

## **REQUEST FOR PROPOSALS (RFP)**

### **DRUG & ALCOHOL RECOVERY SPECIALIST SERVICES**

**December 15, 2011**

#### **I. INTRODUCTION**

As part of the Capital Area Behavioral Health Collaborative's (CABHC) support to its member counties (Cumberland, Dauphin, Lancaster, Lebanon and Perry) and in partnership with its Managed Behavioral Health Care Organization (BHMCO), Community Behavioral HealthCare Network of PA (CBHNP), we are pleased to announce that through its approved 2009-10 reinvestment plan, the development of an innovative Drug & Alcohol Recovery Specialist Services (Program) is being pursued through this Request for Proposal. Funding has been designated for start-up and operational costs for this project, as further presented in the proposal guidelines. It is fully expected that continued funding of this Program will occur as a result of the 2010-11 reinvestment plan. We also anticipate that the Program will demonstrate cost and outcome efficacy, resulting in the designation of the service as a Medicaid eligible supplemental service for our Counties.

Recently, the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration issued a Request for Applications (RFA) for Peer-to-Peer Support Services. This grant project is part of SAMHSA's Center for Substance Abuse Services (CSAT) and has identified that the key focus of this grant is to foster peer-to-peer recovery support services that are designed and delivered by persons in recovery which will network and build strong and mutually supportive relationships with formal systems in their communities. One of the recognized services listed in the RFA is Peer-to-Peer Recovery Support Services, which is designed and delivered by peers to assist others in or seeking recovery to initiate and/or sustain recovery from alcohol and drug use disorders and closely related consequences.

Similar to this model development by SAMHSA, the Bureau of Drug and Alcohol Programs' (BDAP) Treatment Manual regarding Recovery Oriented Systems of Care (ROSC) clearly identifies the importance of moving from an acute care model to a recovery management model. ROSC focuses on becoming responsive to meet the needs of individuals and families using a self directed and person centered approach to care. Part of this commitment to peer recovery support services is to develop opportunities for ongoing participation of peers in the planning, implementation, and delivery of peer support services throughout the full continuum of care. Both the Federal and State positions on the importance of the development of a D&A recovery model that supports peer-to-peer service development demonstrate the support of our reinvestment program to implement a D&A Recovery Specialist service in our Counties.

Services provided by the D&A Recovery Specialists will be non-clinical in nature and will focus more on life and recovery skills development that are vital to the success of an individual's sustained recovery from their addiction. Services are not "given" to an

individual, but rather supports are identified and recovery plans are developed by the member with the assistance and support of the D&A Recovery Specialist. These include but are not limited to recovery education, identification and engagement with community resources that encourage recovery, support systems to remain engaged in formal treatment, and identification and access to stable housing and employment as a cornerstone to assist in an individual's recovery. The D&A Specialist is expected to function as a role model, provide encouragement, and guidance as the person navigates the system to access these supports. This also includes communicating what can be achieved as part of a person's recovery, and "checking in" as an engaged and caring support for the person. Each individual's personal recovery plan will be goal oriented and self directed. Services will primarily be delivered on an individual basis, with supporting family and significant others actively involved as identified by the individual. Group activities will be allowed, but cannot be based on convenience or economy of size but rather must be related to mutual objectives in the person's recovery plan. Services will primarily be delivered face-to-face in the community. Phone contact will be allowed, but is not to exceed 25% of units delivered.

There will be no cap for length of participation, as this will be determined by the individual's recovery and the development of natural supports. This will be monitored to assess the efficacy and desired design of the program, paying close attention to the potential of co-dependency with the person's D&A Recovery Specialist.

This Program is looking to develop a capacity for four (4) FTE D&A Recovery Specialists and one supervisor with assignment of staff to specific county geographic areas in our five County collaborative. Proposers may choose to employ D&A Recovery Specialists on a full-time and/or part-time basis.

Services are targeted for adults (18 years of age or older) who are experiencing a substance abuse disorder. The majority of persons will be enrolled in the Medicaid HealthChoices program, but understanding that this population is less stable in their MA and may occasionally lose their eligibility, some persons served will not be on Medicaid. The adults served will be individuals who have cycled in and out of D&A services and have demonstrated difficulty in engaging in their recovery through traditional treatment and supports. The target population may also include support for persons as a step down from inpatient treatment.

