

State of Hawaii
Department of Health
Adult Mental Health Division

Request for Proposals

RFP No. 420-7-10 Bilingual Support Services on the island of Oahu

Date Issued
May 24, 2010

Date Due
June 24, 2010

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, you may download the RFP Interest form, complete and e-mail or mail to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

May 24, 2010

REQUEST FOR PROPOSALS

**BILINGUAL SUPPORT SERVICES
ON THE ISLAND OF OAHU
RFP No. HTH 420-7-10**

The Department of Health, Adult Mental Health Division (DIVISION), is requesting proposals from qualified applicants to provide Bilingual Support Services on the island of Oahu. The contract term shall be from October 1, 2010 through September 30, 2011. Multiple contracts may be awarded under this request for proposals.

Proposals shall be mailed, postmarked by the United State Postal Service on or before June 24, 2010, and received no later than 10 days from the submittal deadline. Hand delivered proposals shall be received no later than 4:00 p.m., Hawaii Standard Time (HST), on June 24, 2010, at the drop-off site designated on the Proposal Mail-in and Delivery Information Sheet. Proposals postmarked or hand delivered after the submittal deadline shall be considered late and rejected. There are no exceptions to this requirement.

The DIVISION shall conduct an orientation on Thursday, June 3, 2010, from 9:00 a.m. to 11:00 a.m., HST. The time and place for the RFP orientation session is stated in Section 1, Administrative Overview of the RFP. All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 2:00 p.m., HST, on June 7, 2010. All written questions shall receive a written response from the State on or about June 14, 2010.

Inquiries regarding this RFP should be directed to the RFP contact person, Ms. Betty Uyema at 1250 Punchbowl Street, Room 256, Honolulu, Hawaii 96813, telephone: (808) 586-8287, fax: (808) 586-4745.

PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

**NUMBER OF COPIES TO BE SUBMITTED:
THE 3 COPIES MUST INCLUDE ONE (1) SIGNED ORIGINAL AND ONE (1) SINGLE
SIDED, UNBOUND COPY.**

**ALL MAIL-INS SHALL BE POSTMARKED BY UNITED STATES POSTAL SERVICE
(USPS) NO LATER THAN**

June 24, 2010

**and received by the state purchasing agency no later than 10 days from the submittal
deadline.**

All Mail-ins

Department of Health
Adult Mental Health Division
P.O. Box 3378
Honolulu, Hawaii 96801-3378

RFP Contact Person

Ms. Betty Uyema
For further info. or inquiries
Phone: 586-8287
Fax: 586-4745

**ALL HAND DELIVERIES SHALL BE ACCEPTED AT THE FOLLOWING SITE UNTIL
4:00 P.M., Hawaii Standard Time (HST), June 24, 2010.**

Drop-off Site

Oahu:

Department of Health
Adult Mental Health Division
1250 Punchbowl Street, Room 256
Honolulu, Hawaii

BE ADVISED: All mail-ins postmarked by USPS after **June 24, 2010**, shall be rejected.
Deliveries by private mail services such as FEDEX shall be considered
hand deliveries. Hand deliveries shall not be accepted if received after
4:00 p.m., HST, June 24, 2010.

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Section 1

Administrative Overview

Section 1

Administrative Overview

Applicants are encouraged to read each section of the RFP thoroughly. While sections such as the administrative overview may appear similar among RFPs, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

I. Procurement Timetable

Note that the procurement timetable represents the State's best estimated schedule. Contract start dates may be subject to the issuance of a notice to proceed.

Activity	Scheduled Date
Public notice announcing Request for Proposals (RFP)	5/24/10
Distribution of RFP	5/24/10
RFP orientation session	6/03/10
Closing date for submission of written questions for written responses	6/07/10
State purchasing agency's response to applicants' written questions	6/14/10
Discussions with applicant prior to proposal submittal deadline (optional)	
Proposal submittal deadline	6/24/10
Discussions with applicant after proposal submittal deadline (optional)	
Final revised proposals (optional)	
Proposal evaluation period	6/29/10 –
	7/16/10
Provider selection	7/21/10
Notice of statement of findings and decision	7/21/10
Contract start date	10/01/10

II. Website Reference

The State Procurement Office (SPO) website is <http://hawaii.gov/spo>

	For	Click
1	Procurement of Health and Human Services	“Health and Human Services, Chapter 103F, HRS...”
2	RFP website	“Health and Human Services, Ch. 103F...” and “The RFP Website” (located under Quicklinks)
3	Hawaii Administrative Rules (HAR) for Procurement of Health and Human Services	“Statutes and Rules” and “Procurement of Health and Human Services”
4	Forms	“Health and Human Services, Ch. 103F...” and “For Private Providers” and “Forms”
5	Cost Principles	“Health and Human Services, Ch. 103F...” and “For Private Providers” and “Cost Principles”
6	Standard Contract -General Conditions	“Health and Human Services, Ch. 103F...” “For Private Providers” and “Contract Template – General Conditions”
7	Protest Forms/Procedures	“Health and Human Services, Ch. 103F...” and “For Private Providers” and “Protests”

Non-SPO websites

(Please note: website addresses may change from time to time. If a link is not active, try the State of Hawaii website at www.hawaii.gov)

	For	Go to
8	Tax Clearance Forms (Department of Taxation Website)	http://www.hawaii.gov/tax/ click “Forms”
9	Wages and Labor Law Compliance, Section 103-055, HRS, (Hawaii State Legislature website)	http://www.capitol.hawaii.gov/ , click “Bill Status and Documents” and “Browse the HRS Sections.”
10	Department of Commerce and Consumer Affairs, Business Registration	http://www.hawaii.gov/dcca click “Business Registration”
11	Campaign Spending Commission	http://www.hawaii.gov/campaign

III. Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS), Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant. Failure to comply with any requirements may result in the rejection of the proposal.

Applicants are advised that the entire RFP, appendices, amendments, memorandum, written responses to questions and answers, and the corresponding proposal shall be a part of the contract with the successful applicant.

IV. RFP Organization

This RFP is organized into five sections:

Section 1, Administrative Overview: Provides applicants with an overview of the procurement process.

Section 2, Service Specifications: Provides applicants with a general description of the tasks to be performed, delineates provider responsibilities, and defines deliverables (as applicable).

Section 3, Proposal Application Instructions: Describes the required format and content for the proposal application.

Section 4, Proposal Evaluation: Describes how proposals will be evaluated by the state purchasing agency.

Section 5, Attachments: Provides applicants with information and forms necessary to complete the application.

V. Contracting Office

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

**Department of Health
Adult Mental Health Division
1250 Punchbowl Street, Room 256
Honolulu, Hawaii 96813
Phone: (808) 586-8287 Fax: (808) 586-4745**

VI. Orientation

An orientation for applicants in reference to the request for proposals will be held as follows:

Date: **Thursday, June 3, 2010** Time: **9:00 a.m. – 10:30 a.m.**

Location: Department of Health
Kinau Hale
1250 Punchbowl Street, Room 205
Honolulu, Hawaii 96813

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers

provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in paragraph VII. Submission of Questions.

VII. Submission of Questions

Applicants may submit questions to the RFP Contact Person identified in Section 2 of this RFP. All written questions will receive a written response from the state purchasing agency.

Deadline for submission of written questions:

Date: **June 7, 2010** **Time:** **2:00 P.M.** **HST**

State agency responses to applicant written questions will be provided by:

Date: **June 14, 2010**

VIII. Submission of Proposals

- A. Forms/Formats** - Forms, with the exception of program specific requirements, may be found on the State Procurement Office website referred to in II. Website Reference. Refer to the Proposal Application Checklist (Attachment A) for the location of program specific forms.
- 1. Proposal Application Identification (Form SPO-H-200).** Provides applicant proposal identification.
 - 2. Proposal Application Checklist.** Provides applicants with information on where to obtain the required forms; information on program specific requirements; which forms are required and the order in which all components should be assembled and submitted to the state purchasing agency.
 - 3. Table of Contents.** A sample table of contents for proposals is located in Section 5, Attachment B. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.

- 4. Proposal Application (Form SPO-H-200A).** Applicant shall submit comprehensive narratives that address all of the proposal requirements contained in Section 3 of this RFP, including a cost proposal/budget if required. (Refer to Section 3 of this RFP.)
- B. Program Specific Requirements.** Program specific requirements are included in Sections 2, Service Specifications and 3, Proposal Application Instructions, as applicable. If required, Federal and/or State certifications are listed on the Proposal Application Checklist located in Section 5.
- C. Multiple or Alternate Proposals.** Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2 of this RFP. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.
- D. Tax Clearance.** Pursuant to HRS Section 103-53, as a prerequisite to entering into contracts of \$25,000 or more, providers shall be required to submit a tax clearance certificate issued by the Hawaii State Department of Taxation (DOTAX) and the Internal Revenue Services (IRS). The certificate shall have an original green certified copy stamp and shall be valid for six (6) months from the most recent approval stamp date on the certificate. Tax clearance applications may be obtained from the Department of Taxation website. (Refer to this section's part II, Website Reference.)
- E. Wages and Labor Law Compliance.** If applicable, by submitting a proposal, the applicant certifies that the applicant is in compliance with HRS Section 103-55, Wages, hours, and working conditions of employees of contractors performing services. Refer to HRS Section 103-55, at the Hawaii State Legislature website. (See part II, Website Reference.)
- **Compliance with all Applicable State Business and Employment Laws.** All providers shall comply with all laws governing entities doing business in the State. Prior to contracting, owners of all forms of business doing business in the state except sole proprietorships, charitable organizations unincorporated associations and foreign insurance companies shall be registered and in good standing with the Department of Commerce and Consumer Affairs (DCCA), Business Registration Division. Foreign insurance companies must register with DCCA, Insurance Division. More information is on the DCCA website. (See paragraph II, Website Reference.)
- F. Hawaii Compliance Express (HCE).** Providers may register with HCE for online proof of DOTAX and IRS tax clearance, Department of Labor

and Industrial Relations (DLIR) labor law compliance, and DCCA good standing compliance. There is a nominal annual fee for the service. The “Certificate of Vendor Compliance” issued online through HCE provides the registered provider’s current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. Refer to this section’s part II. Website Reference for HCE’s website address.

- G. Campaign Contributions by State and County Contractors.** Providers are hereby notified of the applicability of HRS Section 11-205.5, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, FAQs are available at the Campaign Spending Commission webpage. (See paragraph II, Website Reference.)
- H. Confidential Information.** If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the resulting contract and shall be public record. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

Note that price is not considered confidential and will not be withheld.

- I. Confidentiality of Personal Information.** Act 10 relating to personal information was enacted in the 2008 special legislative session. As a result, the Attorney General’s General Conditions of Form AG Form 103F, *Confidentiality of Personal Information*, has been amended to include Section 8 regarding protection of the use and disclosure of personal information administered by the agencies and given to third parties.
- J. Proposal Submittal.** All mail-ins shall be postmarked by the United States Postal System (USPS) and received by the State purchasing agency no later than the submittal deadline indicated on the attached Proposal Mail-In and Delivery Information Sheet. All hand deliveries shall be received by the State purchasing agency by the date and time designated

on the Proposal Mail-In and Delivery Information Sheet. Proposals shall be rejected when:

- Postmarked after the designated date; or
- Postmarked by the designated date but not received within 10 days from the submittal deadline; or
- If hand delivered, received after the designated date and time.

The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall be rejected if received after the submittal deadline. Dated USPS shipping labels are not considered postmarks.

Faxed proposals and/or submission of proposals on diskette/CD or transmission by e-mail, website, or other electronic means is not permitted.

IX. Discussions with Applicants

- A. Prior to Submittal Deadline.** Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.

In order to provide equal treatment to all applicants, questions from applicants shall be submitted in writing and answers to applicants shall be distributed to all known interested parties.

- B. After Proposal Submittal Deadline -** Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance HAR Section 3-143-403.

From the issue date of this RFP until an applicant is selected and the selection is announced, communications with State staff may be conducted pursuant to Chapter 3-143, HAR.

X. Opening of Proposals

Upon receipt of a proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

XI. Additional Materials and Documentation

Upon request from the state purchasing agency, each applicant shall submit any additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

The DIVISION reserves the right to conduct an on-site visit to verify the appropriateness and adequacy of the applicant's proposal before the award of the contract.

XII. RFP Amendments

The State reserves the right to amend this RFP at any time prior to the closing date for the final revised proposals.

XIII. Final Revised Proposals

If requested, final revised proposals shall be submitted in the manner, and by the date and time specified by the state purchasing agency. If a final revised proposal is not submitted, the previous submittal shall be construed as the applicant's best and final offer/proposal. *The applicant shall submit **only** the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200).* After final revised proposals are received, final evaluations will be conducted for an award.

XIV. Cancellation of Request for Proposal

The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

XV. Costs for Proposal Preparation

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

XVI. Provider Participation in Planning

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the state purchasing agency's release of a RFP, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with HAR Sections 3-142-202 and 3-142-203.

XVII. Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

The DIVISION also reserves the right to waive minor variances in proposals providing such action is in the best interest of the State. Where the DIVISION may waive minor variances, such waiver shall in no way modify the RFP requirements or excuse an applicant from full compliance with the RFP specifications and other contract requirements if the applicant is awarded the contract.

A proposal may be automatically rejected for any one or more of the following reasons: (Relevant sections of the Hawaii Administrative Rules for Chapter 103F, HRS, are parenthesized)

- (1) Rejection for failure to cooperate or deal in good faith. (HAR Section 3-141-201)
- (2) Rejection for inadequate accounting system. (HAR Section 3-141-202)
- (3) Late proposals (HAR Section 3-143-603)
- (4) Inadequate response to request for proposals (HAR Section 3-143-609)
- (5) Proposal not responsive (HAR Section 3-143-610(a)(1))
- (6) Applicant not responsible (HAR Section 3-143-610(a)(2))
- (7) Proof of collusion among applicants, in which case all proposals involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified applicant.
- (8) An applicant without a DIVISION approved repayment plan that is in arrears on existing contracts with the State or has defaulted on previous contracts.
- (9) An applicant shows any noncompliance with applicable laws.
- (10) An applicant's lack of financial stability and viability.

- (11) An applicant adds any provisions reserving the right to accept or reject an award, or enters into a contract pursuant to an award, or adds provisions contrary to those in the solicitation.

XVIII. Notice of Award

A statement of findings and decision shall be provided to all applicants by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the awardee prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

Upon receipt and acceptance of the winning proposal, the DIVISION shall initiate the contracting process. The applicant who has been awarded a contract shall be notified in writing that the DIVISION intends to contract with the applicant. This letter shall serve as notification that the applicant should begin to develop its programs, materials, policies and procedures for the contract. The DIVISION will not reimburse applicants for costs incurred related to services not delivered.

The DIVISION reserves the right to review any applicant's provider contracts or agreements prior to the notification of award of the contract. Upon award of the contract, the applicant shall submit a plan for implementation of services and shall provide progress/performance reports every two (2) weeks beginning two (2) weeks after the notification of contract award. The format to be used shall be approved by the DIVISION. The purpose of the reports is to ensure that the applicant will be ready to provide services as of the implementation date of the contract and that all required elements are in place. If the applicant is not able to demonstrate readiness to implement the contract, the award shall be withdrawn by the DIVISION and the next qualified applicant shall replace the applicant.

After the award of the contract, prior to implementation, an on-site readiness review will be conducted by a team from the DIVISION and will examine the applicant's staffing and provider contracts, fiscal operations, and other areas specified prior to review.

XIX. Protests

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website. (See paragraph II, Website Reference.) Only the following matters may be protested:

- (1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;
- (2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and
- (3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement and 2) the procurement officer who is conducting the procurement (as indicated below) within five (5) working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

Head of State Purchasing Agency	Procurement Officer
Name: Chiyome L. Fukino, M.D.	Name: Amy Yamaguchi
Title: Director of Health	Title: Administrative Officer, Adult Mental Health Division
Mailing Address: P.O. Box 3378 Honolulu, Hawaii 96801-3378	Mailing Address: P.O. Box 3378 Honolulu, Hawaii 96801-3378
Business Address: 1250 Punchbowl Street, Honolulu, Hawaii 96813	Business Address: 1250 Punchbowl Street, Honolulu, Hawaii 96813

XIX. Availability of Funds

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to Chapter 37, HRS, and subject to the availability of State and/or Federal funds.

XX. Monitoring and Evaluation

Any deviation from the contract scope and requirements may result in the temporary withholding of payments pending correction of a deficiency or a non-submission of a report by the provider, in the disallowance of all or part of the cost, or in the suspension of contract services pending correction of a deficiency.

The applicant shall comply with all of the requirements of the RFP and contract and the DIVISION shall have no obligation to refer any consumers to the applicant until such time as all of said requirements have been met. The criteria by which the performance of the contract will be monitored and evaluated are:

- (1) Performance/Outcome Measures
- (2) Output Measures
- (3) Quality of Care/Quality of Services
- (4) Financial Management
- (5) Administrative Requirements

XXI. General and Special Conditions of Contract

The general conditions that will be imposed contractually are on the SPO website. (See paragraph II, Website Reference.) Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary. Terms of the special conditions may include, but are not limited to, the requirements as outlined in Section 5, Attachment C.

The DIVISION may also be required to make small or major unanticipated modifications to individual contracts. Reasons for such modifications may include, but are not limited to, recommendations made by the DIVISION's technical assistance consultant, national trends, and needs of the Hawaii State Department of Health.

