

State of Hawaii  
Department of Health  
Adult Mental Health Division

## **Addendum 1**

**June 14, 2010**

**To**

**Request for Proposals**

**RFP No. HTH 420-7-10**

**Bilingual Support Services on the island of  
Oahu**

**Proposal Deadline**

**June 24, 2010**

June 14, 2010

**ADDENDUM NO. 1**

To

**REQUEST FOR PROPOSALS  
Crisis Services - Statewide  
RFP No. HTH 420-6-10**

The Department of Health, Adult Mental Health Division is issuing this addendum to RFP No. 420-6-10, Crisis Services - Statewide for the purposes of:

- Responding to questions that arose at the orientation meeting of February 10, 2010 and written questions subsequently submitted in accordance with Section 1-V, of the RFP.
- Amending the RFP.
- Final Revised Proposals

The proposal submittal deadline:

- is amended to <new date>.
- is not amended.
- for Final Revised Proposals is <date>.

Attached is (are):

- A summary of the questions raised and responses for purposes of clarification of the RFP requirements.
- Amendments to the RFP.
- Details of the request for final revised proposals.

If you have any questions, contact:

Ms. Betty Uyema  
Telephone: (808) 586-8287  
Facsimile: (808) 586-4745  
1256 Punchbowl Street

Responses to Question Raised by Applicants  
For RFP No. HTH 420-7-10, Bilingual Support Services on the island of Oahu

- 1. Question:**  
On page 2-12. Is hire non-owned automobile insurance policy, an insurance rider to the agency's automobile insurance?

**Answer:**  
Please check with your insurance company or agent if the required insurance is a rider to the agency's automobile insurance.
- 2. Question:**  
Is it acceptable to build partnerships/collaborate with faith-based churches, since some of the cultures have strong ties to them?

**Answer:**  
Yes.
- 3. Question:**  
On page 2-15, item 12, is it permissible to include costs for marketing community presentations/events that target underserved populations? Does the marketing plan need to be established or can it be projected?

**Answer:**  
An applicant is required to identify underserved groups of people and provide outreach and engagement services. If marketing is one aspect that is utilized to target the underserved groups, then it would be acceptable to include the costs in the proposal, however costs should be justified. The marketing plan may be established or projected.
- 4. Question:**  
Does this proposal have a minimum score in order for a contract to be awarded?

**Answer:**  
No. There is no minimum score. However, should all the proposals not meet criteria, no award shall be issued.
- 5. Question:**  
On page 2-13, Multi-term contracts. What happens if the scope changes, does the contract end?

**Answer:**  
If there is a significant change in the contract scope, a new RFP will be released.

- 6. Question:**  
On page 3-11, Item 6. “The applicant’s incorporation of best-practices or evidence-based practices within their services array and their plans to implement the proposed services utilizing best- or evidence-based practices.” Can we reference emerging and promising practices?

**Answer:**

Yes. There are many “emerging” and “promising” best- or evidence based practices, so it is acceptable for this RFP. It is imperative to indicate in the proposal how applicant will implement the proposed services utilizing the “emerging” practices.

- 7. Question:**  
What happens if staff has clinical training in their native country? Is it transferable?

**Answer:**

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.

- 8. Question:**  
On page 2-18. Does the billing clerk, administrative assistant etc. need to be included in the organization-wide chart?

**Answer:**

No. However, the billing clerk and administrative assistant positions should be reflected in the program-specific organization chart.

- 9. Question:**  
On page 2-2. Is the funding set at \$300,000? What happens if the proposal submitted is more than \$300,000?

**Answer:**

The DIVISION projected budget is \$300,000 for bilingual services. All proposals should be submitted with a justification.

- 10. Question:**  
Are the attachments also a part of the sequential page number of the full proposal?

**Answer:**

Please refer to page 3-1. The main text of the proposal shall not be more than 50 pages, with the attachments limited to 200 pages. The entire proposal should not exceed 250 pages.