The selected provider, along with the D&A Reinvestment Work group, will also collaborate to develop outcome measures. Potential areas of measure may include employment, housing stability, family/significant other engagement, involvement in the criminal justice system, community integration, and an overall wellness focused life style. Historical and current measure will be taken at the time of enrollment into the program to establish a baseline of the identified outcome measures. Designated periods of monitoring will be established and reports will be submitted to CABHC. A 6 month and annual report will be developed and presented to the CABHC D&A Reinvestment Workgroup for review.

**No pre-proposal conference will be held.** If your agency is planning on submitting a proposal, it is required that you submit a letter of intent to respond to this RFP. Your letter of intent must be received by CABHC no later than close of business (4:30 PM) on January 5, 2012. Questions may also be emailed to LeeAnn Edelman at [ledelman@cabhc.org](mailto:ledelman@cabhc.org). Questions regarding the RFP will be accepted until January 12, 2012. Formal responses to all accepted questions will be provided to those agencies who submit a Letter of Intent.

Providers submitting a proposal may be asked to meet with the PSC to discuss the details of their proposal and to provide an oral presentation. The PSC reserves the right to request clarification or the submission of additional written material to the PSC prior to the final selection being made.

CABHC reserves the right to reject any and all proposals, and can adjust the time line as deemed necessary by the PSC or CABHC's Board of Directors. CABHC reserves the right to withdraw the RFP for any reason. No reimbursement will be provided to any agency for the cost of submitting their proposal.

CABHC will negotiate with the selected agency the final terms of the agreement, to include any needed changes to the proposal to assure that the Program complies with the approved reinvestment plan description and objectives of the project

## **II. PROPOSAL**

Please respond to the RFP using the format below, numbering each corresponding section as indicated below. The total proposal should **not exceed twelve (12) single sided pages**, excluding the organizational charts and budget forms, using single spacing, Times New Roman 12 pt. font.

**Due Date:** Ten (10) copies of your proposal must be received in the CABHC office no later than 4:30 PM on February 2, 2012. A single CD must also be included that contains all of the information presented in your hard copy proposal. Should there be any discrepancy between the information on the CD and the hard copy, the information provided on the hard copy is what will be accepted.

### **1. Identifying Information**

- A. Provide the name, mailing address, telephone number, fax number, and e-mail address of the designated contact person.
- B. Identify the person who is writing the RFP, the Executive Director of the requesting organization and your designated point of contact for this proposal.
- C. Identify all sites your agency has within the five (5) counties.
- D. Attach an organizational chart of the current structure and indicate where this Program would fit within that organizational structure if awarded the contract.

### **2. Agency Qualifications Provide your Mission Statement and brief history of your**

organization. Include the type of services you currently provide in the drug and alcohol field and MH field and how long your agency has provided these services. Identify any licenses your agency possesses. Describe your agency's experience in working with the Medicaid population and please also include a description illustrating your organization's understanding and application of Recovery principles.

3. **Program Description** This section is the most important component of your proposal. Please be sure to incorporate the philosophy and best practices of recovery when responding to the following in detail:
  - A. Describe how your agency would implement the provision of services in each of the five (5) counties. Please identify if this would include setting up an office, either a new one or making use of an existing office. If it would be a shared office space, please be clear on how this program will maintain its identity while benefiting from this shared space.
  - B. Describe how the service will be run. The intention of D&A Recovery Specialists should be to provide individually focused assistance at a peer level to persons who are struggling with their recovery, particularly by providing help to navigate the various systems, providing encouragement and guidance through communicating their own recovery process, and helping to explore supports that are available to assist in recovery. Please provide additional information on your staffing schedule, to include your anticipated breakdown of time spent working with clients in the community, working with clients in the office and non-client administrative time. It is understood that this will vary based on the needs of each person, but it is important to get a sense of how the program views its interaction with persons and how this will be prioritized with the D&A Recovery Specialists.
  - C. Provide marketing and outreach strategies for obtaining referrals. This must include how to assure access for Members within all five Counties.
  - D. Indicate how many members would be served at any given time by each D&A Recovery Specialist and how long you would anticipate needing to support persons through this Program. It is understood that case load sizes may vary depending on the makeup of each D&A Recovery Specialist's case needs. Explain how this would be managed.
  - E. Please identify the qualifications you will require for the D&A Recovery Specialists and supervisor you hire. Please be sure to specify the minimum educational requirements for Recovery Specialists as well as the Recovery Specialist Supervisor.
  - F. All D&A Recovery Specialists funded through this project will be required to complete the necessary training for the Certified Recovery Specialist (CRS) certification within one (1) year of their hire date. In addition to this required certification, please describe your staff training and supervision plan.
  - G. Address the steps you will take to ensure that you will foster healthy, engaging and timely assistance to the individuals you will serve. This