XXII. Cost Principles

In order to promote uniform purchasing practices among state purchasing agencies procuring health and human services under Chapter 103F, HRS, state purchasing agencies will utilize standard cost principles outlined in Form SPO-H-201, which is available on the SPO website (see paragraph II, Website Reference.) Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

Section 2

Service Specifications

I. Introduction

A. Overview, purpose or need

The Adult Mental Health Division (“DIVISION”) of the Hawaii State Department of Health (“DEPARTMENT”) is responsible for coordinating public and private human services into an integrated and responsive delivery system for mental health needs. Provision of direct services to consumers in the public sector is offered through programs offered by the Community Mental Health Centers (“CENTERS”) and the Hawaii State Hospital (“HOSPITAL”). In addition, the DIVISION contracts on a purchase of service basis with private providers for mental health services to supplement the efforts of the CENTERS and the HOSPITAL.

For purposes related to this RFP, the basic functions or responsibilities of the DIVISION include:

1. Defining the services to be provided to consumers by the applicant;
2. Developing the rules, policies, regulations, and procedures to be followed under the programs administered by the department;
3. Procuring, negotiating, and contracting with selected applicants;
4. Determining initial and continuing eligibility of consumers;
5. Enrolling and disenrolling consumers;
6. Reviewing and ensuring the adequacy of the applicant’s employees and providers;
7. Authorizing and determining necessity of DIVISION funded services;
8. Monitoring the quality of services provided by the applicants and subcontractors;
9. Reviewing and analyzing utilization of services and reports provided by the applicants;
10. Handling unresolved consumer grievances and appeals with the applicants;
11. Monitoring the financial status and billing practices of applicants;
12. Identifying and investigating fraud and abuse;
13. Analyzing the effectiveness of the program in meeting its objectives;
14. Conducting research activities;
15. Providing technical assistance to the applicants;
16. Providing consumer eligibility information to the applicants;
17. Payments to the non-MRO contracted applicants; and
18. Imposing civil or administrative penalties, monetary penalties and/or financial sanctions for violations of specific contract provisions.

Since persons who are severely and persistently mentally ill typically manifest varying levels of need for care and often experience cyclical episodes of recurrence of the illness, a variety of service and housing options must be provided simultaneously to the individual and tailored to meet his/her current

needs. Among these required services are those which must address the needs of persons when they are homeless, when they are experiencing a bout of illness or in relapse, and when services sought reflect the assumption that services provided to persons who are severe and persistent mentally ill, are community-based, are well-coordinated, and produce outcomes that benefit both the consumer and society.

B. Planning activities conducted in preparation for this RFP

The DIVISION published a Request for Information on August 31, 2009 in the design of Bilingual Support Services seeking the public's input on the availability of potential service providers, staffing capabilities for services and culturally specific service capabilities.

C. Description of the goals of the service

The goals for the services described in this RFP include, but are not limited to, the following:

1. Provide culturally sensitive, clinically informed, education, translation, consultation and community outreach for consumers.
2. Increase each consumer's duration and quality of community tenure.
3. Develop and maintain situations for consumer's ability to live, work, and socialize in the community.
4. Enhance each consumer's potential for growth and independence in their communities and social settings.
5. Reduce the number of days of psychiatric hospitalization.
6. Increase social connections of consumers.
7. Improve interpersonal and intrapersonal functioning of consumers.
8. Enhance the natural social support network.
9. Increase independence in living arrangements.

D. Description of the target population to be served

Adults, eighteen (18) years and older, who meet the DIVISION's eligibility and utilization management criteria.

E. Geographic coverage of service

Bilingual Support Services: Community Consultations, Education and Outreach on the island of Oahu

F. Probable funding amounts, source, and period of availability

Approximately \$300,000 has been allocated for this service. The source of funding is state funds or a combination of state and federal funds. Both profit and

non-profit organizations are eligible for state funds. Please note that based on the availability of funds, the amount allocated to providers who are awarded contracts may change.

The DIVISION considers itself the payor of last resort, and expects providers to obtain third party reimbursement as applicable. The DIVISION gives priority to the uninsured.

If an applicant materially fails to comply with terms and conditions of the contract, the DIVISION may, as appropriate under the circumstances:

1. Temporarily withhold payments pending correction of a deficiency or a non-submission of a report by a provider.
2. Disallow all or part of the cost.
3. Restrict, suspend or terminate the contract.

In the event that the additional funds become available for similar services, the DEPARTMENT reserves the right to increase funding amounts.

Competition is encouraged among as many applicants as possible.

II. **General Requirements**

A. **Specific qualifications or requirements, including but not limited to licensure or accreditation.**

1. The applicant shall have current, valid licenses and certificates, as applicable, in accordance with federal, state and county regulations, and comply with all applicable Hawaii Administrative Rules and provide copies to the DIVISION, as requested.
2. The DIVISION will require accreditation by CARF, Commission on Accreditation of Rehabilitation Facilities; Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”); International Center for Clubhouse Development (“ICCD”); Council on Accreditation (“COA”); or by another DIVISION approved certification/licensing process. Applicants that are currently accredited are required to maintain accreditation throughout the contract period. Applicants who are not accredited for this service at the time of contract award are required to achieve accreditation within two (2) years from the date of contract award. Any change in accreditation/certification/licensing must be reported to DIVISION immediately.

3. Applicants shall have an administrative structure in place capable of supporting the activities required by the RFP. Specifically, there shall be clinical, financial, accounting and management information systems, and an organizational structure to support the activities of the applicant.
4. The applicant shall have a written plan for disaster preparedness.
5. The applicant shall cooperate with the DIVISION in approved research, training, and service projects provided that such projects do not substantially interfere with the applicant's service requirements as outlined in this RFP.
6. The applicant shall comply with all specified, applicable existing policies, procedures, directives, and provider manual of the DIVISION and, any applicable policies, procedures, directives, and provider manual developed in the future.
7. Whenever requested, the applicant shall submit a copy of its operating policies and procedures to the DIVISION. The copy shall be provided at the applicant's expense with revisions and updates as appropriate.
8. The applicant shall assign staff to attend provider meetings as scheduled by the DIVISION.
9. The applicant shall notify and obtain the approval of the DIVISION prior to the presentation of any report or statistical or analytical material based on information obtained through this contract. Formal presentation shall include, but not be limited to, papers, articles, professional publications, and presentations.

The applicant shall not advertise, distribute, or provide to any consumer, any material relating to the contract that has not been approved by the DIVISION. The applicant shall not change the material without the consent of the DIVISION. All consumer satisfaction surveys and methodology must be reviewed and approved by the DIVISION prior to implementation.

10. Consumer Management Requirements:

- a. Incorporate "best practices/evidence-based practices" in any consumer service.

"Best practices/evidence-based practices" are defined as a body of contemporaneous empirical research findings that produce the most efficacious outcomes for person with severe and persistent mental illness, have literature to support the practices, are

supported by national consensus, and have a system for implementing and maintaining program integrity and conformance to professional standards. The DIVISION has developed fidelity scales based on best practices/evidence-based practices for some services. Applicants will be required to incorporate these into their service delivery and cooperate with educational and monitoring activities.

- b. Documented evidence of consumer input into all aspects of recovery planning inclusive of service related decisions.
- c. Consumers shall be served in the “least restrictive” environment as determined by the consumer’s level of care assessment, as established in section 334-104, Hawaii Revised Statutes and in any appropriate federal guidelines, and in accordance with any specific court orders that direct a specific treatment or service placement for an individual consumer.
- d. Consumers shall be made aware of and have access to community resources appropriate to their level of care and treatment needs.
- e. Consumers shall, to the extent it is practicable and clinically appropriate, receive services in a manner compatible with their cultural health beliefs, practices and preferred language.
- f. Any suspected case of physical, emotional or financial abuse or neglect of a consumer who is a vulnerable adult shall be reported by the applicant to Adult Protective Services, or of a child to Child Protective Services, and to the DIVISION immediately upon discovery.
- g. In accordance with Chapter 11-175, Hawaii Administrative Rules, and any appropriate federal guidelines, the applicant shall respect and uphold consumer rights. The applicant shall recognize the rights of authority of the consumer in the delivery of services, in deciding on appropriate treatment and services and in providing input into the decisions of all aspects of service.
- h. The applicant shall provide a written record of sentinel events to the DIVISION’s Quality Management program in a manner consistent with the DIVISION policy on Sentinel Events.
- i. The applicant shall comply with any applicable Federal and State laws such as title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80, the Age Discrimination Act 1975 as implemented by regulations at 45

C.F.R. part 91, the Rehabilitation Act of 1973, and titles II and III of the Americans with Disabilities Act (“ADA”).

- j. The applicant shall describe how they protect confidential information. The applicant shall not use or disclose protected health information (“PHI”) in any manner that is not in full compliance with HIPAA regulations or with the laws of the State of Hawaii. The applicant shall maintain safeguards, as necessary, to ensure that PHI is not used or disclosed except as provided by the contract or by law. The applicant shall not use or further disclose PHI for any purpose other than the specific purposes stated in DIVISION contracts or as provided by law and shall immediately report to DIVISION any use or disclosure of PHI that is not provided in this contract or by law.
- k. The applicant shall maintain confidential records on each consumer pursuant to section 334-5, Hawaii Revised Statutes, 42 U.S.C. sections 290dd-3 and 290ee-3 and the implementing federal regulations, 42 C.F.R. Part 2, if applicable, and any other applicable confidentiality statute or rule. Such records shall be made available to the DIVISION upon request.
- l. Written consumer consent shall be obtained for individuals and services funded by the DIVISION including:
 - 1) Consent for evaluation and treatment;
 - 2) Consent to release information by DIVISION funded service providers as needed for continuity of care, including after care services;
 - 3) Consent to enter registration and treatment information in the confidential Statewide DIVISION information system; and
 - 4) Other consent documents as needed.

Consumer consent is not required for oversight activities of the DIVISION and its agents and in the case of Medicaid Rehabilitation Option Services (“MRO”), the Centers for Medicare and Medicaid Services (“CMS”) Office of the Inspector General (“OIG”), the Med-QUEST Division (“MQD”) and their agents.

- 11. Prior written approval must be obtained from the DIVISION if a subcontractor is used. The applicant shall ensure the DIVISION that they, as the applicant, have the ultimate responsibility that subcontractor(s) will

provide behavioral health services that meet the criteria of this RFP. Subcontractors must be responsive and responsible to meet the expectations of the applicant and the DIVISION.

12. Financial Requirements

- a. The State may require providers to submit an audit as necessary. If the applicant expends \$500,000 or more in a year of federal funds from any source, it shall have a single audit conducted for that year in accordance with the Single Audit Act and Amendments of 1999, Public Law 104-156.
- b. The applicant shall comply with the cost principles developed for Chapter 103F, HRS and set forth in the document SOP-H-201. This form (SPO-H-201) is available on the SPO website (see page 1-2, Website Reference).
- c. Eligibility and enrollment is determined by DIVISION assessors utilizing the DIVISION's established eligibility determination criteria and process.
- d. Notification of Changes in Consumer Status.

As part of education conducted by the DIVISION, consumers shall be notified that they are to provide the provider, through their case manager, with any information affecting their status. The case manager and/or consumers should report changes to their case manager and/or provider. The provider shall complete the DIVISION Utilization Management ("UM") Admission/Discharge/Update form and send it to UM. The DIVISION shall describe the information that is to be provided and explain the procedures to be followed through the DIVISION staff and in its printed material. The applicant shall also explain the information and the procedures to be followed by the consumers during the orientation process.

It is expected that not all consumers will remember to or be able to provide information on changes to their status. Therefore, it is important for the provider to obtain and forward such information to the DIVISION on a timely basis and inform the consumer of his/her responsibility to report changes to their case manager.

The provider shall notify each case manager and the DIVISION of changes in consumer status by calling or faxing the information to the DIVISION, UM unit within five (5) calendar days of discovery.

- e. Changes in Consumer Status include:
- 1) Death of the consumer
 - 2) Change in address, including homelessness
 - 3) Change in name
 - 4) Change in phone number
 - 5) Institutionalization (imprisonment or long term care)
 - 6) Short term inpatient psychiatric treatment
 - 7) Loss of Permanent Residency Status for non-U.S. citizens receiving services
 - 8) Third Party Liability (“TPL”) coverage, especially employer-sponsored, Medicare or Medicaid

f. Disenrollment from DIVISION

Consumers will be disenrolled if they no longer meet DIVISION eligibility criteria.

- g. TPL means any individual, entity or Program that is or may be liable for all or part of the expenditures for furnished services. The DEPARTMENT must take all reasonable measures to identify legally liable third parties and treat verified TPLs as a resource of the consumer.

The applicant shall establish systems for determining and continuous monitoring of clinical eligibility for this service, billing, and collecting from all eligible sources to maximize third party reimbursements and other sources of funding before using funds awarded by the DIVISION. The applicant shall bill the DIVISION only after exhausting the third party denial process, or when the consumer is uninsured. The applicant shall maintain documentation of denials and of limits of benefit coverage and make these records available to the DIVISION upon request. The DIVISION is the payor of last resort and the applicant shall consider payment from third party sources as payment in full. An annual review and reconciliation of amounts collected from third party payors by the applicant will be conducted and, if needed, adjustments will be made within ninety (90) days either crediting

the DIVISION or providing payment to the applicant upon the receipt of a claim.

The Applicant shall:

- 1) Provide a list of service expenses, in the format requested by the DIVISION, for recovery purposes.
- 2) Recover service expenses incurred by consumers from all other TPL resources.
- 3) Inform the DIVISION of TPL information uncovered during the course of normal business operations.
- 4) The applicant shall describe all eligible sources of revenue from third parties and plans to pursue additional sources of revenues.

h. Fraud and Abuse/Neglect

Through its compliance program, the applicant shall identify employees or providers who may be committing fraud and/or abuse. The applicant activities may include, but are not limited to, monitoring the billings of its employees and providers to ensure consumers receive services for which the applicant and the State are billed; monitoring the time cards of employees that provide services to consumers under cost payment arrangements; investigating all reports of suspected fraud and over-billings (upcoding, unbundling, billing for services furnished by others, billing for services not performed, and other over-billing practices), reviewing for over- or under-utilization, verifying with consumers the delivery of services and claims, and reviewing and trending consumer complaints regarding employees, subcontractors and providers.

The applicant shall promptly report in writing to the DIVISION instances in which suspected fraud has occurred within thirty (30) days of discovery. The applicant shall provide any evidence it has on the billing practices (unusual billing patterns, services not rendered as billed and same services billed differently and/or separately). If the billing has not been done appropriately and the applicant does not believe the inappropriate billing meets the definition of fraud (i.e., no intention to defraud), the applicant shall notify the DIVISION in writing of its findings, adjustments made to billings, and education and training provided to prevent future occurrences.

Any suspected case of physical, emotional or financial abuse or neglect of a consumer who is a dependent adult must be reported by the applicant to Adult Protective Services, or of a child to Child Protective Services, and to the DIVISION immediately upon discovery.

- i. All reimbursements for services shall be subject to review by the DIVISION or its agent(s) for medical necessity and appropriateness, respectively. The DIVISION or its agents shall be provided access to medical records and documentation relevant to such a review and the applicant agrees to provide access to all requested medical records/documents. It is the responsibility of the applicant to ensure that its subcontractors and providers also provide DIVISION and its agents access to requested medical records/documents. Reimbursements for services deemed not medically necessary or not following billing guidelines by the DIVISION or its agent shall be denied. Reimbursements received by applicants for consumers with third party coverage (including consumers with Medicaid and/or Medicare) will be considered full payment (see Section 2.II.11.g.). Any DIVISION overpayments for services shall be recouped by the DIVISION from the applicant.

The DIVISION has final determination in what is considered a necessary, reimbursable service.

- j. Medicaid

The MQD under the Department of Human Services (“DHS”) administers medical assistance to qualified, indigent, uninsured and underinsured. Aged, blind, and disabled recipients receive medical, dental, and behavioral health services under Quest Expanded Access from contracted providers. A large group of Medicaid eligible recipients receive medical and behavioral health services from contracted Medicaid Managed Care Health Plans under the QUEST and QUEST-Net programs. A small population of Medicaid Quest Expanded Access, QUEST, and QUEST-Net recipients are enrolled in a behavioral health carve-out program for severely mentally ill adults. This behavioral health carve-out program is contracted by MQD. Some of the services provided to the individuals in the carve-out program are similar or identical to services provided by the DIVISION and consumers enrolled in this program shall receive services through them.

- k. The applicant shall submit claims electronically in the HIPAA compliant 837 format unless a waiver permitting use of the CMS

1500 is granted from the DIVISION. Claims shall be submitted for payment within sixty (60) calendar days of the date of service. Claims for payment received after sixty (60) calendar days of the date of service shall be denied for untimeliness.

For claims that have been denied by the DIVISION, the applicant shall have thirty (30) days from the date of denial, to resubmit a claim for payment. Claims resubmitted after thirty (30) days of the date of denial shall be denied for untimeliness. Where a Consumer's primary insurance carrier has been billed, the filing deadline will be extended an additional thirty (30) calendar days, for a total of ninety (90) calendar days from the date of service.

