being a stabilization service (Asam level II.2D) for up to 14 days for the client awaiting placement for an assigned bed 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. The next level of care to be utilized is a transitional program (Asam level II.I) up to a 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 relapsing 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.

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 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.

Secondly, Research has provided over the years the importance of gender specific treatment modalities and the need to clinically address male issues in relation to recovery needs and the concerns about the high rates of incarceration versus treatment involvement. 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.

To meet a third BHDDH priority, contractors will be required to collect performance data on a number of core areas suggested by the Substance Abuse and Mental Health Services Administration (SAMHSA). *(These Core Areas are described under Section 3, Scope of Work: Deliverables)*. Particular attention will focus on clients' rapid access, active participation and retention in treatment, all of which have been consistently associated with positive treatment outcomes. All outcomes defined in this RFP will be evaluated at the end of the two year base period to determine future funding as has been determined by not only this department but in the State's shift to performance based budgeting.

Finally, applicants are required to describe how they will identify and address recent trends in substance use disorders in RI and implement evidence based practices including the incorporation of medication assisted treatment.

Distribution of Funds: The state intends to award funding to at least eight but no more than sixteen contractors. The continuum shall be designed to ensure service accessibility by diverse populations throughout the state and tailored to meet the needs of specific communities or populations.

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</u> <u>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. Client <u>must not</u> be in need of medical detoxification.</p>	10	Maximum of 14 days.	\$105.00 per day. For NON IMD facilities a daily rate of \$30 plus clinical services billed through HP.
ASAM Level III-1	<p><u>Adult Residential (Short Term-Halfway house)</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 resident into the world of work, education and family. In this level the 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.</p>	20	Maximum of 90 days	For NON IMD facilities a daily rate of \$30 for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$60.
ASAM Level III.3 Short term	<p><u>Extended Assessment/Transitional Care. Adult Residential (Short Term)</u> 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 <u>of rehabilitation</u> and relapse prevention education and support. 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.</p>	24	Maximum of 30 days	For NON IMD facilities a daily rate of \$30 for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.

<p>ASAM Level III.3 Medium Extended term</p>	<p>Adult Residential (Medium Extended Term) 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 habilitation, 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.</p>	<p>30</p>	<p>Maximum of 90 days</p>	<p>For NON IMD facilities a daily rate of \$30 for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.</p>
<p>ASAM Level III.5 High intensity</p>	<p>Adult Residential (High Intensity Long Term) Example: Therapeutic Community Alcohol and/or drug services: Clinically-Managed- High Intensity level of a residential treatment 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.</p>	<p>25</p>	<p>Maximum of 180 days</p>	<p>For NON IMD facilities a daily rate of \$30 for bed plus clinical services billed through HP. For IMD facilities a daily rate of \$79.</p>
<p>Recovery Housing</p>	<p>Adult Residential working/recovery houses 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 are encouraged. Memorandums of Understanding (MOUs) with licensed Behavioral Healthcare Organizations are minimally required.</p>	<p>20</p>	<p>Maximum of 180 days (through contract funding)</p>	<p>Daily rate of \$20 for the first 90 days. Daily rate of \$10 for last 90 days of funding through contract.</p>

- 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.

Target Population: 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 all Level III residential treatment and/or recovery housing 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.

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:

- Individuals who are HIV antibody positive or have HIV disease;
- IV users
- Veterans and service men and women from the National Guard;
- Individuals who are homeless or at risk of being homeless;
- Referrals from state-funded detoxification, inpatient psychiatric hospitalization and diversion/step-down units.

Specialized populations targeted for service

The following are special populations identified by the Department which may or may not be identified in proposals. With the exception of the young adult population, this RFP is not soliciting proposals to segregate individuals in these groups, but rather describe how they will be integrated into the treatment milieu if they are identified as a target population. The Department would welcome proposals dedicated to the needs to the young adult population.

18-28 year old males

The overarching goals of 18-28 year old males –Special at-Risk Populations Initiatives are to:

- Decrease the number of young adult males that are moving from prescription medication and/or opiate abuse to heroin dependency.
- Increase the level of completions in treatment, since historically this at risk group is noted for leaving treatment early and often in non-compliance.
- Increase insight and basic education around the progression of drug dependency and addiction substitutions, including but limited to gambling.
- Evaluate candidates for medication assisted recovery and provide necessary resources with a full understanding of both short and long term affects.
- Decrease incarcerations for this high risk population by addressing coexisting issues with addiction such as; drug dealing, domestic violence, driving under the influence and poor anger management skills.