**11. Question:**  
On page 2-16, item 13. Does the FTE staffing reference all line, management or clinical staff?

**Answer:**  
The staffing pertains to direct care staff providing the Bilingual Support Services as described in the RFP

**12. Question:**  
Is the effective date of the new UM criteria effective immediately?

**Answer:**  
No. The UM criteria (draft) is anticipated to start with the new contract

**13. Question:**  
Can we use charts in the proposal?

**Answer:**  
Yes. Charts are acceptable.

**14. Question:**  
Can we attach memorandums of agreements from youth programs or does it need to be adult programs only?

**Answer:**  
Youth programs are also acceptable.

**15. Question:**  
Do we need to attach the Hawaii Compliance Express with the proposal?

**Answer:**  
No, but the tax clearance and certificate of insurance will need to be submitted upon contract award.

**16. Question:**  
If part of the service is on the outreach component, is it acceptable to assist an individual to get into the system?

**Answer:**  
Yes.

RFP No. HTH 420-7-10, Bilingual Support Services on the island of Oahu is amended as follows:

<i>Subsection</i>	<i>Page</i>	
<b>Section 1, Administrative Overview</b>		
No Changes		
<b>Section 2, Service Specifications</b>		
III. Scope of Work,		
A. Service		
Activities, A.4	2-14	The following sentence has been revised to read as follows:  “4. Ensure that each Consumer meets the criteria for bilingual support services as defined by the most current DIVISION Utilization Management criteria (draft), as defined in Section 5, Attachment D.”
	2-16	The following sentence has been added to Item 15 to read as follows:  “Services are also to be consistent with AMHD Policy and Procedure Number 60.645,Cultural Competency, provided in Section 5, Attachment O.”
<b>Section 3, Proposal Application Instructions</b>		
No Changes		
<b>Section 4, Proposal Evaluation</b>		
No Changes		
<b>Section 5, Attachments</b>		
Attachment D		Attachment D, Bilingual Support Services Criteria changed to <i>draft</i> format.
Attachment O		Attachment O, AMHD Policy and Procedure Number 60.645, Cultural Competency.

**Attachment D**  
**Bilingual Support Services**  
**Utilization Criteria**  
**(Draft)**

# **Attachment O**

**AMHD Policy and Procedure  
No. 60.645,  
Cultural Competency**

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Cultural Competency

REFERENCE: Treatment/Recovery Planning P&P 60.604; Interpreter P&P; National Standards on Culturally and Linguistically Appropriate Services (CLAS); E.T.H.N.I.C: A Framework for Culturally Competent Clinical Practice

Number: 60.645

Effective Date: 06/03/05

History: Rev. 04/14/10

Page: 1 of 3

APPROVED:



Title: Acting Chief, AMHD

### PURPOSE

To ensure that the Adult Mental Health Division (AMHD) provides culturally competent services that are responsive to the cultural diversity of consumers.

### RESPONSIBILITY STATEMENT

The Multicultural Services Director or designee is responsible for revisions and updates to this policy and procedure.

### POLICY

The AMHD ensures that services are culturally sensitive and responsive to consumer diversity such as: racial, ethnic, cultural histories, traditions, beliefs, values, sexual orientation and language (see attachment A, CLAS Standards).

### DEFINITIONS

**Cultural competency** is a set of congruent policies, behaviors, and attitudes embedded within the AMHD, provider agencies, and mental health practitioners which results in appropriate and effective services for consumers.

**Cultural** refers to integrated patterns of human customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

## ADULT MENTAL HEALTH DIVISION

**Competence** implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities

### PROCEDURE

1. As part of the assessment, diagnosis, and recovery planning process, the following shall be considered:
  - a. **Assessment:** The assessment, diagnosis, and recovery planning shall be responsive, respectful, and inclusive to the consumer's diversity in areas including, but not limited to, racial, and ethnic cultural traditions, beliefs, values, and primary language. As part of the assessment, diagnosis, and recovery planning (e.g., during the intake process, or specific service areas such as Forensics), the following should be considered:
    - 1) a systematic review of the consumer's cultural background to determine which “cultural” elements are most relevant in their current situation (e.g., ethnicity, religion, language, gender, sexual orientation, age, and/or geographic location).
    - 2) the role of the cultural context in the expression and evaluation of symptoms; (see Attachment B on the E.T.H.N.I.C model);
    - 3) the effect that cultural-related differences may have on the relationship between the consumer and the clinician; and,
    - 4) a formulation on how cultural considerations specifically influence diagnosis and treatment.
  - b. **Recovery Planning:** To ensure culturally-informed and appropriate services, the treatment team shall consider the consumer's preference for therapeutic linkages with traditional healers, religious and spiritual resources, alternative or complementary healing practices, natural supports, bilingual services, self-help groups, and consultation from culturally and linguistically competent independent practitioners, except when clinically or culturally contraindicated.
  - c. **Data Collection:** As consumers enter the system, AMHD shall ensure that data on race, age, ethnicity, and primary language are collected in health records and integrated in the electronic medical record.