- l. If the applicant is required to provide encounter data, the HIPAA compliant 837 format shall be utilized to submit that data electronically.
 - m. When submitting Claims and/or Encounter Data to the DIVISION, the applicant shall: (a) use the most current coding methodologies on all forms; (b) abide by all applicable coding rules and associated guidelines, including without limitation, inclusive code sets; and (c) agree that regardless of any provision or term in this Contract, in the event a code is formally retired or replaced, discontinue use of such code and begin use of the new or replacement code following the effective date published by the appropriate coding entity or government agency. Should an applicant submit claims using retired or replaced codes, the applicant understands and agrees that the DIVISION may deny such claims until appropriately coded and resubmitted.
13. Insurance Policies. In addition to the provisions of the General Conditions No. 1.4, the applicant, at its sole cost and expense, shall procure and maintain policies of professional liability insurance and other insurance necessary to insure the applicant and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of this contract. Subcontractors and contractors shall also be bound by this requirement and it is the responsibility of the applicant to ensure compliance with this requirement.

The applicant shall name the State of Hawaii as an additional insured on all such policies, except on professional liability insurance coverage. The applicant shall provide certificates of insurance to the DIVISION for all policies required under this contract.

Policy limits are listed as follows:

General Liability. Policies shall not be less than ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per occurrence and not less than THREE MILLION AND NO/100 DOLLARS (\$3,000,000.00) in the aggregate annually.

Professional Liability. Policies shall not be less than ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per occurrence and not less than TWO MILLION AND NO/100 DOLLARS (\$2,000,000.00) in the aggregate annually.

Automobile Insurance. Policies shall not be less than ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per accident.

General liability and automobile insurance policies shall be made by occurrence and not on a claims made basis.

B. Secondary purchaser participation
(Refer to HAR Section 3-143-608)

After-the-fact secondary purchases will be allowed.
There are no planned secondary purchases.

C. Multiple or alternate proposals
(Refer to HAR Section 3-143-605)

Allowed Unallowed

D. Single or multiple contracts to be awarded
(Refer to HAR Section 3-143-206)

Single Multiple Single & Multiple

Criteria for multiple awards:

The state needs the flexibility to award funding to more than one (1) applicant. In the event that more than one (1) applicant's proposal for a service meets the minimum requirements in Section III, Scope of Work, the proposal will be reviewed in accordance with the following additional criteria in determining the funding allocations:

1. Interest of the State to have a variety of providers in order to provide choices for consumers.
2. Interest of the State to have geographic accessibility.

3. Readiness to initiate or resume services.
4. Ability to maximize QUEST funding, if possible.
5. Proposed budget in relation to the proposed total number of service recipients.
6. If funded in the past by the DIVISION, ability of applicant to fully utilize funding.
7. Previous DIVISION contract compliance status (e.g. timely submittal of reports and corrective action plans).
8. Accreditation status.
9. Applicant's past fiscal performance based on the DIVISION's fiscal monitoring.
10. Applicant's past program performance, based on the DIVISION's program monitoring.

E. Multi-term contracts to be awarded

(Refer to HAR Section 3-149-302)

Single term (≤ 2 yrs)

Multi-term (> 2 yrs.)

Initial term of contract:	<u>1 year</u>
Length of each extension:	<u>1 year</u>
Number of possible extensions:	<u>4</u>
Maximum length of contract:	<u>5 years</u>
The initial period shall commence on the contract start date or Notice to Proceed, whichever is later.	
Conditions for extension: Contract extensions shall be requested in writing, and must be executed prior to contract expiration.	

F. RFP Contact Person

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the successful provider or providers. Written questions should be submitted to the RFP contact persons and received by the day and time specified in Section I (Procurement Timetable) of this RFP. The contact person is Ms. Betty Uyema. She can be reached at (808) 586-8287.

III. Scope of Work

The scope of work encompasses the following tasks and responsibilities:

A. Service Activities

(Minimum and/or mandatory tasks and responsibilities)

1. Have a policy that emphasizes a welcoming, empathic, and integrated approach to working with individuals with co-occurring substance and mental illness.
2. Provide support services in accordance with the Utilization Criteria as defined in Section 5, Attachment D.
3. Ensure that Consumers who are within one (1) month of discharge from the HOSPITAL are given first priority for bilingual support services. Priority shall also be given to DIVISION Consumers who may be at high risk for psychiatric hospitalization if they do not receive bilingual support services. Assigned bilingual support services staff shall participate in hospital discharge planning for Consumers and provide necessary documentation. The PROVIDER shall comply with the DIVISION's policy and procedure for Continuity of Care ("Transitions"), provided in Section 5, Attachment E.
4. Ensure that each Consumer meets the criteria for bilingual support services as defined by the most current DIVISION Utilization Management criteria.
5. Work directly with CENTERS on Oahu, by providing bilingual support services in accordance with the CENTERS' office hours and the CENTERS' operational policy & procedures. The applicant shall operate in accordance with standards set forth by each CENTER including, but not limited to, protocol for the management of PHI and use of office space.
6. Provide and complete an assessment for each Consumer referred for bilingual support services. The assessment shall be completed primarily through face-to-face contacts with each Consumer and any significant others the Consumer has authorized to participate in the Consumer's assessment and treatment planning. The assessment shall be comprehensive and shall include, but not be limited to, each Consumer's strengths, preferences, abilities, needs, and other current and historical data regarding the Consumer's family; social support; medical status including psychiatric illness; substance abuse, assessment of risk, legal, employment, education, abuse and neglect issues; and activities of daily living.

7. Develop and implement an individual recovery plan (“IRP”) in collaboration with each Consumer. The IRP shall include, but not be limited to, individual Consumer’s strengths, needs, long and short term goals, measureable objectives, timeframes for completion, an indication of the kinds of services and support the Consumer is receiving, frequency and scheduling of special care relating to the Consumer with multiple disabilities, how continuity of care shall be maintained, and the signature of both the Consumer and the staff responsible for the initial and ongoing development and implementation of the IRP. The IRP shall be developed and implemented within thirty (30) days of each Consumer’s admission to the bilingual support services program and shall be reviewed at a minimum of every six (6) months by all treatment team members with each Consumer and shall be revised as significant events occur. The IRP is a product of a comprehensive assessment, the Consumer and provider collaboration and an agreement on what steps will be taken to facilitate and optimize recovery, self-sufficiency and sustainability.
8. Provide services that are designed to foster and support each Consumer’s personal and independent functioning in the community which may include, but is not limited to community linkage to necessary resources, skill-building, psycho-education, support counseling, and social skills training. Services shall be clearly tied to each Consumer’s IRP goals.
9. Advocate on behalf of each Consumer and coordinate services with members of each Consumer’s treatment team inclusive of each Consumer’s family and other persons responsible for treatment (e.g. courts, probation office, homeless programs, crisis services, etc). These services shall be ongoing activities and may be accomplished either face-to-face or through other appropriate means that are compliant with management of PHI. Collaborating with partners requires that the provider has attended to all the State and Federal requirements for maintaining the confidentiality and privacy of each Consumer’s PHI.
10. Provide Consumers with assistance and training on how to access transportation services when indicated.
11. Schedule services in accordance with the clinical needs and preferences of each Consumer which may include offering services during evenings, weekends and holidays.
12. Identify and provide outreach and engagement services for Consumers who may be eligible for DIVISION mental health services. This may be in the form of community presentations to underserved groups and partnerships with other agencies who serve the immigrant community.

13. Assign a minimum of five (5) full-time equivalent (“FTE”) bilingual support staff to work with the CENTERS on Oahu. The bilingual support staff shall provide direct services for a minimum of seventy five percent (75%) of their FTE and twenty-five percent (25%) for administrative activity. Direct services shall include activities such as face-to-face contact, collateral contacts, treatment planning, service linkage, and resource acquisition. Administrative services include activities such as documentation, staff training, supervision, and chart reviews.
14. One (1) FTE bilingual support staff shall have a minimum caseload of fifteen (15) Consumers and a maximum of thirty (30) Consumers.
15. Provide services in a manner consistent with the Comprehensive, Continuous, Integrated System of Care Model by Kenneth Minkoff M.D., provided in Section 5, Attachment F; AMHD Practice Guidelines, provided in Section 5, Attachment G; and AMHD Mission, Vision, Values and Guiding Principles, provided in Section 5, Attachment H.
16. Assign a staff to attend provider meetings as scheduled by the DIVISION.
17. Propose a DIVISION approved education/outreach plan that shall identify opportunities to provide education/outreach for engaging potential Consumers in the target populations to be served. An outreach activity shall be provided at least quarterly in accordance with the plan.
18. Ensure statewide availability for distance consultation including, but not limited to, telephonic and video conferencing, to DIVISION providers on all islands.
19. Ensure statewide availability for a limited amount of interpretation and translation services including, but not limited to, telephonic and videoconferencing to DIVISION providers on all islands.

B. Management Requirements
(Minimum and/or mandatory requirements)

1. Personnel

The applicant’s personnel requirements for staff providing Bilingual Support Services shall include, but are not limited to, the following:

- a. The applicant shall provide support services program under the clinical supervision of a Qualified Mental Health Professional (“QMHP”). The QMHP is defined in Section 5, Attachment I.
- b. Responsibilities of the QMHP shall include, but are not limited to:

- 1) Provide clinical supervision to bilingual support staff or designated staff supervisors;
 - 2) Provide therapy to Consumers, as needed;
 - 3) Ensure that staff is providing services within their scope of practice;
 - 4) Ensure that staff has adequate skills, knowledge and training for the clinical composition of their caseloads;
 - 5) Ensure that staff has access to routine clinical consultation and supervision on an “urgent” or “as needed” clinical consultation basis; and
 - 6) Overseeing program development and clinical management of the program.
- c. Bilingual support services shall be provided by staff who are fluent in English and in another language identified by the proposal.
- d. Bilingual support services shall be provided by staff that meet one (1) of the following definitions:
- 1) Mental Health Worker, the definition and role is provided in Section 5, Attachment J; or
 - 2) Bilingual Assistant, the definition and role is provided in Section 5, Attachment K. A Bilingual Assistant is to be supervised by a QMHP or a Mental Health Professional (“MHP”), the definition and role is provided in Section 5, Attachment L.
- e. All bilingual support staff providing direct care shall have a current and valid driver’s license issued in the State of Hawaii.
- f. Ensure that bilingual support staff receive appropriate supervision including clinical supervision and administrative direction. In addition to the minimum standards stated in the attached definitions, bilingual support staff who have less than five (5) years of experience shall have a minimum of one (1) hour of regularly scheduled clinical supervision for every thirty (30) hours of face-to-face consumer contact.
- Bilingual support staff with more than five (5) years of experience shall follow accreditation, certification and professional standards and shall have a minimum of one (1) hour of supervision for every one hundred-twenty (120) hours of face-to-face consumer contact.
- g. Provide continued education and training, at least quarterly, to bilingual support staff to maintain and upgrade their service skills. The applicant’s education and training shall be based on a strategic

training plan to upgrade the educational and professional qualifications of its bilingual support staff. The strategic training plan shall be developed in conjunction with the DIVISION's designated service director. At a minimum, the training shall include substance abuse; trauma informed care; sentinel events; risk management; compliance; HIPAA compliance; consumer rights; recovery planning; access and treatment for non-English speaking consumers; forensics; ethics; risk assessment, reduction and management; health; safety; and access.

- h. Ensure that bilingual support staff receives appropriate knowledge of techniques and modalities relevant to their service activities.
- i. The applicant shall submit position descriptions for direct care and supervisory staff responsible for the delivery of services as indicated in Section 3.III.A. Position descriptions shall include the minimum qualifications, including experience for staff assigned to the service.
- j. The applicant shall submit an organization-wide and program-specific organization chart for direct care and supervisory staff. The program-specific chart shall show the position of each staff and the line of responsibility including clinical and administrative supervision.
- k. The applicant shall ensure and document that its personnel receive appropriate education and training in techniques and modalities relevant to their service activity for the treatment and rehabilitation of individuals with mental illness, following the organization's policy and procedures.
- l. Continued education and training to bilingual support staff at least semi-annually to maintain and upgrade their skills. The content of the education and training shall be based on a strategic training plan to upgrade the educational and professional qualifications of its staff and shall be developed in conjunction with the DIVISION.
- m. Provide a minimum of one (1) training session each contract period to address the areas of substance abuse and dual diagnosis.
- n. The applicant shall ensure that all of its personnel attend trainings sponsored or required by the DIVISION, as appropriate to the service(s) they are providing. Training shall include compliance with DIVISION requirements for fraud and abuse prevention.

2. Administrative

- a. Services shall be authorized by the DIVISION's utilization management process, by prior authorization or registration, and in accordance with the DIVISION's processes as outlined in current DIVISION policies and procedures and directives from the DIVISION Chief. It is the responsibility of each program to understand and follow these policies, procedures, and directives in order that reimbursement can be approved by the DIVISION. Authorization of services is not a guarantee of payment.
- b. The applicant shall accept all referrals deemed appropriate by the DIVISION's utilization management process. If the applicant is unable to meet the needs of the referral, the applicant shall work conjointly to find an alternate approach that will adequately meet the needs of the referred case.
- c. There will be a single point of accountability for each Consumer entering the system that will be responsible for the continuity of communication, care, and follow up regardless of service, setting, or provider. In most cases, the single point of accountability will be the DIVISION designated case manager.
- d. All consumers shall be registered for services and have a record open within the DIVISION'S information system. When requested by the DIVISION, the applicant shall obtain and provide the information necessary to register, open and monitor services received. Applicants shall also report all required information when cases are closed or Consumers transferred to another level of care within one (1) working day of such action. All recipients shall be registered with the DIVISION and authorized for services as appropriate.
- e. The applicant shall cooperate with the coordination and the transition of services for newly enrolled Consumers with the Consumer's current DIVISION provider, Medicaid fee-for-service provider, Community Care Services ("CCS"), and/or a QUEST health plan, since many of the eligible Consumers already have an established behavioral health care provider.

Individuals who are receiving services from the Child and Adolescent Mental Health Division ("CAMHD"), and will no longer be eligible for services (age 21) with CAMHD, will also need to be transitioned to the DIVISION, if determined to meet DIVISION eligibility criteria, or back to their QUEST health plan

or Medicaid fee-for-service if they are determined to no longer meet DIVISION criteria for continued enrollment.

If the consumer is to be enrolled in the DIVISION from a QUEST health plan, CAMHD, Fee-for-Service Program, or CCS, the disenrolling program and the applicant shall equally assist the consumer in the transition process.

- f. All applicants shall submit a rate schedule which outlines charges made to individuals for service(s) rendered.
- g. Consumers shall not be charged finance charges, co-payments for services, or no-show fees. Consumers shall be informed that they cannot be terminated by the applicant for non-payment of co-payments, finance charges, no-show fees, and non-covered services; or for receipt of services from unauthorized applicant employees or providers.
- h. The applicant shall acknowledge on all printed materials, including program brochures and other publicly distributed matter, and at public presentations, that program funding has been received from the Adult Mental Health Division, Department of Health, State of Hawaii.

3. **Quality assurance and evaluation specifications**

- a. The purpose of quality management is to monitor, evaluate, and improve the results of the applicant's services in an ongoing manner. Quality care includes, but is not limited to:
 - 1) Provision of services in a timely manner with reasonable waiting times;
 - 2) Provision of services in a manner which is sensitive to the cultural differences of consumers;
 - 3) Provision of services in a manner which is accessible for consumers;
 - 4) Opportunities for consumers to participate in decisions regarding their care;
 - 5) An emphasis on recovery;
 - 6) Appropriate use of services in the provision of care;

- 7) Appropriate use of best practices and evidence-based practices;
 - 8) Appropriate documentation, in accordance with defined standards;
 - 9) Improved clinical outcomes and enhanced quality of life;
 - 10) Consumer satisfaction;
 - 11) User friendly grievance procedures which resolve issues in a timely manner; and
 - 12) Upholds consumer rights.
- b. The applicant's quality management program shall include, at a minimum, the content indicated in Section 3, II.C and shall specifically address the quality management needs of the services noted within.
- c. The applicant shall participate in the DIVISION's continuing quality management program and activities as directed by the DIVISION. The applicant shall ensure that a staff member be available to participate in system-wide quality management meetings as scheduled by the DIVISION.
- d. The Quality Management reporting requirements provide:
- 1) Information on the activities and actions of the applicant's Quality Management and related programs; and
 - 2) Performance measures.

The objectives of the performance measures are:

- 1) To standardize how the applicant specifies, calculates, and reports information; and
 - 2) To trend an applicant's performance over time and to identify areas with opportunities for improvement.
- e. Required Quality Management Activities Reports

The applicant shall provide the following reports and information:

- 1) Annual consumer satisfaction survey report;

- 2) Written notification of any quality management program (if written program required) modifications;
- 3) Senior personnel and direct care staff changes, including professional staff/consultants, within thirty (30) calendar days of change;
- 4) Annual quality management program evaluation if written quality management program required;
- 5) Written request for approval of any delegation of quality management activities to subcontractors and providers;
- 6) Written notification of lawsuits, license suspensions, and revocation to provide Medicaid or Medicare services, or other actions brought against the applicant, employees, subcontractors or providers as soon as possible, but no later than five (5) working days after the applicant is made aware of the event;
- 7) Notice to UM of consumer admission and discharge from services or change in level of care in writing within one (1) working day of such action;
- 8) Written notification of suspected fraud within thirty (30) calendar days of discovery, and of consumer abuse and neglect immediately upon discovery; and
- 9) Report of the quality management activities conducted quarterly. The content of the quarterly reports will be prescribed by the DIVISION and may be amended at any time with prior notification to the provider. At a minimum, these reports shall include the following:
 - a) Number of cases selected for quality of care reviews and medical record documentation. Minimum data for each case selected for review shall include: (1) sample of records reviewed; (2) findings; (3) actions taken, if applicable; and (4) progress toward meeting performance goals established by the applicant's quality management committee.
 - b) Aggregated report of any suspected consumer, employee, subcontractor, or provider fraud and the status of any investigations.