should include your strategy for addressing how D&A Recovery Specialists will maintain a professional relationship with the individuals they are supporting and how to differentiate that from personal relationships.

- H. Identify the discharge criteria you will use to indicate successful or unsuccessful completion of recovery services.
- I. Include a time line as an attachment to the proposal that presents the steps, tasks and anticipated completion dates for the start-up period. This is measured by the Program being fully staffed and operational.
- J. Recovery Specialist Services are to be independent of other Substance Abuse services. Recognizing the intent to have Recovery Specialist Services function as a “stand alone” program, please describe how you envision integrating this service with existing Substance Abuse services and engaging participants with other components of Substance Abuse treatment community.
- K. Please describe the anticipated impact that implementation of this project will have on utilization of Substance Abuse services. Specifically, how could this have a positive impact on the funding of Medicaid SA services in the HealthChoices Program, and also on the community as a whole?
- L. Please identify recovery objectives that you would expect to achieve through the Program and how they will be measured. The outcome measures must be consumer focused, measureable and directly associated with the Recovery Specialist Services. Please indicate what plan you will use to monitor these outcomes, including any instruments you will use to deploy them. Please note that ongoing technical assistance will be available from CBHNP/CABHC for the successful agency.

4. **Budget Narrative and Form** It is expected that the contract for the RSS Program will be awarded sometime in early 2012. Therefore, we are requesting two budgets and all supporting material to be submitted in your financial section of the proposal. The first budget should be a start up budget. This budget must include all staff being hired by June 30, 2012 and detail prorating their costs based on projected hire dates. A listing of one time capital purchases must be included. Costs should correspond to the implementation time line required with the proposal.

The second budget will be a twelve (12) month operating budget that represents a fully annualized cost to run this program. The total funding for the annualized 12 month budget is designated at \$309,500. Both the start up and annualized budgets will be cost reimbursed with monthly advances made contingent on the Program’s expense sheet being submitted each month by the Provider and the encounter data being submitted once services begin. Up to a 5% retention may be earned by the Provider, but cannot be added as a line item in the budget.

Please complete all budgeting using the attached budget form (Attachment A). Include staff salaries listed by position using the Staff Position Roster form (Attachment B). Please be sure to review the line item definitions that accompany

Attachment A of the budget form. To assure that there is clear understanding of the budget proposal, a line item narrative should be included as determined by the Provider. Finally, please provide a clear written narrative of any allocation methodology used by indicated line items in the budget. The Provider will be required to include a yearend audit/accounting of this program. This can be the annual corporate audit completed by the agency, but it must clearly delineate this program from the other contracts and revenues/expenditures of the agency

### **III. SELECTION PROCESS**

The following outline provides a general overview of how the winning proposal will be selected, including some key areas of review.

1. A Proposal Selection Committee (PSC) made up of representatives from the County SCAs, CABHC, CBHNP and consumers in the recovery community will review the proposals.
2. A proposal must be submitted following the above terms. CABHC will review all received proposals and those that do not follow these guidelines will be disqualified. The provider will be notified once this determination is agreed upon by the selection committee.
3. Follow-up questions may be issued to any or all of the providers at the discretion of the PSC.
4. Oral presentations may be requested of any or all of the agencies at the discretion of the PSC.
5. This is not a "lowest bid" selection process but financial efficiencies to use the available funds in the best way to support the program will be reviewed.
6. The Agency's ability to demonstrate capacity to serve all five Counties will be critical.
7. Presentation of objectives and outcomes of the Program will be an important aspect of the proposal review.
8. The PSC will make a final recommendation of the selected provider to CABHC's Board of Directors for their final approval for awarding the contract.