The Offeror Will:

1) Provide groups to address co-occurring and developmental issues, anger management and improved coping skills for relapse preventions. Trauma survivor recovery should also be addressed with a focus on developing the individual's ability for emotional self regulation beyond using drugs. Additional educational groups should address criminal relapsing behaviors, the dangers of drug substitution with other drugs and other addictions such as gambling. The major concern for this population stems from data research from the department of BHDDH about 18-25 year old males addicted to prescription medications and their eventual progression to heroin addiction at the ages 25-30.

2.) Develop an organized mechanism for a behavioral system based on contingency management that provides rewards for positive, recovery-focused behaviors and consequences for negative behaviors (other than discharge). Research has been providing on the importance of moving through stages of treatment and the reinforcement of positive rewards with out drug use. There will be written policies, procedures and training for staff and clients on building strengths based treatment.

3.) Establish completion criteria based on performance in acquiring relapse prevention skills, recovery attitudes and beliefs. Indicators of performance can be included in a behavioral assessment instrument or a checklist of attitudinal criteria and goal attainment in the client's case or treatment plan reviews. Documentation of new recovery skills attained will be noted in clients chart.

4.) Teach clients to monitor and anticipate problem situations through modeling and demonstrations by staff. Staff and clients should be knowledgeable of relapse triggers and alternatives to relapse along with managing and planning to avoid high risk situations.

Contractors will have clients practice and rehearse recovery responses to these situations. Role plays should be built into curricula in an organized fashion so the approach is consistent. The role plays that are to be used should be documented. Clients can practice these skills outside of group on short term passes and reportback on their experiences.

6.) Provide educational services to include attention to developmental factors, family dysfunction, and educational and vocational needs.

Veteran Population

While the 2008 Department of Defense Health Behavior Survey reveals general reductions over time in tobacco use and illicit drug use, it reported increases in other areas, such as prescription drug abuse and heavy alcohol use. In fact, prescription drug abuse doubled among U.S. military personnel from 2002 to 2005 and almost tripled between 2005 and 2008. Alcohol abuse is the most prevalent problem and one which poses a significant health risk. A study of Army soldiers screened 3 to 4 months after returning from deployment to Iraq showed that 27 percent met criteria for alcohol abuse and were at increased risk for related harmful behaviors (e.g., drinking and driving, using illicit drugs). Rhode Island has maintained one of the highest rates of National Guard deployment in the nation along with one of the highest rates of positive toxicology screens and suicide. And although soldiers frequently report alcohol concerns, few are referred to alcohol treatment. Initiatives for this level are:

- Improving screening and access to care for drug and alcohol -related problems among service members returning from combat deployments.

- Attention paid to the specific issues presented by this population including an understanding of the military culture and the relation of traumatic brain injury and post-traumatic stress disorder to substance use.
- Involvement of family in treatment, understanding the impact of deployment, PTSD, and substance use on the military family.

Re-Entry Population

Individuals being released from incarceration often have completed a substance abuse treatment program while incarcerated and have been drug-free for a period of time but require recovery supports and transitional services to implement their recovery plan into every-day living. These clients often need re-entry sober supports but do not meet the ASAM criteria for long-term placement. Such clients may require placement, case management and stabilization for a short term interval such as the 30 day residential option or recovery housing supported by outpatient treatment. The overarching goals for this special at risk population are:

- Reduce and/or eliminate substance use and the risk factors associated with substance use
- Reintegrate into home community with focus on skills building which will facilitate functioning in the community with minimal supervision.
- Provide planning for the next academic and/or vocational steps.
- Improve family relationships.
- Reduce recidivism through evidence-based, gender responsive programs that address substance use behaviors and criminogenic risks and needs.
- Ensure that staff are adequately trained in the needs of this population by employing individuals with the CCJP credential.
- Increase participation in community aftercare substance abuse programs by promoting their value and ensuring the successful linkage between residential programs and community peer and housing supports are in place.

Sex Offender Population

Sex offenders present a special challenge for the provider of substance abuse residential treatment. Placement issues have presented obstacles for Department of Corrections discharge planners and other staff working on community reintegration.