- c) Number of consumers served per level of service, per month, by county.
- d) A report on consumer grievances and appeals. Minimum data for each case shall include: (1) date of grievance or appeal; (2) date of service; (3) type of service; (4) consumer name, age, and diagnosis; and (5) date of resolution.
- e) Sentinel events.

4. **Output and performance/outcome measurements.**

The applicant shall be required to meet ongoing informational needs of the DIVISION over the course of the contract period through the production of informational responses in both paper and computer format.

The specific content of these requests cannot be readily specified in advance as the DIVISION is required to provide a variety of ad hoc reports to funding sources including the Legislature and other branches of State government, as well as to national tracking and research groups, the Federal government, advocacy organizations, accreditation bodies, professional groups, stakeholder groups, and others. Regular requests for information to the applicant shall occur in the following areas including, but not limited to, consumer demographics, consumer needs, clinical and service information including encounter data, staffing and capacity patterns, risk management areas, consumer outcomes, regulatory compliance, organizational processes, resource utilization, and billing and third party insurance data. Clinical and service information including encounter data such as dates and duration of encounters; modality of encounter, e.g. in-person, telephonic etc.; target of encounter such as family member, collateral agency, consumer etc. and type of service provided. The DIVISION will work with the applicant over the contract period to streamline requests for information when those requests are regular and ongoing. Services activities should constitute 75% of direct care staff time. These activities include, but are not limited to:

- a. Direct service to consumer, family intervention, collateral contacts, linkages, advocacy, and treatment planning.
- b. Case consultation to neighbor island providers and Purchase of Service providers.
- c. Outreach and education.
- d. Non-service related activities include:

- 1) Charting, paperwork
- 2) Training attendance
- 3) Quality Improvement activities
- 4) Supervision
- 5) Staff meetings

Staff activity logs should be kept for all direct care staff as well as aggregate reports for quarterly reports to AMHD regarding the above.

5. Experience

Direct care staff shall meet the minimum qualifications as prescribed in this RFP. Applicants with verifiable expertise and experience in serving this target population will be given preference in the evaluation process. Applicants are strongly encouraged to identify all previous experience providing similar services and/or the target population. Details of the applicant's performance in providing these services, past contracts, performance outcomes, and references should be included in their proposal.

6. Coordination of Services

Providers are required to document coordination of services with other involved agencies or partners including each consumer's case managers/ DIVISION personnel and contracted service providers, primary care physicians, justice personnel and agencies, MedQuest, community service providers and organizations. Refer to the Service Activities, Section 2, III.A for coordination of care and activities.

7. Reporting requirements for program and fiscal data

- a. Reports shall be submitted in the format and by the due dates prescribed by the DIVISION.
- b. The required content and format of all reports shall be subject to ongoing review and modification by the DIVISION as needed.
- c. At the discretion of the DIVISION, providers may be required to submit reports in an approved electronic format, replacing some written reports.

8. Contract Compliance

The State performs periodic reviews, including validation studies, in order to ensure contract compliance. The State is authorized to impose financial penalties if the data is not provided timely and accurately.

The DIVISION reserves the right to request additional data, information and reports from the applicant, as needed, to comply with external requirements and for its own management purposes.

a. **Timeliness of Data Submitted**

All information, data, medical records, and reports shall be provided to the DIVISION by the specified written deadlines. The applicant shall be assessed a penalty of \$200.00 per day until the required information, data, medical records, and reports are received by the DIVISION. If the applicant will not be able to comply with the request, the applicant may ask for an extension in writing with an explanation to justify the extension. The DIVISION reserves the right to determine if an extension is acceptable and set a new date for submission.

The applicant, shall in turn, sanction providers if the required information, data, medical records, and reports are not provided to the applicant within the timeframe established by the applicant.

b. **Accuracy and Completeness**

The information, data, medical records, and reports provided to the DIVISION shall be reasonably accurate and complete. Data and reports shall be mathematically correct and present accurate information. The applicant shall be notified within thirty (30) calendar days from the receipt date of the initial submission of any information, data, medical records, and reports that do not appear to be accurate and complete. The applicant shall be given thirty (30) calendar days to correct the errors or provide documentation to support the accuracy of the initial submission. If at the end of the thirty (30) calendar days the new submission continues to inaccurate or incomplete, a penalty will be assessed.

C. Facilities

Bilingual support service shall adhere to the following facility quality standards:

1. The facility shall be structurally sound so as not to pose any threat to the health and safety of the Consumers and to adequately protect Consumers from the elements.
2. The facility shall be free of pollutants that threaten the health and safety of the Consumers. Smoking areas must be clearly identified and must conform to state law for distances away from building entrances.

3. The facility shall include, at a minimum, one (1) battery-operated or hard-wired smoke detector on each level of the facility. Smoke detectors shall be maintained in proper working condition at all times.
4. The facility shall adhere to all health, fire and safety regulations in accordance with State, City, or County regulations governing licensed and residential settings. Program staff will maintain vigilant supervision of the residents and facility in order to ensure adherence to these standards.

IV. COMPENSATION AND METHOD OF PAYMENT

A. Pricing structure or pricing methodology to be used.

Bilingual support services shall be on a Cost Reimbursement pricing structure.

The cost reimbursement pricing structure reflects a purchase arrangement in which the purchasing agency pays the provider for budgeted agreed-upon costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation.

B. Units of service and unit rate.

Not applicable

C. Method of compensation and payment.

- 1) Payments shall be made in monthly installments upon the monthly submission by the provider of expenditure reports for the services provided in accordance with the contract and in accordance with the costs identified in the budget. The first payment shall be an advance installment of approximately one-twelfth (1/12) of the total compensation and shall be made within approximately thirty (30) calendar days after execution of the contract and submission of an invoice. The state shall withhold the last monthly installment until final settlement of the contract.
- 2) After the initial advance, payments shall be made monthly based on the monthly expenditure reports submitted by the provider starting from the first month of the contract period. Payments for the last one (1) month of the contract period shall be withheld to determine if it is within the initial advance. If the invoice exceed the initial advance and the expenditures are allowable and within the total contract amount, the state shall pay the provider the difference between the total of the invoice for the last one (1) month of the contract period and the initial advance.

- 3) The expenditure reports shall be reviewed by the state and shall be subject to the state's preliminary determination of appropriateness and allowability of the reported expenditures. The state's preliminary determination of appropriateness and allowability of the reported expenditures shall be subject to later verification and subsequent audit.

Section 3

Proposal Application Instructions

Section 3

Proposal Application Instructions

General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section. The proposal shall be organized and presented in the sections and subsections designated in the RFP and with prescribed content for each section.*
- *The numerical outline for the application, the titles/subtitles, applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one (1) and continuing through the complete proposal.*
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections is required. Each tab should be placed on a separate sheet of paper and shall not be counted as a page.*
- *Proposals should be single-spaced, with 1” margins on all sides, utilizing a 12 point font size.*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant’s score.*
- *Each section shall be scored in its entirety. Information submitted in another section, shall not be considered.*
- *Other supporting documents may be submitted in an appendix, including visual aids to further explain specific points in the proposal; if used, the information is required to be referenced in the appropriate section.*
- *The Proposal Application shall not exceed 50 pages of main text, not including appendices, attachments, identification form (and/or title page), required forms, and table of contents. Appendices, attachments, identification form (and/or title page), required forms, and table of contents shall not exceed 200 pages. Document pages in excess of 250 shall not be considered (i.e., page 251 ...).*
- *This form SPO-H-200A is available on the SPO website (see Section 1, paragraph II, Website Reference). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*
- *One (1) original and two (2) copies (one unbound) of each proposal are required.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*

The Proposal Application comprises the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

I. Program Overview

Applicant shall give a brief overview to orient evaluators as to the program/services being offered. No points are assigned to the Program Overview.

II. Experience and Capability

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

A. Necessary Skills and Experience

The applicant shall demonstrate that it has the necessary skills, abilities, and knowledge relating to the delivery of the proposed services.

1. Possess the skills, abilities, knowledge of, and experience relating to the delivery of the proposed services including, but not limited, to previous and current contract performance with the DIVISION and other agencies.
2. The applicant shall provide a description of projects/contracts, including references from people in the community, pertinent to the proposed services within the most recent five (5) years. The applicant shall include points of contact, addresses, e-mail addresses, and phone numbers. The State reserves the right to contact references to verify experience.
 - a. Detailed list of experience as an agency providing bilingual support services.
 - b. Detailed list of experience as an agency providing services to adults with severe and persistent mental illness.
 - c. If an applicant has prior experience providing bilingual support services for the DIVISION, describe in detail any problems,

concerns or difficulties encountered by the agency or by the DIVISION, which was brought to the agency's attention, and how it was resolved.

- d. List of contracts performed for the Department of Health.
 - e. List of other current or prior contracts with the public sector in providing services in general for adults with severe and persistent mental illness. Discuss any problems or difficulties encountered in current or prior contracts. Applicant shall provide a point of contact and telephone number for each contract listed. The Department reserves the right to contact any of the listed points of contact to inquire about the applicant's past service performance and personnel.
 - f. Success applicant has had in recruiting and retaining quality staff.
3. Applicant's proposal thoroughly describes the agency's vision, mission and goals showing commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles.
 4. Applicant's proposal indicates a sufficient knowledge base, skills and abilities regarding the proposed services and the importance of the proposed services in the context of a comprehensive, community-based mental health system.
 5. Applicant's proposal indicates a satisfactory history of providing the same or similar community-based mental health services.
 6. Applicant's proposal indicates successful capability in coordinating services with other agencies, providers or other resources in the community.

C. Quality Assurance and Evaluation

The applicant shall describe its own plans for the sufficiency of quality assurance and evaluation for the proposed services, including methodology.

The agencies quality assurance shall include, but not be limited to, the following elements, and the information shall be submitted in the appropriate sections listed above.

1. A written Quality Management Program description and outlined structure which includes the quality committee reporting structure, including governing board involvement, voting composition, and a written process

for goal and priority setting following standardized methodology and data collection, which is updated and signed annually.

2. The Quality Management Program shall address consumer complaints, grievances, appeals, sentinel events and consumer satisfaction.
3. The Quality Management Program shall have a system or policy that outlines how items are collected, tracked, reviewed, and analyzed and reported to the DIVISION as appropriate.
4. The Quality Management Program Work Plan is established annually and selects goals and activities that are based on the annual program evaluation and are relevant to the DIVISION consumer and problem area under review, with designated timelines for the project and indicates department/persons responsible for carrying out the project(s) on the Work Plan.
5. Provision for the periodic measurement, reporting, and analysis of well-defined output, outcome measures and performance indicators of the delivery system, and an indication of how the applicant will use the results of these measurements for improvement of its delivery system.
6. A process of regular and systematic treatment record review, using established review criteria. A report summarizing findings is required. Additionally, the applicant shall develop a written plan of corrective action as indicated.
7. Provision of satisfaction surveys of consumers.
8. Assurance that a staff member be available to represent utilization and quality management issues at meetings scheduled by the DIVISION.
9. Provision of a utilization management system including, but not limited to the following: a) system and method of reviewing utilization; b) method of tracking authorization approvals; c) method of reviewing invoices against authorizations; d) consumer appeals process; e) annual evaluation of the applicant's utilization management plan; and f) identification of the person in the organization who is primarily responsible for the implementation of the utilization management plan.
10. A policy and procedure for consumer complaints, grievances and appeals which includes documentation of actions taken, and demonstration of system improvement.
11. Assurance that the applicant has established and will maintain and regularly update the following Quality Management policies and

procedures:

- a. Consumer complaints, grievances and appeals;
 - b. Consumer safety;
 - c. Consumer satisfaction;
 - d. Disaster preparedness;
 - e. Emergency evacuation;
 - f. Evidence-Based practice guidelines;
 - g. Level of care placement criteria;
 - h. Compliance;
 - i. Consumer rights and orientation;
 - j. Confidentiality/HIPAA;
 - k. Treatment records;
 - l. Individualized service plans;
 - m. Transition of consumers to other programs;
 - n. Treatment team;
 - o. Use of restraints;
 - p. Restricting consumer rights; and
 - q. Credentialing staff.
12. Where there is an intention to subcontract, the applicant must demonstrate that services provided by the subcontractor are consistent with all applicable requirements specified in Section 2 including, but not limited to, compliance with reporting requirements. The applicant must describe the monitoring it will perform to ensure subcontractors are compliant with the DIVISION requirements.
13. For applicants whose annual contract or estimated reimbursements will be less than \$100,000.00 or whose staff number five (5) or less, a modified Quality Management and Utilization Management Plan are acceptable

with prior approval from the DIVISION. A modified quality and utilization management system shall include the following:

- a. A method for tracking authorizations.
 - b. A method for assuring that consumers are informed of their rights, including the right to file a complaint, grievance, or appeal a service delivery decision.
 - c. A method of documenting goals and service activity as they relate to the “ISP” developed by the DIVISION designated case manager and consumer.
 - d. Consumer involvement in service planning.
 - e. Statement that the applicant will participate in the use of outcome instruments at the discretion of the DIVISION.
 - f. Identification of a fiscal and program contact person.
14. For services described in this RFP, a statement that the applicant shall participate with the DIVISION’S quality and utilization management process including, but not limited to, case reviews, specific data gathering and reporting, peer review, concurrent review, site visitation, special studies, monitoring, credentialing, and training.

D. Coordination of Services

The applicant shall demonstrate, through description and documentation, the capability or plan to coordinate services with other agencies and resources in the community. Demonstration or plan of the applicant’s coordination efforts shall include, but not be limited to, the following:

1. A history of the applicant’s cooperative efforts with other providers of mental health and primary health care services.
2. Memorandum of agreements with other agencies.
3. Applicant’s current efforts to coordinate with the DIVISION, CENTERS, HOSPITAL, and other POS providers, and where there is no current coordination, the applicant’s plans to do so.

E. Facilities

The applicant shall provide a description of its facilities and demonstrate its adequacy in relation to the proposed services. If facilities are not presently available, describe plans to secure facilities. The applicant shall also describe

how the facilities meet ADA requirements, as applicable and special equipment that may be required for the services.

F. Management Information System (“MIS”) Requirements

The applicant shall submit a description of its current MIS and plans for the future. The description shall include, but not be limited to, the following:

1. An explanation of how the applicant will ensure that outcome, quality improvement and satisfaction measures will be completed on the required scheduled basis for all consumers, with data uploaded to DIVISION. Examples include the annual satisfaction survey and the Quality of Life Inventory.
2. A statement about whether the applicant is a covered entity as defined by HIPAA. A statement that the applicant will comply with all HIPAA privacy, security and transactional code set requirements. The applicant shall include the name of their Privacy Officer in their application.
3. An explanation of how the applicant currently manages information in order to submit required information and data in the format prescribed by the DIVISION. Required data elements captured in the provider system and reported to the DIVISION may include, but are not limited to consumer’s last name, first name, middle name, any aliases, social security number, DIVISION-generated unique ID number, DIVISION-generated authorization number(s), Medicaid Identification Number, Medicare Identification Number, other third party insurer numbers, address, telephone number, admission date, discharge date, service data using DIVISION approved procedure codes, date of birth, gender, and primary language spoken.
4. The DIVISION may add data reporting requirements or specify required formats for downloading data or submitting claims in the future. Applicants are encouraged to describe their flexibility in meeting changing data requirements.
5. For any Fixed Unit of Service Rate contracts, a statement that the applicant shall submit claims electronically in the 837 format.
6. The applicant shall provide a clear statement and describe how the MIS system is fully functional.
7. Where infrastructure is lacking to meet MIS requirement, applicants shall propose solutions, include an implementation plan to create a fully functional MIS system by initiation of a contract, and include the proportion of cost related to this contract in their response to the RFP.

8. In regards to flexibility, a statement that describes flexibility in adding data elements or reporting requirements is addressed in their information system.
9. The applicant shall provide a clear statement that encounter data, will be submitted electronically using the HIPAA compliant 837 format.

III. Project Organization and Staffing

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

A. Staffing

1. Proposed Staffing

The applicant shall describe and demonstrate that (a) the proposed staffing pattern, consumer/staff ratio, coverage, and proposed caseload capacity are reasonable and appropriate to insure viability of the services and complies with applicable DIVISION requirements, and (b) that the applicant's assignment of staff would be sufficient to effectively administer, manage, supervise, and provide the required services. The applicant shall give the number and title of the positions needed to provide the specific service activities. Positions descriptions shall also be submitted. (Refer to the personnel requirements in the Service Specifications, as applicable.)

The applicant shall fully explain, justify, and demonstrate any proposed use of a subcontractor to be as effective as in-house staff for the provision of the required services; demonstrate that a proposed subcontractor is fully qualified for the specific work that would be subcontracted by including a description of the proposed subcontractor's experience, capability, project organization, staffing, and proposed services as set forth for applicants in these RFP's; and explain how it would assure quality and effectiveness of the subcontractor, monitor and evaluate the subcontractor, and assure compliance with all the requirements of the RFP.