**ADULT MENTAL HEALTH DIVISION**

**POLICY AND PROCEDURE MANUAL**

**Number: 60.645**

AMHD Administration

Page: 3 of 3

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2. Personnel Development: All AMHD personnel, including State Operated Community Mental Health Centers (CMHC), and the Hawaii State Hospital (HSH), shall participate in cultural competency training per standards of accreditation bodies (such as the Commission on Accreditation of Rehabilitation Facilities – CARF).

**ATTACHMENT**

1. Attachment A – National Standards on Culturally and Linguistically Appropriate Services (CLAS).
2. Attachment B – E.T.H.N.I.C: A Framework for Culturally Competent Clinical Practice.

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

Initials: [        ] [        ] [        ] [        ]

## ATTACHMENT A

### **National Standards on Culturally and Linguistically Appropriate Services (CLAS)**

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS **guidelines** are activities recommended by the U.S. Department of Health and Human Services' Office of Minority Health (OMH) for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

#### **Standard 1**

Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

#### **Standard 2**

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

#### **Standard 3**

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

#### **Standard 4**

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

#### **Standard 5**

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

**Standard 6**

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

**Standard 7**

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

**Standard 8**

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

**Standard 9**

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

**Standard 10**

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

**Standard 11**

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

**Standard 12**

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

**Standard 13**

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

**Standard 14**

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Source: Office of Minority Health; Toll Free: 1-800-444-6472 / Fax: 301-251-2160; Email: [info@omhrc.gov](mailto:info@omhrc.gov).

**E.T.H.N.I.C: A Framework for Culturally Competent Clinical Practice**

Empirical evidence suggests that consumers are most satisfied with therapy and medical care when their psychiatrist or physician shares their model of understanding health, distress, and treatment.<sup>1</sup> Given the support for a person-centered approach, the University of Michigan Health System's Program for Multicultural Health developed the E.T.H.N.I.C framework which is a mnemonic interviewing protocol aimed at eliciting the health views of diverse consumers. The E.T.H.N.I.C (Explain, Treatment, Healers, Negotiate, Intervention, and Collaborate) framework is a type of relationship centered interviewing that has shown positive results with culturally diverse consumers.<sup>2</sup> The E.T.H.N.I.C framework has the same components as the evidenced-based Relationship Centered Interviewing approach (e.g., engagement, empathy, education and enlistment)<sup>3</sup> but also engages the consumer in a dialogue on cultural healing practices they would like to integrate into their recovery, which is a foundation principle in increasing buy-in.

**Explanation:** What do you think may be the reason you have these symptoms? What do friends, family, others say about these symptoms? Do you know anyone else who has had or who has this kind of problem?

**Treatment:** What kinds of medicines, home remedies, or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Please tell me about it. What kind of treatment are you seeking from me?

**Healers:** Have you sought any advice from alternative/folk healers, friends, or other people (non-doctors) for help with your problems? Tell me about it.

**Negotiate:** Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate, your patient's beliefs.

**Intervention:** Determine an intervention with your patient. This may include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general, and when sick).

**Collaboration:** Collaborate with the patient, family members, other health care team members, healers, and community resources.

**Sources:**

1. Callan, A. & Littlewood, R. (1998) Patient satisfaction: ethnic origin or explanatory model? *International Journal of Social Psychiatry*, 44, 1-11.
2. Steven J. Levin, Robert C. Like, & Jan E. Gottlieb. 1997. MPH Center for Healthy Families and Cultural Diversity Department of Family Medicine UMDNJ-Robert Wood Johnson Medical School.
3. NASMHPD, 2006