The overarching goals for this special at risk population are:

- Ensure community safety and legal ability to house sex offenders in the program
- Educate on self management of psychiatric symptoms and problem behaviors
- Improve ability to recognize, express, and manage feelings
- Teach social skills necessary to form positive peer and adult relationships
- Reduce and/or eliminate substance use and learn to identify triggers and strategies for relapse prevention and risk factors associated with relapse
- Improve family relationships
- Plan for reintegration into home community with a focus on skills building to facilitate functioning in the community with minimal supervision
- Coordinate treatment services with other providers and the legal system.

Other specialized populations may be presented in an application, depending on demonstration of specialized need within the region and demonstrated clinical capacity, funding permitting.

In accordance with the principles of a true Recovery Oriented System of Care (ROSC), treatment, community, and recovery support service connections are strongly encouraged in order to maximize service capacity and accessibility. It is expected that this person centered and strengths based approach will result in services being gender and age responsive and culturally appropriate. Use of peers to support clients in treatment and/or transitioning into the community is strongly encouraged.

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. Admit and discharge data will be entered weekly by awardee into RBHOLD.

Contract Terms:

The State of Rhode Island intends to award a contract for a period of two years beginning on Sept 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 for residential treatment services, 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, demonstrate the ability to provide a range of ASAM Level III residential services as described under Section 3, “Scope of Work”.
- 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.

In order to be eligible to receive funding under this initiative for recovery housing services, applicants 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 must meet the standards as described in Appendix I.

Preference will be given to applicants and participating subcontractors who:

- Demonstrate experience in and ability to refer 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 cultural and linguistic minorities,, 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.
- Demonstrate an ability to work with Specialized Populations as described above.
- Maintain required staffing to work with Specialized Populations.
- Demonstrate an ability to provide outcomes as dictated from The Department using evidence based practices.

SECTION 3 - SCOPE OF WORK

GENERAL DESCRIPTION:

The contractor(s) will be responsible for the development and implementation or referral of a full continuum of treatment as described within ASAM Level III.I, III.2D, III.3 or III.5 and Recovery Housing.

Applicants must demonstrate ability to provide or arrange for the level of care omitted if the need arises. The service continuum may be provided collaboratively with other providers **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 of residential treatment services include:

- **Screening, Assessment and Treatment Planning** consistent with the BHO Regulations.
- **Educational Sessions** providing information related to addiction and recovery including:
 - Substance Abuse / dependency / recovery
 - Cross addiction
 - Self-help and other recovery support programs
 - HIV/STD, Tuberculosis and Hepatitis infection and risk reduction
 - Relapse prevention
 - Recreation/life and social skill building
 - Employment readiness
 - Gender and cultural issues
 - Trauma/grief issues
 - Parenting issues including effects of substance abuse on children
 - Discharge planning for continuing care / aftercare
 - Any specialized topics related to specialized populations targeted for service.
 - Mental Health Issues
- **Counseling Services**, including individual and group counseling, according to documented client need, application of ASAM criteria and level of care.
 - Individual counseling shall consist of 50 to 60 minute sessions. These sessions should continuously monitor and evaluate the effectiveness of the interventions identified in the treatment plan and continue the process of discharge planning.
 - Family counseling should be considered an integral component of residential treatment. Family counseling shall consist of 50 to 60 minute sessions and must include the primary client in the session.
 - Group counseling as defined by the use of varying therapeutic models and techniques appropriate to achieving client objectives, focusing on group process as well as content. Models and techniques should incorporate evidence based counseling theory, treatment, practice and outcomes literature relevant to the

population. Clinical Group counseling sessions shall contain a maximum of ten clients and shall be of 60 to 90 minutes in duration.

- **Drug Testing (includes alcohol):** Possible drug use during treatment shall be monitored continuously, particularly in the initial phases. The frequency of testing should be individualized to the phase of treatment, relapse potential and primary drug of use. Frequency should be consistent with the client's level of care and progress in treatment, and may provide early evidence of drug use so that an individual's treatment plan can be adjusted. Applicants must describe the frequency of collection, the procedures for randomizations and observation, the name of the laboratory that will conduct the testing, and how the results will be used by the program.
- **Criminal Justice/DCYF Collaboration:** The applicant must identify a defined system for contacts with the criminal justice system regarding clients involved in the probation/parole, adult and family drug courts and DCYF. The program must identify a clear and simple process for two-way communication to provide information on client progress or lack thereof to the appropriate criminal justice system officials and to assure that reports required are completed and delivered on time. The process must include a procedure for immediate notification about clients who drop out of treatment before completion.
- **Collaboration with providers of medication assisted treatment and/or mental health treatment.** Individuals are not to be discriminated against on the basis of medications used to assist treatment (suboxone, methadone, vivitrol, naltrexone, etc.) or to treat mental illness. Applicants must address efforts to reduce stigma for this population within the treatment setting that may be presented by staff or other clients. Applicants must discuss procedures for safe storage and self administration of prescribed medication.
- **Case Management services:** Case management services may not be required for all clients, and most likely will be required for limited periods of time during an individual's treatment experience, with the ultimate goal of promoting self sufficiency. Services may be provided by paraprofessionals with appropriate expertise or training in human service resource coordination.
- **Service coordination:** depending on need, **including** the provision of or connection to providers of the following services
 - Medical services (including gender-specific services for primary clients and their children, if applicable). This should include referral to Rite Care for uninsured children, as well as HIV, TB, STD, and HCV testing, counseling, and treatment.
 - Smoking cessation programs
 - Transportation assistance
 - Housing, vocational, financial, legal and educational services
 - Domestic violence/sexual abuse/trauma counseling
 - Childcare
 - Mental health and/or psychiatric symptom management, including referrals for necessary medications.
 - Cultural and linguistic accommodations and accommodations for clients with mobility or other disabling conditions, governed by ADA.
 - Child welfare services, the criminal justice system, public welfare agencies, elder services, health care, vocational and/or educational services.
- **Aftercare/Continuing Care:** Services should include a mechanism to provide supportive care following the client's completion of formal treatment to non-treatment phases of

recovery. Continuing care services offer clients support and opportunity for further growth and development, which may include, but not be limited to, case management; telephone or family support; liaison and advocacy; and monitoring.

- **Referrals:** The contractor shall have a plan for referral of individuals who require inpatient detoxification or psychiatric services, more intensive outpatient psychiatric services (such as “dual diagnosis enhanced services” described within ASAM PPC), medication assisted treatment, or medical care.
- 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.

Descriptions of Levels of Housing

Respite/Transitional Crisis Sites (ASAM Level III.2D)

Individuals in need of, but unable to immediately access residential treatment, are perhaps the most vulnerable population in the addictions field. Whether completing detox or living in a dangerous environment, not having access to a residential bed can be a matter of life or death for addicted individuals. Expansion of services to include this level of care provides a safety net for these individuals and access not only to a safe place to stay, but clinical interventions that prepare the client to fully engage in the next step in the treatment continuum. This treatment provides a “step-up” or “step-down” option for providers and clients. This level of care requires the following:

- An interdisciplinary team providing daily clinical services to assess and address the needs of each patient.
 - A range of cognitive, behavioral, medical, mental health and other therapies, administered to the patient on an individual or group basis. These are designed to enhance the client’s understanding of addiction, the completion of the detoxification process, and referral to an appropriate level of care for continuing treatment
 - Multidisciplinary individualized assessment and treatment
 - Health Education Services
 - Sufficient biopsychosocial screening assessments to determine the level of care in which the client should be placed, and for the individualized care plan to address treatment priorities.

Adult Residential - Short Term-Halfway house (ASAM Level III.1)

Anticipated lengths of stay for this modality are 90 days, providing clients a safe and stable living environment while encouraging community reintegration and development of social and daily living skills. This level of care requires the following:

- A minimum of five clinical service hours per week
- Services designed to improve the client’s ability to structure and organize the tasks of daily living and recovery such as personal responsibility, personal appearance and timeliness
- Planned clinical program activities designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of a social network supportive of recovery. These may include (but are not limited to) individual and group therapy, educational groups, and occupational or recreational activities
- Counseling and clinical monitoring to promote successful involvement in regular,

productive daily activity and, as indicated, successful reintegration into family living

•Coordination with Office of Rehabilitation services and/or other employment focused agencies.

Extended Assessment/Transitional Care. Adult Residential (Short Term – ASAM Level III.3)

Anticipated lengths of stay for this level of care are up to 30 days. This treatment modality seeks to provide a safe and stable living environment for two primary populations: individuals with a history of addiction being released from incarceration and individuals with addiction histories who have achieved a period of abstinence who experience relapse and need a more structured environment to get back on track.

For recently incarcerated individuals, short-term residential allows for an extended assessment of the client’s needs, case management services which will connect clients to the needed community resources, opportunity to assess the client’s stage of change and ability to transition into the community. Clinical components need to include relapse prevention, life skills development, criminal thinking and behaviors, safe discharge planning, and development of a social support network.

Programs designed to meet the needs of individuals with recovery experience who have relapsed need to describe a clinical format that will build upon the individual’s recovery capital. Emphasis should be placed on stabilization, relapse prevention, engaging recovery supports and community reintegration.

This level of care requires the following:

- A minimum of 12 hours structured clinical activities per week.
- Counseling and clinical monitoring to promote successful involvement in regular, productive daily activity and, as indicated, successful reintegration into family living
- Random toxicology screens

Adult Residential (Medium Extended Term – ASAM Level III.3))

Anticipated length of stay of up to 90 days in these programs which provide a structured recovery environment in combination with medium-intensity professional clinical services to support and promote recovery. For Level III.3 residents, the effects of addiction on the individual’s life is so significant and the level of addiction- related impairment is so great that outpatient motivational strategies are not feasible or effective. Persons appropriate for this level of care are characterized by their need for a slower paced treatment presentation because of mental health problems or reduced cognitive functioning or the chronicity of their illness. They may also be homeless, but this alone is not sufficient for admission to this level of care. Reintegration of these clients involves case management activities directed toward networking with community-based ancillary services. This level of care requires the following;

- A minimum of 12 hours structured clinical activities per week. This may include medical services, nursing services, individual and group psychotherapy, family therapy, educational groups, occupational and recreational therapies, arts therapy, and vocational rehabilitation activities.

- Services designed to improve the client’s ability to structure and organize the tasks of daily living and recovery such as personal responsibility, personal appearance and timeliness
- Planned clinical program activities designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of a social network supportive of recovery. These may include (but are not limited to) individual and group therapy, educational groups, and occupational or recreational activities
- Counseling and clinical monitoring to promote successful involvement in regular, productive daily activity and, as indicated, successful reintegration into family living
- Random toxicology screens
- Daily scheduled professional addiction treatment services are designed to develop and apply recovery skills including relapsed prevention, interpersonal choices and development of a social network supportive of recovery.

Adult Residential (High Intensity Long Term – ASAM Level III.5)

High intensity residential treatment programs are designed to address significant problems with living skills and allow an extended period of time to recover from the effects of long-term substance use disorders. This level of care provides a highly structured recovery environment in combination with moderate – to – high intensity professional clinical services to support and promote recovery. The expected length of stay is up to 180 days. This level of care requires the following:

- A minimum of 12 hours structured clinical activities per week. This may include medical services, nursing services, individual and group psychotherapy, family therapy, educational groups, occupational and recreational therapies, arts therapy, and vocational rehabilitation activities.
- Services designed to improve the client’s ability to structure and organize the tasks of daily living and recovery such as personal responsibility, personal appearance and timeliness
- Planned clinical program activities designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of a social network supportive of recovery. These may include (but are not limited to) individual and group therapy, educational groups, and occupational or recreational activities
- Counseling and clinical monitoring to promote successful involvement in regular, productive daily activity and, as indicated, successful reintegration into family living
- Random toxicology screens
- Daily scheduled professional addiction treatment services are designed to develop and apply recovery skills including relapsed prevention, interpersonal choices and development of a social network supportive of recovery.
- Clinical and didactic motivational interventions designed to facilitate the client’s understanding of the relationship between substance-related and attendant life problems.
- Planned community reinforcement designed to foster pro-social values and group living skills.

All residential levels of care may be extended beyond the maximum length of stay with prior approval of DBH. Requests for extensions are included in Appendix 3. Agencies providing residential treatment services are not prohibited from charging residents additional fees for their services based on a percentage of income. However,

specific details of fee structures and policies on nonpayment must be submitted with the application. Treatment CANNOT be denied based on inability to pay.

Recovery Housing

Recovery Housing offers a safe and supportive environment for individuals who do not or no longer require a residential level of care. Such individuals may have completed residential treatment (including residential treatment during incarceration) and are unable to access safe housing or unable to return to their original environments that may not support recovery. Recovery Houses are expected to meet the standards identified in Appendix II. Recovery Houses are not expected to be clinical programs, but are required to have MOUs (see appendix I) with licensed behavioral healthcare organizations so that clinical support is available to residents. Recovery Houses are also expected to be staffed (though not 24 hours per day) with resident managers. There is no expected length of stay for recovery housing, though this contract will not pay for housing indefinitely. Reimbursement for recovery housing is tiered, with full payment for housing in the first 90 days, and half payment for the following 90 days with the expectation that the client will contribute the remaining portion of the housing costs.

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;
 - IV drug users
 - Veterans and service men from the National Guard;
 - 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 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) Awardees will report on waiting lists to the Department on a weekly basis in a format to be determined by The Department.

DELIVERABLES:

- 1) Submission of client data to the Division of Behavioral Healthcare Services in format and schedule to be determined by the Division of Behavioral Healthcare Services.
- 2) Collection and submission of client Performance Measure /National Outcome Measure data for Core Areas as required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Most of the requisite data is to be reported as part of client admission/discharge data submitted to the Division, and shall initially include:

Desired Outcome/Core Area	Measurement	Outcome Tool
Decreased Drug/Alcohol Use	Change in percentage of clients abstinent at discharge compared to the number/proportion at admission	Collected from RIBHOLD
Decreased Criminal Justice Involvement	Change in percentage of clients with criminal justice involvement at discharge compared to the percentage at admission	Collected from RIBHOLD
Increased access to vocational resources	Percentage to clients that participate in vocational programs through ORS	To be determined by the Department.
Increases in Stabilized Family and Living Conditions	Percentage of clients in stable living situations at discharge compared to the number/proportion at admission (i.e., homelessness*)	Collected from RIBHOLD
Increased Access to Services	Unduplicated count of persons served Penetration rate – Numbers served compared to those in need* Wait list reporting**Length of time between referral and placement.	Unduplicated count collected in RIBHOLD. Other Outcomes to be sent to the Department in a format developed by the Awardee and approved by The Department.
Increased Retention and completion in Substance Abuse Treatment	Length of stay and reasons for discharge. Percentage of clients completing Residential Treatment.	Collected from RIBHOLD
Increased Social Supports	Participation in 12 Step or other Self-Help Support Groups Engagement with recovery support services as needed** Engagement with Sponsor or Recovery Coach**	All outcomes to be sent to the Department in a format developed by the Awardee and approved by The Department.

**All of the above measures, except for those with the ** designation, are provided through RIBHOLD client data submissions to DBH.

- 3) The contractor is responsible for collecting and reporting on the above ** measures with data collection methods and format to be determined in conjunction with DBH and other contract awardees. The contractor 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.

SECTION 4 – 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 # 7449738: Residential Substance Abuse Treatment Services for Adult Males**” 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 font print or larger, and in English. The technical proposal (which includes the Executive Summary, Previous Experience and Background, Workplan/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 Workplan or approach proposed for this requirement.

The Technical Proposal must contain the following sections:

Executive Summary (Not to Exceed One Page)

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, 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 outpatient and day 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 offeror'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 listing of **sites to be utilized** (see attachment I).
 - a) Letters of agreement mutually signed by the lead agency and each Behavioral Health subcontractor must be appended.
 - b) Information regarding any 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. Two examples follow:

Example A.

Screening and Assessment: All program participants 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.

Example B.

Specialized Populations: The Region's specialized program for young adults will be provided at ___ and will include, including a specialized track for Based on a specific need within the region and specialized expertise of the subcontractor.

- 2) The applicant will describe how it will provide access to a residential continuum (ASAM 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) Describe how **services and coordination of care will be developed** to serve clinically and financially eligible populations described under Scope of Work, including:
 - Young adults (18-28)
 - Individuals with co-occurring disorders. Specify mechanisms and resources for referring more severely affected clients to services that are "dual diagnosis enhanced". This discussion should also include any available resources for accessing needed medications, if available.
 - Individuals involved with the criminal justice system
 - Individuals involved with DCYF/child welfare
 - Individuals with physical or other disabilities or medical conditions
 - Racial and ethnic minorities (as appropriate and needed within the region)
 - Linguistic minorities including the deaf and hard of hearing
 - Elderly 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*,
- f) Mechanisms for **accessing other related services** during treatment, such as:
 - Tuberculosis, Hepatitis C, HIV, and STD services,
 - Primary care.
- f) 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. Describe how peers will be incorporated into the treatment milieu if proposed.
- 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 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 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.

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 each residential facility is staffed
- An organizational chart showing how each facility falls under the larger umbrella of the awarded agency.

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.

Appendixes

This section shall, at a minimum include:

- A completed List of Behavioral Healthcare Sites to be Utilized for the project
- 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 5 – 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 issues of understanding of the problem, availability, accessibility and comprehensiveness of client services, and use of available resources, using the following criteria:

Agency Experience and Background (up to 15 points)

Proposals will be rated on the extent to which the agency (including collaborating or sub-contracted agencies, if applicable) has

- Demonstrated experience in providing outpatient and related services to the target populations identified in the request?
- A sound financial background as evidenced by submission of a recent audit?
- A satisfactory history of meeting Departmental licensing standards?
- A satisfactory history of compliance with Departmental contract requirements, including meeting programmatic requirements, utilization, and responding to corrective action plans?

Quality of Work Plan/Approach (up to 55 points)

Applicants will be rated according to the extent to which proposals address issues under Scope of Work, including how proposals address:

Accessibility:

- Do the site locations and hours of operation provide adequate service access for a variety of populations in need of service?
- Do admission application procedures and hours facilitate ease of access to information and requirements for potential clients seeking service?
- Does the project offer a range services tailored to all the target populations (as well as other specialized populations which may be unique to the service region) through specialized programming, staffing, hours of operation, etc.?
- Do services include transportation, location on bus lines or other innovative approaches to enhancing access?
- Does the proposal address access for individuals with handicapping conditions governed by ADA?
- Does the project describe referral mechanisms for those who cannot be served by the project?

Comprehensiveness of Services

- Does the proposal adequately address coordination of services beyond the scope of traditional “treatment”, including, but not limited to housing, vocational or educational services, or other social services? Does the proposal reflect a clear understanding of other resources available to the population, and how such services will be coordinated?
- Does the proposal adequately describe how it will address testing and/or referral for treatment of HIV/AIDS, tuberculosis, STDs and Hepatitis?
- Does the proposal adequately describe how it will coordinate services with the criminal justice system, including but not limited to drug courts and DCYF?
- Does the proposal include schedules of a typical week for each level of service to be provided? Do these schedules reflect appropriate intensity and content for the population(s) served?
- Does the proposal address the role of 12 step or other self-help programs in the recovery process?
- Does the proposal address how it will create a system that is “Dual Diagnosis Capable”?

Clinical Soundness:

- Does the project propose to use valid screening and assessment tools appropriate to the population(s) to be served?
- Does the application present a clear understanding of ASAM Level III
- Do educational and counseling session content reflect themes appropriate to the client population, and sound clinical approaches?
- Is there an emphasis on family involvement in treatment?
- Is there a clear plan for integration of medication assisted treatment and mental health treatment?
- Does the project include provisions for access to emergency medical, psychiatric, detoxification or other care?

Respect for Consumer Rights:

- Do admission and discharge policies and procedures reflect an understanding of client needs and issues, including the issue of relapse during treatment?
- Does the project describe a client grievance procedure, including mechanisms for clients to appeal decisions made by the program?
- Does the proposal discuss how client rights are made known to clients upon admission and/or during the treatment experience?
- Does the project address how it solicits client input into the delivery of services?
- Does the project address mechanisms for referring clients to alternative programs, such as Narcotic Treatment, if appropriate?
- Is there a plan to address staff and patient stigmatization of clients receiving medication assisted treatment services or mental health treatment services?

Miscellaneous:

- Does the proposal identify a reasonable timeline for implementation of services?
- Does the proposal reflect any additional services beyond the requirements of the request?
- Does the proposal identify any requirements of the request that cannot be met?

Organization and Staffing (Up to 20 points)

- Does the proposal identify appropriately trained and credentialed clinical staffing for the variety of sites and populations proposed?
- Does the staffing address the project's ability to provide culturally competent services to specialized population proposed in the application?
- Does the proposal identify any specialized staff training to be provided to effectively serve the proposed population?
- Do organizational plans reflect an appropriate span of control within individual agencies and among various project participants?
- Does the proposal include a reasonable plan for ensuring communication among the various partners involved in the project?
- Does the proposal include any complementary funding sources and/or in-kind contributions which enhance program services funded under this Request?
- Does the proposal describe existing relationships with third party payors for coverage of similar services for insured clients?
- Does the proposed staffing pattern insure the appropriate number of clients will be treated given the dollars available per region.

Reporting (Up to 10 Points)

- Does the proposal describe how offeror intends to comply with reporting requirements
- Does the proposal provide details on the methods for collecting and format for reporting data of non-NOM measurements (wait list, length of time from phone call to assessment, engagement with recovery support services, and engagement with sponsor and/or recovery coach).

The highest possible score is 100 points.

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.

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.