The applicant shall fully explain, justify, and demonstrate any proposed use of a volunteer to be as effective as in-house staff for the provision of the required services; demonstrate that proposed volunteers are or would be fully qualified for the specific work assigned, could be relied on, and would be available when and where needed to provide the required services; explain how it would provide sufficient management, supervision, oversight, and evaluation of volunteers, and otherwise assure their work quality and effectiveness; and explain how it will assure that

volunteers perform in compliance with the requirements of the RFP.

2. Staff Qualifications

The applicant shall describe in this section of its proposal how it will ensure its compliance with the minimum personnel qualifications which include, but are not limited to, licensure, educational degrees, and experience for staff assigned to the program, and comply with applicable DIVISION requirements. The applicant shall provide the minimum qualifications for staff assigned to the program; include position descriptions and explain how the minimum qualifications and/or actual qualifications would assure delivery of quality of services. (Refer to the qualifications in the Service Specifications, as applicable.)

B. Project Organization

1. Supervision and Training

The applicant shall describe and demonstrate its ability to adequately supervise, train and provide clinical administrative direction to staff relative to the delivery of the proposed services and comply with applicable DIVISION requirements. The description shall include frequency and method of conducting supervision and documentation of same.

The applicant shall explain how the program organization and assignment of personnel are sufficient for the effective administration, management, supervision, and provision of services under the program to meet the projected caseload. The applicant shall describe the training that would be provided for program staff to strengthen their capability to effectively provide the program services.

Applicant's proposal includes a description of the agency's plan for staff orientation and training, which includes detail about frequency and content of training which, at a minimum, meets content requirements outlined in the RFP.

2. Organization Chart

The applicant shall describe their approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks. The organization-wide and program-specific organization charts shall accurately reflect the proposed structure.

The applicant shall provide an "Organization-wide" chart that shows the program placement of the required services within the overall agency, and a "Program" organization chart that shows lines of communication

between program administration and staff. Written explanations of both charts shall be included as needed for clarification.

The applicant shall reflect the position of each staff and line of responsibility/supervision. (Include position title, name and full time equivalency) Both the “Organization-wide” and “Program” organization charts shall be attached to the Proposal Application. Percentage of full time equivalent (FTE) shall be indicated for each position.

The applicant shall demonstrate that the applicant’s proposed organization would be sufficient to effectively administer, manage and provide the required services.

3. Evidence of Licensure/Accreditation

Applicable submission of evidence that the applicant is licensed if licensure is required; and for all applicants, current and valid accreditation of the service(s) the applicant is applying for if it is an accreditable service. The applicant shall submit documentation of appropriate licensure and/or accreditation.

IV. Service Delivery

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

A. Scope of Work

The applicant shall include a detailed discussion of the applicant’s approach to applicable service activities and management requirements from Section 2, Item III. - Scope of Work, including (if indicated) a work plan of all service activities which the applicant is proposing to provide and tasks to be completed, related work assignments/responsibilities and timelines/schedules.

A detailed description of the service which the applicant is proposing to provide including:

1. The applicant’s understanding of the role of bilingual support services within the broader array of community-based mental health services including functional descriptions of each service category, their inter-connectedness, and strategies that might be employed to address the needs of both over- and under-utilizers of bilingual support services.
2. The applicant’s analysis and recommendations for addressing the needs of

the DIVISION eligible consumer(s) who are primarily non-English speaking regarding what languages are most in demand/need, and how they propose to address this need. This should include the languages they are proposing to provide, the rationale, and at what capacity (number of FTE per language.)

3. Barriers to services which may naturally or artificially occur and the applicant's efforts or plans to overcome those barriers.
4. Agencies, providers or organizations with which it might be important to have collaborative relationships in order to successfully implement the proposed services, including how those relationships are identified, built and contribute to consumer recovery, challenges around linkage, and the role of the case management organization.
5. The applicant's ability to provide flexibility in the hours of operation to meet the consumer needs.
6. The applicant's incorporation of best-practices or evidence-based practices within their service array and their plans to implement the proposed services utilizing best- or evidence-based practices.
7. The applicant's understanding of cultural competence and their efforts to provide culturally relevant services and support for the consumer's role in decisions regarding services being planned or provided.

B. General Requirements

The applicant shall state/describe how it will comply with the general requirements specified in Section 2.II., and document the information in the appropriate section of their RFP proposal application.

C. Administrative Requirements

The applicant shall describe how it will comply with the administrative requirements specified in Section 2.III.B.2., and document the information in the appropriate section of their RFP proposal application.

V. Financial

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

A. Pricing Structure

The applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the Proposal Application.

The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation. All budget forms, instructions and samples are located on the SPO Website (see Section 1, paragraph II Website referred to in this RFP.) The following budget forms shall be submitted with the Proposal Application:

- SPO-H-205 – Budget
- SPO-H-205A – Organization-Wide Budget by Source of Funds (special instructions are located in Section 5)
- SPO-H-206A – Budget Justification – Personnel: Salaries & Wages
- SPO-H-206B – Budget Justification – Personnel: Payroll Taxes, Assessments & Fringe Benefits
- SPO-H-206C – Budget Justification – Travel-Inter-Island
- SPO-H-206E – Budget Justification – Contractual Services - Administrative
- SPO-H-206F – Budget Justification – Contractual Services - Subcontracts
- SPO-H-206H – Budget Justification – Program Activities
- SPO-H-206I – Budget Justification – Equipment Purchases

B. Other Financial Related Materials

1. Proposal Budget Costs for Bilingual Support Services program.
 - a. Personnel costs are reasonable and comparable to other organizations in the community; non-personnel costs are reasonable and adequately justified, and the budget included supports the scope of services and requirements of the RFP.
 - b. A cost allocation plan clearly provides a fiscally sound explanation of how costs are allocated across different funding sources, not related to the DIVISION.

2. Accounting System

In order to determine the adequacy of the applicant's accounting system as described under the administrative rules, the following documents are requested as part of the Proposal Application (may be attached):

- a. The applicant shall submit a cost allocation plan, clearly providing a fiscally sound explanation of how costs are allocated across

different funding sources, not related to the DIVISION. This is one measure that indicates the agency's commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles.

- b. The applicant shall submit copies of their single audit report, financial audit, or compiled financial statements for fiscal years (FY) 2008 and 2009. The FY 2008 and FY 2009 reports or financial statements shall indicate minimal or no material deficiencies and an adequacy of their accounting system.

If an applicant has not had their FY 2009 single audit report, financial audit or compiled financial statement completed, they shall submit a statement indicating when the FY 2009 audit or FY 2009 compiled financial statement shall be completed, and may submit their completed audits or compiled financial statements for FY 2007 and FY 2008.

- c. The applicant has the cash-flow to sustain their organization financially for a minimum of two (2) months without receiving any payments for this service being procured.

- 3. The applicant shall describe all eligible sources of revenue from third parties and plans to pursue additional sources of revenue and how the applicant will prevent billing more than one (1) payer and submit overpayments to the DIVISION. The applicant may not bill other payers for services already paid for by the DIVISION or bill the DIVISION for services eligible for payment by another payer.
- 4. The applicant shall describe its billing/claims process and how it ensures accurate and timely submission of billing/claims based on written documentation which supports the bill/claim, and how it processes adjustments, reconciles payment, and posts payment.

VI. Other

A. Litigation

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

Section 4

Proposal Evaluation

Section 4 Proposal Evaluation

I. Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

II. Evaluation Process

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

Evaluation Categories and Thresholds

<u>Evaluation Categories</u>	<u>Possible Points</u>
Administrative Requirements	
Proposal Application Sections	
1. Program Overview	0 points
2. Experience and Capability	25 points
3. Project Organization and Staffing	15 points
4. Service Delivery	45 points
5. Financial	15 points
TOTAL POSSIBLE POINTS	100 Points

III. Evaluation Criteria

A. Phase 1 - Evaluation of Proposal Requirements

1. Administrative Requirements

2. Proposal Application Requirements

- Proposal Application Identification Form (Form SPO-H-200)
- Table of Contents
- Program Overview
- Experience and Capability
- Project Organization and Staffing
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

**B. Phase 2 - Evaluation of Proposal Application
(100 Points)**

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from all other sections. The scores from each section will be added together to arrive at a total score. Applicants are responsible to place the appropriate information in each section to be scored.

The RFP Review Committee shall use the scale in the table below to rate the applicant’s response to each section from the RFP. Each section will be rated from Not Addressed to Excellent using the rating scale definitions outlined below. The percentage for the rate level will be multiplied by the maximum number of points for that section. For example, if a section is worth 20 points and the reviewer rated it as Satisfactory, the score for that section would equal 12. (.60 x 20 = 12)

0	20% (.20)	40% (.40)	60% (.60)	80% (.80)	100% (1.00)
Not Addressed	Unsatisfactory	Somewhat satisfactory	Satisfactory	Very Satisfactory	Excellent

Use the following rating scale definitions as a general guide for scoring:

Not Addressed: A majority of the items rated in the section were not addressed in the proposal, or were addressed incorrectly.

Unsatisfactory: Applicant appears to have just re-stated the requirements outlined in the RFP or, applicant's submission fails to indicate a clear understanding of the scope of services or other requirements of the RFP.

Somewhat satisfactory: A major item was addressed but in the wrong category or was not covered completely; significant lack of original effort in formulating responses; much of the proposal simply repeats back what the RFP stated as requirements; responses indicate a limited understanding of at least some of the scope of services or other requirements of the RFP.

Satisfactory: All major items were addressed. Applicant's submission reflects an understanding of the scope of service and other requirements of the RFP.

Very satisfactory: All major items were addressed completely and thoroughly. Proposal includes concise, detailed descriptions of how the provider intends to deliver services. Concepts are stated clearly and evidence of creative or original thinking is present; applicant includes evidence of having researched the services and indicates a solid understanding of the scope of services or other requirements of the RFP.

Excellent: The majority of items were addressed in an exceptionally clear, concise, or original manner; applicant not only indicates a full understanding of the scope of services and other RFP requirements but also the implications of the service for the broader community and the necessity of coordinating services closely with other providers. Applicant's proposal includes value added services or service components which go beyond the minimum requirements outlined in the RFP.

Program Overview: No points are assigned to Program Overview. The intent is to give the applicant an opportunity to briefly orient evaluators as to the applicant's understanding of the service array and the service(s) being offered.

1. Experience and Capability Total 25 Points

Up to 10 points may be deducted from agencies who in the past demonstrated unsatisfactory performance. Indicators for unsatisfactory performance may include, but are not limited to:

- a. History of Provider monitoring and oversight scores that did not meet minimum satisfactory requirements.
- b. History of non-compliance with corrective actions or plans of improvement.

- c. Substantial failure in providing required reports or other documentation, including satisfaction, outcomes and quality improvement measures, in a timely manner.
- d. Non-Compliance with DIVISION's Quality Management, Utilization Management and/or Business Compliance initiatives.
- e. Prior termination or non-extension of contracts due to contract performance issues.

The State will evaluate the applicant's experience and capability relevant to the proposed contract, which shall include:

a. Necessary Skills and Experience (10 points)

- 1) Applicant's proposal thoroughly describes the agency's vision, mission and goals showing commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles.
- 2) Applicant's proposal indicates a sufficient knowledge base, skills and abilities regarding the proposed services and the importance of the proposed services in the context of a comprehensive, community-based mental health system.
- 3) Applicant's proposal indicates a satisfactory history of providing the same or similar community-based mental health services.
- 4) Applicant's proposal indicates successful capability in coordinating services with other agencies, providers or other resources in the community.

b. Quality Assurance and Evaluation (5 points)

- 1) The applicant has sufficiently described its quality management program which shall, at a minimum, include the following: program structure and accountabilities, resources devoted to the program including staffing and oversight, selection of performance measures and standards, frequency of internal performance monitoring, identification of

opportunities for improvement, and an annual evaluation of program effectiveness.

- 2) The applicant has sufficiently described its utilization management program which shall include, at a minimum, the following: program structure and accountabilities, resources devoted to the program including staffing and oversight, selection of performance measures and standards, frequency of internal performance monitoring, identification of opportunities for improvement, and an annual evaluation of program effectiveness.
- 3) The applicant has a program which effectively addresses identification, tracking and resolution of consumer complaints, grievances and appeals.

c. Coordination of Services (3 points)

Applicant's proposal demonstrates a successful history of coordination of services with other agencies and programs in the community, or for new organizations, an indication that collaboration and coordination of care is necessary for successful recovery and includes a plan for establishing collaborative relationships with other agencies and providers.

Demonstration of a successful history of coordination requires more than simply submitting copies of agreements with other agencies or providers.

d. Facilities (2 points)

Applicant has the minimum, necessary facilities in which to provide the proposed services. Agency facilities are located near major transportation alternatives or are otherwise geographically accessible to a broad range of consumers. Agency facilities are managed and maintained in a manner which ensures a safe, sanitary and comfortable environment for consumers receiving services.

e. Management Information Systems ("MIS") (5 points)

The applicant shall submit a description of its current MIS and plans for the future. The description shall include, but not be limited to, the following:

An explanation of how the applicant currently manages information in order to submit required information and data in the format prescribed by the DIVISION. Required data elements captured in the provider's system and reported to the DIVISION may include, but are not limited to: consumer's last name, first name, middle name, any aliases, date of birth, gender, primary language, address, telephone number, social security number, DIVISION-generated unique ID number, DIVISION-generated authorization number(s), Medicaid Identification Number, Medicare Identification Number, other third party insurer numbers, admission date, discharge date, and service data using DIVISION approved procedure codes. The explanation must also include a description of how the applicant obtains and updates information within the organization as well as how the organization will provide updated information to the DIVISION. Examples might include how the organization ensures that when a clinician is informed of a change in address, that information is forwarded to other departments in the organization as well as making sure the DIVISION is informed of the change, or how recommended changes in diagnosis are communicated from the treating psychiatrist to the billing department.

- 1) An explanation of how the applicant will ensure that outcome, quality improvement and satisfaction measures will be completed on the required scheduled basis for all Consumers, with data uploaded to DIVISION. Examples include the annual satisfaction survey and the Quality of Life Inventory.
- 2) A clear statement indicating whether or not the applicant is a covered entity as defined by HIPAA. If the applicant is a covered entity the applicant's response to the RFP must include the name of the applicant's Privacy officer.
- 3) The Applicant's response to the RFP must clearly state an intention to comply with all state and federal privacy, security and transactional code set requirements, including HIPAA. Applicants that do not include this statement will be disqualified.
- 4) The DIVISION may add data reporting requirements or specify required formats for downloading data or submitting claims in the future. Applicants shall

- 1) The applicant included agency-wide and program-specific organizational charts and role descriptions with their proposal. The agency-wide and program-specific organization charts and role descriptions adequately reflect the applicant's understanding of the proposed services, service delivery requirements and the organizational structure and support necessary to fully implement and provide the proposed services.
- 2) Applicant included copies of all necessary, relevant licenses and accreditation documentation for program components where licensing and accreditation is required or, applicant submitted a comprehensive plan for meeting licensing and/or accreditation requirements before services are implemented.

3. Service Delivery **Total 45 Points**

Evaluation criteria for this section will assess the applicant's approach to the service activities and management requirements outlined in the Proposal Application. This section should reflect that the applicant has a thorough understanding of the scope of services being proposed and that the applicant's service delivery system is capable of meeting the goals and objectives of the RFP. Evaluation of this section will include, but not necessarily be limited to descriptions of:

- a. The applicant's understanding of the role of bilingual support services within the broader array of community-based mental health services. **(5 points)**
- b. The applicant's analysis and recommendations for addressing the needs of DIVISION eligible consumers who are primarily non-English speaking, what languages are most in demand/need, and how they propose to address this need. This should include the languages they are proposing to provide, the rationale, and at what capacity (number of FTE per language) as well as an estimate of the number of consumers it will serve and the amount of services they will provide. **(18 points)**

- c. A description of how the applicant proposes to provide consultation and interpreter services to neighbor islands, if required. **(2 points)**
- d. A description on how the applicant proposes to provide community outreach and education to identify unserved and underserved non-English potential DIVISION eligible consumers. **(4 points)**
- e. A clear description of the services for consumers from point of entry to discharge, including interventions being utilized. This should include support for the consumer's role in decisions regarding services being planned or provided. Any services to be subcontracted out should be included in this description. **(5 points)**
- f. A discussion regarding agencies, providers or organizations with which it might be important to have collaborative relationships in order to successfully implement the services. This should also address the interface between bilingual support services and the state mental health centers. **(5 points)**
- g. The applicant's ability to provide flexibility in the hours of operation to meet consumer needs. **(2 points)**
- h. The applicant's incorporation of best-practices or evidence-based practices within their service array and their plans to implement the proposed services utilizing best- or evidence-based practices. **(2 points)**
- i. The applicants understanding of cultural competence and their efforts to provide culturally relevant services and support for the consumer's role in decisions regarding services being planned or provided. **(2 points)**

proposed
between
operated community
(5 points)

4. Financial Total 15 Points

Evaluation criteria for this section will include:

- a. Personnel costs are reasonable and comparable to similar positions in the community, non-personnel costs are reasonable and adequately justified, and the budgets included supports the scope of services and requirements of the RFP.

- (3 points)**

b. A cost allocation plan clearly provides a fiscally sound explanation of how costs are allocated across different funding sources, not related to the DIVISION;
(3 points)
- c. The single audit report, financial audit, or compiled financial statements for fiscal years 2008 and 2009 indicates minimal or no material deficiencies and an adequacy of their accounting system. If an applicant's agency has not had their FY 2009 audit or compiled financial statements completed, they should submit a statement indicating when their FY 2009 audit or compiled financial statements shall be completed, and may submit their completed audits or compiled financial statements for FY 2007 and FY 2008. The applicant has the cash-flow to sustain the organization for a minimum of two months; **(3 points)**
- d. An indication of the third party reimbursements the applicant is eligible to receive and of the plans the applicant has made or is making to obtain as many third party reimbursements as possible without collecting payment from more than one (1) payer; **(3 points)**
- e. Description of all eligible sources of revenue from third parties and plans to pursue additional sources of revenue. **(3 points)**

C. Phase 3 - Recommendation for Award

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.

Section 5

Attachments

- A. Proposal Application Checklist**
- B. Sample Table of Contents**
- C. Draft Special Conditions**
- D. Bilingual Support Services Utilization Criteria**
- E. Division P&P – Continuity of Care (Transitions)
No. 60.638**
- F. Comprehensive Continuous, Integrated System of
Care Model by Kenneth Minkoff, M.D.**
- G. AMHD Practice Guidelines**
- H. AMHD Mission, Vision, Values and Guiding
Principles**
- I. QMHP and Supervision**
- J. Mental Health Worker**
- K. Bilingual Assistant**
- L. Mental Health Professional**
- M. Certifications**
- N. Form SPO-H-205A Instructions**

Attachment A

Competitive POS Application Checklist

Proposal Application Checklist

Applicant: _____

RFP No.: HTH 420-7-10

The applicant's proposal must contain the following components. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website References.*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	X	
Proposal Application Checklist	Section 1, RFP	Attachment A	X	
Table of Contents	Section 5, RFP	Section 5, RFP	X	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	X	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	X	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5	X	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	X	
SPO-H-206B	Section 3, RFP	SPO Website*	X	
SPO-H-206C	Section 3, RFP	SPO Website*	X	
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*	X	
SPO-H-206F	Section 3, RFP	SPO Website*	X	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*	X	
SPO-H-206I	Section 3, RFP	SPO Website*	X	
SPO-H-206J	Section 3, RFP	SPO Website*		
Certifications:				
Federal Certifications		Section 5, RFP		
Debarment & Suspension		Section 5, RFP	X	
Drug Free Workplace		Section 5, RFP	X	
Lobbying		Section 5, RFP	X	
Program Fraud Civil Remedies Act		Section 5, RFP	X	
Environmental Tobacco Smoke		Section 5, RFP	X	
Program Specific Requirements:				

Authorized Signature

Date

Attachment B

Sample Table of Contents for the POS Proposal Application

**Proposal Application
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 - 1. Supervision and Training.....10
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- VI. Litigation.....20**
- VII. Attachments**
 - A. Cost Proposal
 - SPO-H-205 Proposal Budget
 - SPO-H-206A Budget Justification - Personnel: Salaries & Wages
 - SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits
 - SPO-H-206E Budget Justification - Contractual Services – Administrative
 - B. Other Financial Related Materials
Financial Audits for fiscal year ended June 30, 2009 and June 30, 2008
 - C. Organization Chart
 - Program
 - Organization-wide

Attachment C

Draft Special Conditions

SPECIAL CONDITIONS

1. The General Conditions is attached hereto as Attachment 4 and made a part of this Contract.

2. The Special Conditions is attached hereto as Attachment 5 and made a part of the Contract.

3. Campaign Contributions by State and County Contractors. Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body.

4. Insurance. In addition to paragraph 1.4, General Conditions, the PROVIDER shall obtain, maintain, and keep in force throughout the period of this Contract the following types of insurance:

a. General liability insurance issued by an insurance company in the amount of at least ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) for bodily injury and property damage liability arising out of each occurrence and THREE MILLION AND NO/100 DOLLARS (\$3,000,000.00) aggregate.

b. Automobile insurance issued by an insurance company in an amount of at least ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per occurrence.

c. Professional liability insurance issued by an insurance company in the amount of at least ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per occurrence and THREE MILLION AND NO/100 DOLLARS (\$3,000,000.00) aggregate.

Prior to or upon execution of this Contract, the PROVIDER shall obtain a certificate of insurance verifying the existence of the necessary insurance coverage. The parties agree that the certificate

of insurance shall be attached hereto as Exhibit “B” and be made a part of this Contract. The certificate shall provide the STATE and its officers and employees are additional insured. If the scheduled expiration date of the insurance policy is earlier than the expiration date of the time of performance under this Contract, the PROVIDER upon renewal of the policy, shall promptly cause to be provided to the STATE an updated certificate of insurance. If the PROVIDER’s insurance policy is being cancelled, the insurance company shall give the STATE thirty (30) calendar days written notice of the intended cancellation. Should either the general liability, automobile, or professional liability insurance coverage be cancelled before the PROVIDER’s work under this Contract is certified by the STATE to have been completed satisfactorily, the PROVIDER shall immediately procure replacement insurance that complies in all respects with the requirements of this Special Condition.

5. Option to Extend Contract. Unless terminated, this Contract may be extended by the STATE for specified periods of time not to exceed four (4) years or for not more than four (4) additional twelve (12) month periods, upon mutual agreement and the execution of a supplemental agreement. This Contract may be extended provided that the Contract price shall remain the same or is adjusted per the Contract Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.

6. Contract Price Adjustment. The Contract price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.

7. Audit Requirements. The PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit “C” attached hereto and made a part

hereof. Failure to comply with the provisions of this paragraph may result in the withholding of payments to the PROVIDER.

8. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

DRAFT

Attachment D
Bilingual Support Services
Utilization Criteria



Bilingual Support Services

Group B

ADULT MENTAL HEALTH DIVISION Service Authorization Request

Fax Completed Form To: AMHD Utilization Management
PHONE NUMBER: 586-7400 FAX NUMBER: 453-6966 Fax Date: _____

Reason for form completion:

Admission Continued Stay Discharge

CONSUMER INFORMATION (Type or Print Clearly)

Name: _____ Alias: _____

Date of Birth: _____ SSN: _____ Phone: _____

Address: _____

City: _____ State: HI Zip Code: _____

Current DX Code, Axis I: _____ Current DX Code, Axis II: _____

Axis III: _____ Axis IV: _____ Axis V: _____

Other Benefit Coverage: _____ Policy #: _____

SERVICE REQUESTED:

Coordination Services Interpreter Services

Language Requested:

Japanese Mandarin Cantonese Korean Tagalog Illocano Vietnamese
 Samoan Chuukese Other _____

PROVIDER CONTACT INFORMATION

Provider Agency: _____ Submitted by: _____

Provider Phone: _____ Fax: _____

Address: _____ City: _____ State: HI Zip: _____

CBCM Provider Agency/Level of Care: _____

Case Manager: _____ Phone: _____

Consumer Name: _____ Bilingual Support Services

Admission Criteria

Admit Date:

Meets **one** of the following:

1. Consumer is unable to adequately communicate with providers with language proficiency, and would be unable to continue to utilize services without the use of a bilingual support worker
2. Consumer is unable to adequately access mental health and other community services without bilingual support services. Bilingual needs are at an intensity which exceed the regular use of an interpreter.

Continued Stay Criteria

Continued Date:

Meets **all** of the following:

1. Continues to meet initial criteria.
2. In order to maintain current community stability, requires this level of service and remains linked with a AMHD psychiatrist.
3. Consumers receiving bilingual support services remain assigned to a state operated community mental health center.
4. There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, increased environmental supports and engagement to reasonably conclude that continued services at this level will further stabilize/increase consumers functioning.

Discharge Criteria

Discharge Date:

Meets **one** of the following:

1. Service no longer needed due to **all** of the following:
 - a. Functional stability has been maintained in the current community setting in the past 12 months.
 - b. Consumer is able to independently access ongoing services to maintain stability in the community without the assistance of a bilingual support worker.
2. Consumer has regular and reliable access to interpreter services to support their ongoing utilization of mental health and other community services.
3. Consumer refuses cultural and linguistic coordination services.

Additional Discharge Reasons:

1. Consumer deceased. (Discharge date should reflect the same date as the date of death). Sentinel event should be reported to AMHD Performance Improvement.
2. Transferred to State Institution.
 - a. Incarceration.
 - b. Long-term hospitalization.

3. Admitted to a long term (over 30 days) private institution (nursing home, etc).
Please state:

Consumer Name: _____ Bilingual Support Services

- 4. Consumer moved from geographic service area.
 - a. Out of area.
 - b. Out of state.

- 5. Change in eligibility
 - a. Change in Diagnosis (to an ineligible diagnosis).
 - b. Legal requirement is dismissed.

- 6. Consumer has access to alternative funding source (i.e. obtained insurance).

- 7. Unable to locate.

- 8. Consumer is refusing service.

- 9. Other (please state): _____

Service Exclusions

- 1. Consumers receiving CBCM from a POS provider (bilingual support services shall be assigned case management services only through a state operated CMHC).

Clinical Exclusions

- 1. Consumers who are able to communicate independently with service providers without the assistance of a bilingual support worker would not be appropriate.

Justification for request despite exclusions:

Name and Title of Provider Representative Completing Form (Please Print):

Name _____ Title _____

Date Form Completed _____

Signature _____

Attachment E

**Continuity of Care (Transitions)
No. 60.638**

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Continuity of Care (Transitions)

REFERENCE: American Association of Community Psychiatrists (AACP) Continuity of Care Guidelines; : Plan for Community Mental Health Service IV,B,1,b

Number: 60.638

Effective Date: 10/26/04

History: New

Page: 1 of 4

APPROVED:



Title: Chief, AMHD

PURPOSE

To establish standards for the transition of care between levels of care and between providers of services.

POLICY

Adult Mental Health Division (AMHD) shall adopt the transition guidelines and outcome indicators established by the American Association of Community Psychiatrists (AACP) to assure that consumers who are moving between levels of care or between service providers are given adequate support and structure to assure a positive transition through the use of the following principles that are detailed in the AACP Continuity of Care Standards:

- Prioritization
- Comprehensiveness
- Coordination
- Continuity
- Service User Participation
- Support System Involvement
- Service User Choice
- Cultural Sensitivity

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 60.638

AMHD Administration

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- Prevention
- Resource Utilization
- Timing
- Designation of Responsibility
- Accountability
- Special Needs
 - o Addictions
 - o Geriatrics
 - o Forensics
 - o Child and Adolescence

DEFINITIONS

Transition:

The movement between levels of care or between providers of services. According to AACAP guidelines:

- “Transition implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change.
- Transition implies collaboration among providers, which is required for a successful progression through the continuum.”

Designated Case Manager:

The case manager who is designated as the primary person responsible for the development and updates of the Individualized Service Plans (ISPs).

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 60.638

AMHD Administration

Page: 3 of 4

PROCEDURE

AMHD shall adhere to the following procedures:

1. The Level of Care for Utilization Systems (LOCUS) shall be the primary clinical tool used in determining when a change in level of care is needed. The designated case manager shall be responsible for the completion of the LOCUS.
2. Consumer involvement and choice shall guide the development of transition planning and provider selection. Transition planning shall include the consumer, the consumer's case manager, the consumer's support systems, and both the current and new provider(s).
3. The Individual Service Plan (ISP) shall incorporate transition planning and the new provider shall "incorporate relevant elements of any preexisting treatment plan" into the new ISP.
4. Transition plans that involve movement to a lower level of care shall include relapse prevention planning.
5. Transition planning shall detail specific timelines and responsibilities of all parties involved in the transition period.
6. The existing provider shall maintain responsibility for the service being provided to the consumer until the time that the consumer is adequately ready for transfer to another provider.
7. AMHD shall establish a payment schedule for transition services for the new provider at the beginning of the transition and for the old provider at the end of the transition.
8. Transition periods shall be limited and shall be based upon the individual needs of the consumer and not the convenience of any provider.
9. In cases where a consumer moves to a higher level of care due to safety or functional reasons and a transition period cannot occur, the previous provider and the new provider shall cooperate with the consumer's case manager in providing information and supports to assure a smooth transition to the higher level of care.

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

Number: 60.638

AMHD Administration

Page: 4 of 4

10. The following services and conditions constitute Transitions and require the above detailed planning to occur:
 - a. Between any level of Case Management or change in Case Management provider
 - b. Between Specialized Residential services and all other community services
 - c. Between levels of Housing
 - d. Between Day Services (Intensive Outpatient Hospital, Psychosocial Rehabilitation, Clubhouse, Day Treatment for Dual) or change in providers of these services

11. AMHD Quality Management (QM) shall include transition standards in their monitoring process based on the Outcome Indicators established by the AACCP.

ATTACHMENT

AACP CONTINUITY OF CARE GUIDELINES

Date of Review: / / ; / / ; / / ; / /

Initials: [] [] [] []

AACP CONTINUITY OF CARE GUIDELINES

Best Practices for Managing Transitions Between Levels of Care

INTRODUCTION

Continuing engagement with treatment and recovery services is one of the most important aspects of addressing an episode of illness or ongoing disabilities associated with severe behavioral health problems. Interruption of care, for whatever reason, is among the most significant obstacles to establishing a stable recovery. It is in response to these circumstances that the AACP has prepared these guidelines to assist providers and planners in establishing standards for the management of transitions between levels of care.

A Progressive Conceptualization of the Service Continuum

With the development of LOCUS and CALOCUS, the AACP developed a structure of variable intensity service arrays that incorporate evolving concepts of "Levels of Care". In contrast to traditional concepts, overlapping and integrated levels of resource intensity are described, more conducive to providing true linkages between the phases of treatment for a given episode of illness. It is from this perspective that we have elaborated these guidelines for transition management.

Critique of Traditional Terminology

The traditional terminology of "discharge" planning is usually counterproductive in establishing continuity of care as it reinforces the notion of discreet, independent treatment programs operating in a fragmented system of care. Consequently, "discharge" terminology implies:

- Termination of service rather than a *transformation* of service variables and continuation of service in another setting.
- Recovery is sufficiently established and stable that services are no longer required.
- The *complete* termination of one provider's responsibility and the *equally complete* assumption of responsibility by another provider.

These concepts associated with discharge often lead to conflict between providers and the development of cracks in the service continuum through which many consumers readily fall.

Transition Rather Than Discharge

"Transition" planning better captures the concept of continuing care (not aftercare) throughout the episode of illness or service need.

- Transition implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change.
- Transition implies collaboration among providers, which is required for a successful progression through the continuum.

Although this concept of fully integrated service systems still remains idealistic in most cases, the articulation of this ideal is an important element in the reform process. In this document we will use the traditional terminology in parallel with the more progressive "transition" terminology described here, recognizing that reality and idealism must rub shoulders during the process of change.

Applications of the Guidelines

These guidelines are intended to be more than a simple statement of principles. Rather, they are intended to provide a quality management framework by which systems of any type can continuously monitor and improve their processes for managing client transitions. For this to occur, it is essential that these organizations not only endorse these principles in theory, but also create methods to measure their implementation in practice. With this thought in mind, a sample outcome indicator is attached to each of the principles elaborated in the guidelines. Indicators of this type, customized and quantified to reflect the specific circumstances of the organization developing them, would allow for the measurement of the adherence to these principles.

These guidelines, along with their companion documents for special populations, will continue to evolve. We hope that these guidelines will be useful in their present form to all elements of the service system.

- Governmental agencies and other purchasers can use them for developing standards for contracts.
- Regulatory agencies can use them in practice guidelines and standard development.
- Program managers and quality managers can use them for developing program standards and quality indicators.
- Clinicians can use them in elaborating transition plans.

Continuity of Care Guidelines for Behavioral Health Service Systems

The following are general principles for developing transition plans for persons using behavioral health services moving from one level of care to another. They offer a synopsis of elements common to this process regardless of the setting or the population that is being served. Specific needs and issues related to special populations are elaborated in a series of companion documents, which will only be summarized here. Continuity of Care Guidelines can only offer a framework to facilitate transitions and plans which incorporate them must be adapted for each individual. They may provide a template for developing standards regarding transitions in specific circumstances throughout a service system.

Implementation of any set of guidelines is subject to the availability of resources. Community resources should be conceived of as an array of services and mutual supports which will operate as a unified system of care. If community resources are limited, the transition plan should make the most effective use of the resources that are available and reflect the most important priorities for the patient in question. Realistic determinations should be made on a case-by-case basis. Ideally, transitions between levels of care will be based on clear criteria such as those contained in the AACCP's LOCUS or ASAM's PPC2. Only with an integrated, client driven, community based system of care will the ideal planning for level of care transitions be achieved.

Principles for Transition of Care Between Levels of Service

1. **Prioritization:** Transition or discharge planning should begin at the time of admission to any level of care and should be a part of the treatment plan. Identification of transition needs and the coordination of services required to meet them will be most urgent at the most intense levels of care.

Outcome Indicator: Treatment plans, assessments and progress documentation will demonstrate activities relevant to issues likely to be encountered in anticipated transitions in treatment setting or providers.

2. **Comprehensiveness:** Transition plans should include all aspects of an individual's service needs. These would typically include continuing treatment, supportive services such as case management or child care, residential stabilization, treatment of co-morbid health issues, realistic financial supports, and mutual support networking. In some cases interface with the legal system or child protection/family service agencies will be required.

Outcome Indicator: All aspects of a service user's needs, as identified in completed assessments, will be adequately addressed in the transition plan.

3. **Coordination:** Coordination of and collaboration between elements of the service system which are involved with the client on either side of the transition should occur as part of the treatment plan such that a sense of continuity is achieved while the transition evolves. Whenever possible, information regarding the most recent experience should be provided to the agency where the client will be continuing care. Appropriate incentives for providers are an essential consideration in efforts to achieve this objective.

Outcome Indicator: Significant communication and coordination between all involved service providers is evident through service user's experience and relevant documentation.

4. **Continuity:** Transitions, either upward or downward in the continuum of services, should incorporate relevant elements of any preexisting treatment plan. Treatment plans should be relevant to the entire course of an episode of illness/disability so that they can provide a degree of continuity in the context of change if properly elaborated and utilized.

Outcome Indicator: Treatment plans incorporate significant aspects of previous treatment plans and build on prior treatment initiatives.

5. **Service User Participation:** Extensive participation of the service user in the formulation of transition planning is critical to success. Efforts should be made to elicit the service user's perspective on the specific difficulties they anticipate in making the transition and their preferences for services, and to address these issues in the elaboration of the plan.

Outcome Indicator: Documentation of the service user's perspective on the transition and his or her preferences for services is available.

6. **Support System Involvement:** Client and family involvement in the elaboration of the discharge/transition plan is essential from the time of admission at any level of care. The degree of family involvement will generally be dictated by the client's and the family's willingness to engage in the process. Other persons providing support in the community should be included as well if a client indicates a desire for their participation.

Outcome Indicator: Significant members of the service user's support system are consulted in the formulation of the transition plan or an effort to obtain their participation is evident.

7. **Service User Choice:** Transition/Discharge plans must reflect reality and address client needs in the most practical way possible. This will require recognition of the phase of illness and/or recovery of the client for which services are being planned. In many cases, clients may choose to leave treatment early or they may have had marginal investment in the service they are departing from. Regardless of the circumstances of their departure or the likelihood of their continuing in treatment, a comprehensive plan should be elaborated in a manner that is as inclusive of client wishes as possible.

Outcome Indicator: Service users will be offered comprehensive attention to their transition needs even when their choices do not coincide the service provider's.

8. Cultural Sensitivity: Transitions should be managed in a culturally sensitive manner. Considering this in its broadest sense, an individual's beliefs, customs, and social context must be considered when making transitions upward (to more intensive levels of service) or downward (to less intensive levels of service).

Outcome Indicator: Cultural issues relevant to the transition of services are identified and adequately addressed in the transition plan.

9. Prevention: Discharge planning from highly structured settings to loosely structured settings should include comprehensive relapse prevention planning. Strategies to avoid re-initiating old, dysfunctional patterns of behavior should be identified, as well as available community supports and treatment programming. Financial supports should be arranged in such a manner as to avoid undue potential to misuse funds in detrimental ways.

Outcome Indicator: Factors contributing to exacerbation of illness or disability have been identified and transition plan has included attention to strategies to minimize their impact.

10. Resource Utilization: The transition/discharge plan should be designed to maximize the resources available to the client for continuing care. This includes efforts to secure benefits for which the client is eligible with the active participation of the client. Planning should foster self-reliance while recognizing that significant support may be required in the early stages of recovery.

Outcome Indicator: Resources necessary for the support of the service user in the transition environment are identified and arrangements have been completed to meet those needs.

11. Timing: Whenever possible, transitions should take place gradually, titrated according to an individual's ability to adapt to changing roles and expectations.

Outcome Indicator: Opportunities to experience transition situations partially prior to termination of referring entities involvement are available and used.

12. Designation of Responsibility: Systems should develop clear protocols delineating responsibility for care of clients in transition periods. In most cases responsibilities should incorporate redundancies between the referring and receiving entities. These concurrent responsibilities will be more likely to ensure a smooth transition and prevent some of the discontinuations commonly observed in systems that do not contain overlaps between levels of care. Reimbursement arrangements should incentivize processes that incorporate concurrent responsibilities where appropriate, for the following transition functions:

- Assuring the service user's awareness of location, time, and contact person for next scheduled treatment session.

- Assuring that the service user has access to prescribed medication and that a sufficient quantity is available to allow uninterrupted use between physician contacts.
- Assuring that the service user is aware of the person(s) to contact should there be any difficulties with either obtaining or using medication during the transition period or with any other aspects of required services.
- Assuring that the service user can identify contact persons for arranging alterations in the original discharge plan should such changes become necessary.
- Assuring that the service user is aware of the tracking plan and the process that will be initiated to re-engage him/her should unplanned alterations in the plan occur.

Outcome Indicator: Contacts during transition period are clearly identified and service user was well informed and able to use specified arrangements.

13. **Accountability:** A mechanism for monitoring outcomes of transition plans and identifying opportunities to improve the process should be in place.

- Appropriate quality indicators should be established with realistic benchmarks that can be easily measured.
- A mechanism for establishing corrective action plans for systems unable to meet those expectations should be elaborated.
- Documentation should clearly indicate that all responsibilities delineated above occur and that they do so within appropriate time frames.
- Oversight of the quality management process should include all stakeholders in the system, including persons in recovery.
- Standards established should be incorporated into contracts with Managed Care Organizations to assure proper incentives in reimbursement.

Outcome Indicator: A quality improvement process is in place and is comprehensive.

14. **Special Needs:** Recognition of the needs of special populations and their incorporation into the transition plan is an essential element of the process. Specific guidelines have been elaborated for each of the populations considered below. The following points regarding transition planning for these populations are brief summaries of some of the unique aspects of this process for these people.

Addictions:

- Confrontation of disparities between a substance user's wishes and his/her needs to maintain abstinence are critical. The distinction between engagement and enabling is frequently a fine one, and transition efforts must attempt to maximize the former while attempting to minimize the latter.
- Recognizing that co-occurring psychiatric and medical problems are expected to be present in this population, transition plans should be particularly vigilant in assuring that identified needs are met.
- Plans should emphasize fluidity in the treatment continuum and acknowledge the continuing availability of services at any required level of care should the initial transition attempt be unsuccessful. Awareness of an individual's readiness for change will guide the types of transitions that might be recommended.
- Confidentiality is given particular emphasis in this population due to the stigma associated with it. Careful consideration must be given to the transfer of information between substance use treatment providers and must be done with the full consent and knowledge of the service user.
- Family members are often involved in the dynamic that contributes to the maintenance of addictions and therefore their participation in the transition plan and continuing treatment is a critical priority whenever it is possible.
- Mutual support programs, such as the twelve steps, have traditionally been an important component of the recovery process and have played a crucial role in relapse prevention plans. Transition plans should always attempt to acknowledge and incorporate the tradition of mutual support, while emphasizing the rationale for concurrent treatment.

Geriatrics:

- Involvement of the support system is an essential aspect of care. A primary caregiver should be identified and supported to the greatest extent possible by other service providers. Early establishment of this person as one who can make decisions in cases where the service user is unable to make informed choices is essential.
- The service user's participation in transition planning will vary according to cognitive capacities, but efforts must be made to assure that the elderly person is not assumed to have limited capacity when this is not so, and that their ability to make self-determined choices are maximized by clear communication and cognitively appropriate education.
- Interface with providers of physical health care is particularly important for the elderly. It must be established early and attention to these needs must be well integrated in the transition plan.

- Assessment of needs in all spheres of function must be obtained in order to insure a comprehensive transition plan. Multi-agency cooperation and communication will often be necessary to meet multiple needs.
- Insurance status may be a significant issue for many elderly clients, particularly with regard to prescription medication, as Medicare does not currently have provisions to cover these expenses.

Forensic:

- Post release planning may be avoided altogether if efforts to divert persons with mental illness from incarceration are successful.
- Post release planning cannot occur if persons with mental illness and substance use problems are not identified and engaged in treatment during the period of their incarceration.
- Residential components of the plan will be of particular importance, particularly for those persons who are homeless. This part of the plan may well be the difference between recidivism and successful community adjustment, and liaisons with community based housing resources are essential.
- Establishment or resumption of health insurance benefits will be a critical element in the post release plan.
- Interface with probation and parole supervision is vital to reducing repetition of illegal behaviors in the future.
- Facilitation of transitions may be enhanced through opportunities for inmates to meet with community providers prior to release. This is more difficult in a highly secured setting, but developing this capacity can have significant benefits with regard to service use.

Child and Adolescent:

- Multi-agency involvement in the provision of C&A Services require mutual engagement throughout periods of treatment.
- Parental responsibility or guardianship/custody must be established as quickly as possible in the course of treatment, and those who will be responsible must be involved actively in the planning process. Extended family should be included as well, unless specifically prohibited.
- Developmental level and capabilities will determine the extent of the child's participation in the planning process, but efforts should be made to maximize their role.

- Families or other responsible parties will be responsible for engagement of the child with the receiving agencies, and it will be critical to address their concerns as well as allowing for opportunities for them to interface with community providers prior to transition.
- Integration of treatment needs and educational needs should be an important aspect of transition planning and schools and teachers must be part of the planning process.
- Transitions from adolescent to adult systems of care are particularly difficult and will require special vigilance and coordination to be successfully completed. Gradual, titrated transitions will usually be required.

Attachment F

**Comprehensive,
Continuous, Integrated
System of Care Model
by Kenneth Minkoff, M.D.**

Comprehensive, Continuous, Integrated System of Care Model

By Kenneth Minkoff, M.D.

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating individuals with co-occurring psychiatric and substance disorders (“ICOPSD”) with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.
2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high SA (Quadrant III), high MH – low SA (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High SA individuals are appropriate for receiving episodes of addiction treatment in the SA system, with varying degrees of integration of mental health capability.
3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate

intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community based reinforcers to make incremental progress within the context of continuing treatment.
5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting
6. *Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)
7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which

each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a “job”: to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in “harm” (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

Attachment G

AMHD Practice Guidelines

AMHD Practice Guidelines:

1. Employ a Recovery Perspective

- a. People with mental illness can and do overcome the barriers and obstacles that confront them.
- b. Recovery is a long term process which is self-directed by the consumer, who defines his or her life goals and designs a unique path towards these goals.
- c. The role of the worker is to facilitate and support the consumer in their recovery and encourage the consumer to participate in all decisions that would affect his or her life.

2. Consumer Engagement

- a. Engage the consumer in a warm, empathic manner.
- b. Include trained peer support, when appropriate.
- c. Partner with the consumer by attending to their strengths, needs, treatment preferences, experiences, and cultural background.

3. Cultural Competency

- a. In the building of a therapeutic alliance, recognize that culture (which includes gender, ethnicity, sexual orientation, religion, language, etc) plays a significant role in enhancing engagement. Engagement influences how comfortable consumers are with seeking help, who they seek help from, what types of help they seek, what coping styles and social supports they have. This influences how they view the problem and solutions, and how much stigma they attach to mental illness.

4. Service Provision

- a. Where available, services should be based on evidence based practices, best practices and recognized consensus panel recommendations
- b. Assessments should be timely and include a comprehensive and holistic approach.
- c. Treatment should be informed by the assessment and customized according to consumer preferences, needs, stage of change, and other factors, such as legal, spiritual, cultural, etc.
- d. Treatment is a team process. It is dynamic and constantly shifting. No one should feel solely responsible or isolated in the process. All members of the team interact and mutually collaborate in providing inter-disciplinary interventions for the benefit of the consumer.
- e. Individuals are inherently complex and multi-dimensional. Therefore treatment should be tailored to expect Co-Occurring Conditions (substance use, trauma etc). Understanding and support of influencing vital dimensions is necessary in providing effective intervention.
- f. Teams should identify and contact other providers currently or previously providing services to the consumer, and use that information to better inform the current plan.
- g. Treatment is not a linear progression (i.e., hospitalization to specialized residential to 24 hr. group home to supported housing). Rather, they are all options, which can be tailored to best “fit” the consumer’s situation.

- h. Teams should include, whenever possible, the natural supports. Strengthening the consumers family and significant others may strengthen the consumers recovery.
- i. Teams should teach, implement, and monitor (in accordance with standard fidelity measures, if applicable) evidence based practice, best practices, and/or promising practices.
- j. Teams must consider and address safety concerns throughout treatment and ensure that pre-crisis interventions are documented and in place.

5. Continuity of Care

- a. Caseworkers must ensure proper follow through and not leave it up to the consumer or the “other system”. The key for the case worker is to stay involved in the process and to provide key information such as medication updates, what worked in the past, contact information, etc.
 - i. For example, with regard to crisis, did the consumer make it to the emergency room? If so, what was the disposition? Another example could be arranging for the consumer to attend a Clubhouse interview. What would the consumer need to attend the interview? Transportation? Bus instructions? Prompting on how to ask for services, etc.
- b. In referring to other programs, the caseworker must continue active involvement and function as an integral part of the team.
- c. Workers should obtain support and consultation whenever needed (who to ask? how to contact? who serves as back up? etc)

6. Documentation

- a. Documentation must be recovery focused by using person first language and avoiding generalizations that are judgmental (e.g., “non-compliant”, “resistant”). This language style tends to reinforce beliefs that the consumer needs to do what we want them to do rather than viewing ourselves as partners.
- b. Use descriptions that focus on conveying clinically useful information. For example, instead of the term “medication non-compliance”, consider descriptions such as, “Consumer often forgets to take their medication”, “Consumer does not use the medication because of uncomfortable side-effects”, etc.
- c. Documentation effectiveness can be enhanced when stages and stage appropriate interventions are utilized. (e.g. “Individual is pre-contemplative in acceptance of illness, however is in action stage in taking their meds. Therefore will work on increasing their understanding of the medications and proper administration.” In this case, they don’t necessarily have to accept that they have a mental illness to effectively take their medications.

7. Crisis

- a. The goal of crisis intervention is to decrease self-harm or dangerousness and movement toward self-regulation.
- b. The QMHP should be actively involved throughout the process by, a) being consulted during and at the resolution of the situation; b) reviewing and

- approving the outcomes of the interventions; and c) ensuring appropriate debriefing to improve the process and support those involved.
- c. Documentation of consultations are an effective way of establishing community standards of practice and mediating risk.
 - d. Documentation should include the nature of the crisis (e.g. crisis antecedents), the assessment of the risks, interventions used, and the rationale for final disposition (e.g., “Hospitalization was considered, however the consumer included his family in the intervention of which the family agreed to provide 24 hour supervision and will call Dr. K for assistance, if needed”).
 - e. The caseworker should ensure proper follow-up, which is documented and including in the consumers record (e.g., where is the consumer now? What can we do the next time to prevent a crisis? What can the consumer do?).

8. Co-Occurring Disorders

- a. Dual diagnosis is an expectation, not an exception
- b. All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.
- c. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.
- d. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting
- e. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended
- f. Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change
- g. There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.
- h. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.

9. Supervision

- a. Clinical supervision teams should routinely review cases.
- b. In addition to “as needed supervision”, caseworkers should have access to timely, routine supervision, and opportunities for continued skill development.

- c. Supervisors should establish agreed upon competencies with each supervisee and routinely document supervision outcomes as part of the quality improvement process.

10. Psychopharmacology

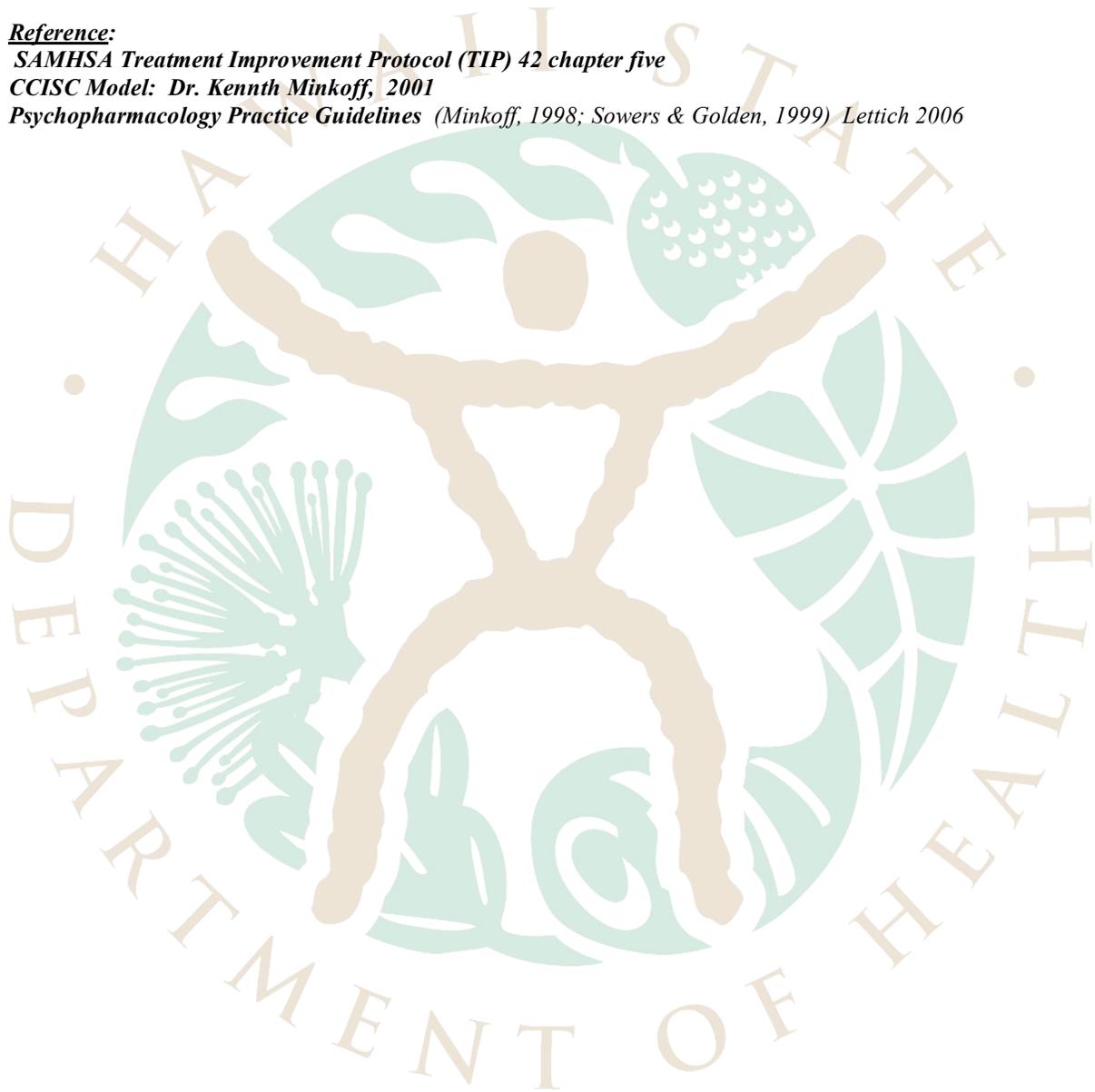
Prescribing clinicians will adhere to the most recent version of the MISA Psychopharmacology Guidelines. (see attached)

Reference:

SAMHSA Treatment Improvement Protocol (TIP) 42 chapter five

CCISC Model: Dr. Kenneth Minkoff, 2001

Psychopharmacology Practice Guidelines (Minkoff, 1998; Sowers & Golden, 1999) Lettich 2006



Attachment H

AMHD Mission, Vision, Values and Guiding Principles

Adult Mental Health Division

Mission, Vision, Core Values, Guiding Principles

Mission

We provide a comprehensive, integrated mental health system supporting the recovery of adults with severe mental illness.

Vision

Everyone has access to effective treatment and supports essential for living, working, learning and participating fully in the community.

Core Values

Commitment:

We value and are dedicated to providing the public's mental health services.

Integrity:

We expect honesty, professionalism, and ethics in our work environment.

Collaboration:

We value teamwork and endeavor to build partnerships, consumer and community participation to attain our goals.

Diversity:

We celebrate diversity and treat all people with fairness, respect, and compassion.

Excellence:

We strive to ensure high quality and effective use of our resources.

Wisdom:

We learn from each other and acknowledge that there are many ways of knowing.

Innovation:

We seek to explore new and creative ideas.

Accountability:

We are committed to personal responsibility for our actions and for achieving our planned outcomes.

Guiding Principles

1. The following guiding principles apply to persons with SPMI who also have:
 - Co-occurring medical conditions
 - Substance use disorders
 - Homelessness
 - Mental retardation
 - Involuntary civil or penal commitment status.
2. Informed Self Directed Recovery is the foundation on which all mental health services are provided.
3. All mental health services are based on the individual's needs, strengths and desires.
4. Empathic and hope instilling relationships are an essential component of all services.
5. The major goal of services is a safe and decent place to live, meaningful relationships and activities.

6. Consumers are an integral component of the service system design throughout AMHD.
7. Everyone is mindful, respectfully inquires, and makes adjustments to behave in a culturally informed, sensitive and responsive manner.
8. Services are provided that is in the least restrictive, most integrated community settings, which are warm, welcoming, and respectful of consumers.
9. Service standards are based on professional, national standards and Evidence Based Practices.
10. Significant others are involved and supported to maintain relationships that are critical for healthy community living.

Attachment I

DEFINITION AND ROLE OF THE QMHP

Definition and Role of the Qualified Mental Health Professional

The requirements established below are **minimum requirements** that the Department of Health Adult Mental Health Division (“AMHD”) has set for this position. Individual services may have additional academic or experience requirements depending on the intensity of the service. Any additional service specific requirements beyond these minimum requirements will be stated in the Request for Proposal and/or in the contract.

Definition / Role and Activities:

The Qualified Mental Health Professional (“QMHP”) in the AMHD service delivery system is the individual generally responsible for clinical oversight and development of the service. A QMHP may provide a wide range of service and support including, but not limited to the following:

- Oversees the development of each consumer’s treatment plan to ensure it meets the requirements stated of applicable funding streams and sign each treatment plan.
- Serves as a consultant to the treatment team.
- Serves as the LOCUS expert.
- Provides oversight and training.
- Reviews and signs each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.
- Provides clinical supervision.
- Provides therapy.
- Provides clinical consultation and training to team leaders and/or direct care providers as needed.

Additionally, for Specialized Treatment Programs such as Intensive Out-Patient Hospital and Specialized Residential Services, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

QMHP Minimum Requirements:

A QMHP is required to have an advanced degree and is licensed to practice in Hawaii as a:

- Licensed Psychiatrist,
- Licensed Psychologist (Ph.D. or Psy.D.),
- Licensed Clinical Social Worker (“LCSW”),
- Licensed Marriage and Family Therapist (“LMFT”), or
- Licensed Advanced Practice Registered Nurse (“APRN” or “APRN-Rx”) in behavioral health currently licensed in the State of Hawaii.

Attachment J

Mental Health Worker

Definition and Role of the Mental Health Worker

The requirements established below are **minimum requirements** that the Department of Health Adult Mental Health Division (“AMHD”) has set for this position. Individual services may have additional academic or experience requirements depending on the intensity of the service. Any additional service specific requirements beyond these minimum requirements will be stated in the Request for Proposal and/or in the contract.

Definition / Role and Activities:

The Mental Health Worker (“MHW”) in the AMHD service delivery system is an individual who routinely provides much of the front-line consumer-focused work within the community-based mental health system. A MHW may provide a range of clinical and supportive services under the supervision of a Mental Health Professional (“MHP”) or Qualified Mental Health Professional (“QMHP”). Services or interventions provided by the MHW include, but are not limited to, the following:

- Provide specialized services in conjunction with other professionals such as case management, crisis intervention, skill-building activities, and group and/or individual psycho-education.
- Coordinate services with ancillary treatment providers.
- Make referrals to additional services and supports when indicated on the consumer’s Recovery Plan.
- Assist with the development of the Recovery Plan, Crisis Plan or Wellness Recovery Action Plan.
- Monitor, evaluate and document consumer progress.
- Provide supportive counseling.
- Provide screening and gather clinical information for intake or other assessment.
- Participate in the update of recovery plans.

MHW Minimum Requirements:

A MHW is required to have a Bachelors degree from a nationally accredited college or university in one or more of the following fields:

- Social Work,
- Nursing,
- Counseling,
- Psychology,
- Psychosocial Rehabilitation,
- Sociology,
- Human Development,
- Other closely related fields, as approved in writing by the AMHD Chief or

designee, providing the individual has completed:

- 12 credit hours of post high school coursework in the areas of psychology, counseling, social work or other areas of human development, and
- 1 year of experience providing direct services to individuals with mental illness or other behavioral health issues.

Individuals may also qualify as a MHW by having one (1) or more of the following credentials:

- A Certified Psychiatric Rehabilitation Practitioner (“CPRP”)
- A Certified Substance Abuse Counselor (“CSAC”) in the state of Hawai’i providing the individual has completed:
 - 12 credit hours of post high school coursework in the areas of psychology, counseling, social work or other areas of human development, and
 - 1 year of experience working with individuals with mental illness or other behavioral health issues
- A Certified Peer Specialist in the state of Hawai’i (“HCPS”) who possesses a High School Degree or High School Equivalency and, providing the individual has completed:
 - 12 credit hours of post high school coursework in the areas of psychology, counseling, social work or other areas of human development, and
 - 1 year of experience working with individuals with mental illness or other behavioral health issues
- A Registered Nurse (“RN”) with less than a Bachelor’s Degree providing the individual has completed:
 - 12 credit hours of post high school coursework in the areas of psychology, counseling, social work or other areas of human development, and
 - 1 year of experience working with individuals with mental illness or other behavioral health issues
- A Licensed Practical Nurse (“LPN”) providing the individual has completed:
 - 12 credit hours of post high school coursework in the areas of psychology, counseling, social work or other areas of human development, and
 - 1 year of experience working with individuals with mental illness or other behavioral health issues.

All post high school coursework must have been completed at, and the degree issued by a nationally-accredited institution. For degrees issued outside of the United States, the issuing institution must meet similar accrediting standards or be recognized within the United States as having equal standing.

Definition of Experience

Social Service experience may include identification and evaluation of the consumer’s problems and needs, the development of a service or treatment plan, the initiation and implementation of the treatment plan, monitoring of services and evaluation/assessment of the consumer’s progress. It may be in areas such as human services, social welfare,

human services worker and/or criminal justice. Applicable experience will be included regardless if it was paid or unpaid experience.

Supervision

Clinical supervision of the MHW shall be provided by a QMHP, or an MHP under the supervision of a QMHP. A MHP may provide the supervision for programs that do not require a QMHP. The frequency and content of supervision should follow accreditation, certification and professional standards and shall be for a minimum of one (1) hour of supervision for each 160 hours worked. A team meeting which focuses on administrative detail and general case consultation does not meet the standard for clinical supervision.

Clinical Supervision should minimally include the following components:

- Is guided by a supervisory plan which identifies the skills, knowledge and attitudes that are the focus for development.
- Establishes a learning alliance between the supervisor and supervisee in which the supervisee learns therapeutic skills while developing self awareness at the same time.
- Enhances the professional skills, knowledge, and attitudes necessary to achieving competency in providing quality consumer care.
- Be different from staff development and in service training.
- Meets requirements for licensing bodies and third party payers.
- Consists of regularly scheduled face-to-face individual meetings.
- Content focus, feedback and evaluation is based on direct observation of work performance.
- Preplanning and preparation are necessary.
- Supervisee is engaged in a critical analysis of the work s/he did and is planning to do.

Attachment K

Bilingual Assistant

Definition and Role of the Bilingual Assistant

The requirements established below are **minimum requirements** that the Department of Health Adult Mental Health Division (“AMHD”) has set for this position. Individual services may have additional academic or experience requirements depending on the intensity of the service. Any additional service specific requirements beyond these minimum requirements will be stated in the Request for Proposal and/or in the contract.

Definition / Role and Activities:

The Bilingual Assistant in the AMHD service delivery system primarily provides support to consumers. Tasks may include, but are not limited to, the following:

- Provide specialized services in conjunction with other professionals.
- Coordinate services.
- Make referrals.
- Provide ongoing support.
- Provide screening, and gather clinical information.
- Provide input into the recovery plans.

Bilingual Assistant Minimum Requirements:

A Bilingual Assistant is required to possess a high school diploma, or high school equivalency, AND

- have 12 credit hours of post high school coursework in the areas of psychology, counseling, social work or other areas of human development;
- 1 year of experience providing direct services to individuals with mental illness or other behavioral health issues;
- be a Certified Substance Abuse Counselor (“CSAC”);
- be a Certified Peer Specialist in the state of Hawaii (“HCPS”).

Definition of Experience:

Social Service experience may include identification and evaluation of the consumer’s problems and needs, the development of a service or treatment plan, the initiation and implementation of the treatment plan, monitoring of services, and evaluation/assessment of the consumer’s progress. Example may be in areas such as human services, social welfare, human services worker, and/or criminal justice. Applicable experience will be included regardless if it was paid or unpaid experience.

Supervision:

Supervision for the Bilingual Assistant shall be provided by a Mental Health Professional (“MHP”) under the supervision of a Qualified Mental Health Professional (“QMHP”) or by a QMHP. The MHP may provide the supervision for programs that do not require a QMHP. The frequency and content of supervision should follow accreditation, certification, and professional standards and shall be for a minimum one (1) hour for each

eighty (80) hours of work. A team meeting which focuses on administrative and general case consultation does not meet the standard for clinical supervision.

Clinical Supervision should minimally possess the following components:

- Is guided by a supervisory plan which identifies the skills, knowledge and attitudes that are the focus for development.
- Establishes a learning alliance between the supervisor and supervisee in which the supervisee learns therapeutic skills while developing self awareness at the same time.
- Enhances the professional skills, knowledge, and attitudes necessary to achieving competency in providing quality consumer care.
- Be different from staff development and in service training.
- Meets requirements for licensing bodies and third party payers.
- Consists of regularly scheduled face-to-face individual meetings.
- Content focus, feedback and evaluation is based on direct observation of work performance.
- Preplanning and preparation are necessary.
- Supervisee is engaged in a critical analysis of the work s/he did and is planning to do.

Attachment L

Mental Health Professional

Definition and Role of the Mental Health Professional

The requirements established below are **minimum requirements** that the Department of Health Adult Mental Health Division (“AMHD”) has set for this position. Individual services may have additional academic or experience requirements depending on the intensity of the service. Any additional service specific requirements beyond these minimum requirements will be stated in the Request for Proposal and/or in the contract.

Definition / Role and Activities:

The Mental Health Professional (“MHP”) in the AMHD service delivery system provides a wide-array of clinically-oriented services under the supervision of a Qualified Mental Health Professional (“QMHP”), which may include, but are not limited to, the following:

- Function as a Team Leader and supervise and direct the work of Mental Health Worker and/or Mental Health Assistant staff;
- Provide direct intervention within their scope of practice, including case management, crisis intervention, counseling, individual or group psycho-education, or other interventions which do not include or meet the definition of therapy;
- Provide intake assessment and recovery plan development;
- Attend and contribute to recovery planning or recovery plan review meetings with ancillary treatment providers on behalf of the treatment team; and
- Serve as the AMHD Utilization Management Liaison.

MHP Minimum Requirements:

The MHP is required to be professionally prepared and experienced with an advanced degree and/or licensure. Degrees and license includes the following categories:

- Licensed Social Worker (“LSW”),
- Master of Science in Nursing (“MSN”),
- Advanced Practice Registered Nurse (“APRN”) whose specialty is in a non-behavioral health field,
- Master’s degree with a major in one of the following areas:
 - a) Counseling,
 - b) Psychology,
 - c) Psychosocial Rehabilitation,
 - d) Sociology,
 - e) Human Development,
 - f) Other closely-related fields, as approved in writing, by the AMHD Chief or designee.

All graduate degree work must be completed at and the degree issued by a nationally-accredited academic institution. For degrees issued outside of the United States, the issuing institution must meet similar accrediting standards or be recognized within the United States as having equal standing.

Definition of Experience:

Social Service experience may include identification and evaluation of the consumer's problems and needs, the development of a service or treatment plan, the initiation and implementation of the treatment plan, monitoring of services, and evaluation/assessment of the consumer's progress. Example may be in areas such as human services, social welfare, human services worker and criminal justice. Applicable experience will be included regardless if it was paid or unpaid experience.

Supervision:

Clinical supervision of the MHP shall be provided by a QMHP. The frequency and content of supervision should follow accreditation, certification and professional standards and shall be for a minimum one (1) hour of supervision for each 160 hours of work.

Clinical Supervision should minimally include the following components:

- Is guided by a supervisory plan which identifies the skills, knowledge and attitudes that are the focus for development.
- Establishes a learning alliance between the supervisor and supervisee in which the supervisee learns therapeutic skills while developing self awareness at the same time.
- Enhances the professional skills, knowledge, and attitudes necessary to achieving competency in providing quality consumer care.
- Be different from staff development and in-service training.
- Meets requirements for licensing bodies and third party payers.
- Consists of regularly scheduled face-to-face individual meetings.
- Content focus, feedback and evaluation is based on direct observation of work performance.
- Preplanning and preparation are necessary.
- Supervisee is engaged in a critical analysis of the work s/he did and is planning to do.

Attachment M

Certifications

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE	
APPLICANT ORGANIZATION		DATE SUBMITTED

Attachment N

Form SPO-H-205A

Instructions

**Instructions for Completing
FORM SPO-H-205A ORGANIZATION - WIDE BUDGET BY
SOURCE OF FUNDS**

Applicant/Provider:	Enter the Applicant's legal name.
RFP#:	Enter the Request For Proposal (RFP) identifying number of this service activity.
For all columns (a) thru (d)	<p>Report your total organization-wide budget for this fiscal year by source of funds. Your organization's budget should reflect the total budget of the "organization" legally named. Report each source of fund in separate columns, by budget line item.</p> <p>For the first column on the first page of this form, use the column heading, "Organization Total".</p> <p>For the remaining columns you may use column headings such as: Federal, State, Funds Raised, Program Income, etc. If additional columns are needed, use additional copies of this form.</p>
Columns (b), (c) & (d)	Identify sources of funding in space provided for column titles.
TOTAL (A+B+C+D)	Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d).
SOURCE OF FUNDING: (a) (b) (c) (d)	Identify all sources of funding to be used by your organization.
TOTAL REVENUE	Enter the sum of all revenue sources cited above.
Budget Prepared by:	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

Special Instructions by the State Purchasing Agency: