



REQUEST FOR PROPOSALS (RFP)

CRISIS SERVICES: ROCKINGHAM COUNTY

Alamance-Caswell-Rockingham Local Management Entity is requesting proposals from Providers to assume delivery of Walk-In Crisis Services in Rockingham County. Currently, these services are provided Monday-Friday, 8:00am-5:00pm, excluding Holidays and Weekends. The LME will give priority consideration to proposals that offer availability of these services 24/7/365, including Holidays and Weekends.

Only proposals from currently enrolled providers or providers who are eligible for enrollment by an LME/County Program in the State of North Carolina will be considered. Acceptable and verifiable documentation of corporate endorsement or enrollment eligibility, must accompany the proposal, by the submission date, in order to be considered. For information regarding enrollment eligibility, please contact Linda Jones at ljones@acmhdds.org or 336-513-4200, ext. 4222.

It is anticipated that one contract will be awarded as a result of this RFP, with implementation of services by **January 5, 2009** and will be renewable for additional fiscal one-year terms.

Proposals must be completed on the attached form and **may not exceed 15 pages in length**, exclusive of any requested addendums/attachments. An electronic copy of the RFP is available via the ACR website at www.acmhdds.org. All questions must be submitted electronically to Alicia Graham, Clinical Director, at agraham@acmhdds.org by **5:00 P.M. on Monday, September 8th, 2008**. Responses to questions will be posted on the website.

Proposals must be received no later than 5:00 PM on Friday, September 15th, 2008. Proposals submitted after the deadline will not be considered. There are no exceptions to this requirement. Proposals must be submitted to:

**Alamance-Caswell-Rockingham LME
ATTN: Alicia Graham, Clinical Director
319 N. Graham-Hopedale Rd., Suite A
Burlington, NC 27217**

Submitted proposals shall include a cover letter signed by the designated leadership of the provider organization, two (2) hard copies and one (1) electronic copy (on CD) of the proposal with attachments.

Proposals will be reviewed and rated by a review team that may include, but not be limited to, LME staff, CFAC, and stakeholder representatives. Upon request from the LME, each provider shall submit

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any additional materials, information and documentation reasonably required by the LME in its evaluation of the Proposals. The evaluators reserve the right to request that the provider orally present or discuss their Proposal for the purpose of clarification.

Upon completion of the evaluation process a recommendation will be made to the Executive Director for approval of the selected Proposal. It is anticipated that notification of award by email to all applicants will occur by **Monday, October 6th, 2008.**

The Request for Proposals may be cancelled at any time and any or all Proposals may be rejected in whole or in part, when it is determined to be in the best interest of Alamance-Caswell-Rockingham LME. The award of a contract and any allowed renewal or extension thereof, is subject to allocations to be made by local governments and the State of North Carolina and subject to the availability of local, State, and/or Federal funds.

Description of Crisis Services

The goal of Crisis Services is to assure the safety and immediate care for consumers in crisis, to maintain the public safety, and to improve access to behavioral health services by diverting consumers in crisis to the least restrictive care possible. This strategy implements the values of the public mental health system, reduces consumer trauma, and reduces the overall cost of mental health care by avoiding unnecessary use of expensive services.

Expectations of the Provider:

1. The crisis provider will provide face-to-face emergency services to persons with mental illness, substance abuse or co-occurring disorders including developmental disabilities. Priority consideration will be given to proposals that offer availability of these services 24/7/365, including Holidays and Weekends.

An emergency is defined as “an acute disturbance in thought, mood or social relationship that requires an immediate intervention as defined by the consumer, family or the community”. This includes persons who are intoxicated or in withdrawal and unable to access services without immediate assistance.

The following must be taken into consideration to ensure the delivery of crisis services:

- An emergency has the potential to rapidly deteriorate and result in a catastrophic outcome.
- Resources are not available at the time of the occurrence to facilitate an understanding of the situation or support resolution.
- Emergencies are unscheduled, are not planned, are severe, dynamic, and demonstrate a need for access to a higher level of care.
- The need for intervention is immediate and there is limited time for decision-making.

- There is a need to be prepared to change course rapidly with the situation or as new information is available.
 - Emergencies are traumatic for the consumer.
2. The Provider should triage, provide comprehensive assessments, interventions and referral services to those in crisis and provide assessment and referral to non-emergent walk-ins.
 3. Logs must be maintained for each request for service and submitted to the LME by the 10th of the each month. Reports shall be submitted on time and show the number of persons requesting services; the number and percent that are determined to need emergent, urgent and routine care and the percentage for which access was available as dictated by the timeliness standard. Emergent access is defined as having a qualified provider on the physical premises ready to provide immediate care to the consumer. Urgent is defined as having access or treatment within 48 hours. Routine is defined as having access or treatment within 10 calendar days.
 4. The provider is responsible for providing crisis services for new consumers, for established consumers without a primary provider who provides first response, and for established consumers when the capacity of the first responder has been exceeded. If a consumer is known to the system it is expected that the first responder will be contacted to facilitate the crisis management. If the consumer has an established crisis plan, the crisis service should be consistent with the established plan. Crisis services do not require prior authorization from the LME, but will be obtained retrospectively the next working day.
 5. The state standard screening form is used for all new consumers and for consumers who have not been screened in sixty days. Referrals are then made to the appropriate agencies chosen by the consumer. The consumer is given names, contact information and locations of providers to assist in making an informed choice. Warm line transfers or Relay will be used to make referrals to appropriate sources. All populations are served and expertise in all disabilities should be available. The screening shall be submitted within 5 calendar days of completion to UR/STR Unit of the LME. TTY capability, for persons who have a hearing impairment and foreign language interpretation will need to be provided for the purposes of receipt of appropriate information for referral of services at no cost when necessary.
 6. The provider shall have the capacity and ability to assess and stabilize the presenting individual.
 7. The provider shall be knowledgeable of involuntary commitment procedures and have appropriate staff available to carry out a commitment. The first evaluation should be by a MD, licensed psychologist, or a Licensed Clinical Social Worker who has received state approved training and waiver. A notary must also be available to complete the commitment process.
 8. The provider shall work collaboratively and have positive relationships with the LME and community agencies such as: local police, sheriff, magistrates, hospitals, Department of Social Services, Department of Juvenile Justice, Mobile Crisis and schools to optimize services for consumers.
 9. A working knowledge of community and state resources is needed so that appropriate referrals can be made. Referrals may be made to respite beds, detoxification settings, halfway houses, outpatient providers, inpatient setting, etc.

10. The provider would be expected to cooperate in crisis planning for the community and participate in and regularly attend the LME's Crisis Committee to ensure quality services to all consumers in the LME catchment area.

Alamance-Caswell-Rockingham's philosophy regarding 24/7 Crisis walk-in services is that the provider incorporate the following principles into the delivery of services: culturally competent, customer friendly, visible to the community, partnerships with stakeholders, welcoming to all populations, highly qualified, experienced and appropriately trained staff, delivery of timely and convenient service, crisis planning where needed, diversions from state hospitals, emergency departments, jails and detention facilities, and care coordination.

Facilities and Location Expectations:

The location where the LME anticipates this service being provided to the community meets the following criteria:

- Easy to locate and access by individuals with disabilities, community members, & stakeholders; including law enforcement.
- Located within Rockingham County.
- Sufficient parking available at a close distance to the building to allow for easy access by law enforcement.

The building where the service is to be provided must meet the following criteria at a minimum:

- Building must be handicapped accessible.
- Building and/or signage must be clearly visible from the road indicating walk-in crisis services.
- Building must be conducive to providing crisis service with safety and security of consumers, staff and the community being a focus.
- It is not necessary for the building to be licensed unless a service is being provided in the location that requires licensure or the agency's accrediting body requires.
- Preference to have a "safe holding area" that is separate for those who are brought in by law enforcement in restraints or when behavioral issues threaten a person's safety.

Community Collaboration and Education:

It is essential that the provider of the Crisis Service work collaboratively with the community. This collaboration should include presentations, meetings, relationship building, education, advocacy, memberships and other means of bringing the community together to support the Crisis Service and the needs of the community. It is the LME's expectation that the provider selected to provide Crisis Services for Rockingham County will become familiar with local resources.

In addition, the Crisis Provider must be aware of other providers in the community and the resources they provide for those with mental health issues, developmental disabilities and substance abuse issues.

Related to marketing, the Provider must be willing to:

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- Advertise the Crisis Service to the community via print, website and presentation.
- Educate the community concerning the provider agency and the service provided.
- Inform the provider community of the service and guidelines for accessing the service.
- Have business cards and directions readily available on website and in written form to distribute.

Staffing/Qualifications:

The following staff is required to be on-site during hours of operation:

- ❖ Qualified Professional or Licensed Professional
- ❖ MD, licensed psychologist, or a Licensed Clinical Social Worker who has received state approved training and waiver.

Due to the nature of this service and the need for a multi-disciplinary approach to treatment, priority consideration will be given to proposals offering these additional staff:

- ❖ Registered Nurse
- ❖ Physician

All staff must meet standards for the service specified by the Division of Mental Health, Developmental Disability, and Substance Abuse services in the Service Definitions Manual for non-enhanced services. This manual can be accessed at the DMH/DD/SAS website:

<http://www.ncdhhs.gov/mhddsas/stateplanimplementation/DMHDDSA%20Service%20Definitions%20Manual%20-%20Revisions%2015%20January%20..pdf>

Effective July 1, 2008, the services of provisionally licensed clinicians may be billed to Medicaid and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funds in three ways: 1) when those clinicians are engaged in providing enhanced services, such as Intensive In-Home, Substance Abuse Intensive Outpatient, Assertive Community Treatment Team, etc.; 2) when they provide outpatient therapy under the revised “incident to” policy and their services are billed under the supervising physician’s provider number; and 3) when they provide outpatient therapy and the services are billed through the LMEs using “H” billing codes.

UTILIZATION:

The data below indicates utilization at the current walk-in crisis location in Rockingham County. Please note that these services are currently being provided Monday-Friday, 8:00-5:00 and do not reflect after-hours, weekend, or holiday crisis traffic.

MONTH	ROUTINE	URGENT	EMERGENT
January 2008	15	10	15
February 2008	11	14	10
March 2008	11	4	4
April 2008	17	5	8
May 2008	17	3	21
June 2008	4	7	9
July 2008	5	7	18

Proposal for Crisis Services:

Name of Applicant (Organization Name):

Applicant Address:

Proposal Submitted by (Staff Name and Title):

Date Submitted:

Phone:

Fax:

E-mail:

Designate Status of Profit or Not For Profit (List Board Chair and CEO):

CEO Address:

Phone:

Fax:

E-Mail:

Federal Tax ID#:

Name, Address, Telephone, and Email of Reference in doing this business:

Name, Address, Telephone, and Email of Reference in doing this business:

Name, Address, Telephone, and Email of Reference in doing this business:

Proposal for Crisis Services:

- 1. Experience and Capability of Organization in Providing Crisis Services:** List all other organizations with whom you currently contract, have contracted or had agreement to provide services with in the past three years. List the services provided under each contract/agreement.

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2. Service Design and Implementation: Include proposed project including service organization, activities, and description. Include a timeline for implementation/transition of the service.

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3. Plan for Community Collaboration: What is your plan for community collaboration and coordination with stakeholder, providers and consumers concerning the Crisis Service being a viable resource in the community?

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4. **Internal Measures and Accountability:** Provide specific internal measures that will enable your organization to maintain internal quality controls and accountability.

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5. **Other Relevant Issues:** Applicant may add any additional information deemed necessary to clarify this proposal.

Proposal for Crisis Services: Attachment Packet

The following attachments must be completed and submitted with proposal:

- 1) ATTACHMENT A: Network Provider-Annual Program Budget
- 2) Detailed Budget Narrative (Description of Costs outlined in Attachment A)
- 3) ATTACHMENT B: Anticipated Revenue for Service Operations
- 4) ATTACHMENT C: Fiscal Criterion Evaluation Form
- 5) Copy of Corporate Endorsement
 - a. If locally endorsed, copy of Local Endorsement
 - b. If no currently endorsed, the following must be submitted to enroll in the ACR LME Network:
 - i. Certificate of Insurance
 - ii. License (if facility based)
 - iii. Financial Statement
 - iv. Consumer Rights policy
- 6) Copy of DMA enrollment letter – include NPI# information
- 7) Copy of letter granting national accreditation, if applicable
- 8) Copy of most recent compliance review from current licensure, contractor, and/or other oversight agencies
- 9) Legal: Include any and all details of any pertinent judgment, criminal conviction, investigation or litigation pending against the organization or any of its officers, directors, employees, agents or subcontractors of which the organization has knowledge, or a statement that there is none. ACR LME reserves the right to reject a proposal based on this information.

ATTACHMENT A: NETWORK PROVIDER - ANNUAL PROGRAM BUDGET

FY: _____ **CONTRACT STATUS:** PROPOSED NEW RENEWAL

CORPORATE NAME:	FEIN:
PROGRAM NAME:	MEDICAID NPI#:

	PROGRAM COMPONENT	FTE	AMOUNT	AVERAGE SALARY
ACCOUNT CODE	Direct Care/Program Support Staff/Overtime/Shift Differential & Relief			
	SUB-TOTAL STAFF			
	Payroll Taxes			
	Fringe Benefits			
	TOTAL DIRECT CARE/PROGRAM STAFF			
ACCOUNT CODE	OTHER DIRECT CARE/PROGRAM SUPPORT (USE UFR TITLES)			
	Program Facilities			
	Fac. Oper./Main/Furn			
	Direct Care Consultant			
	Temporary Help			
	Client/Caregivers/Reimb/Stipends			
	Subcontract Dir.Care			
	Staff Training			
	Staff Mileage/Travel			
	Meals			
	Client Transportation			
	Incid. Health/Med Care			
	Medicine/Pharmacy			
	Client Per. Allowances			
	Prov. of Material Good			
	Other Commercial Products & Servs.			
	Program Supplies/Mat			
	Program Support			
	Other Direct Administrative Expenses			
	SUBTOTAL PROGRAM COSTS			
	Agency Admin. Support Allocation		%	\$
	PROGRAM TOTAL			

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ATTACHMENT B: ANTICIPATED REVENUE FOR SERVICE OPERATIONS FORM

CORPORATE NAME:	FEIN:
PROGRAM NAME:	MEDICAID NPI #:

REVENUE ACCOUNT DESCRIPTION	PROPOSED ANNUALIZED BUDGET
General Contributions and Donations	
LME Program Subsidy Requirement	
Allocated by Federated Fund Raising Organizations	
Other Government Purchase of Service	
Medicare	
Medicaid	
SSI and SS	
Grants from Governmental Agencies	
HMO/PPO Revenue from Title XIX-AFDC Clients	
HMO/PPO Revenue from Non – Title XIX Clients	
Membership Dues	
Program Service Fees – Other	
Program Service Fees – Client Collections	
Program Service Fees – Insurance	
Intra-Agency Sales of Supplies and Services	
Revenues from Disposal of Assets	
Investment Income	
Gains (and Losses) on Investment Transactions	
Revenues from Disposal of Assets	
Unrestricted Cash	
Restricted Cash	
Special Events	
Endowments	
Trust	
Collected Through Local Member Units	
Contributed By Association Orgs	
Allocated by Federated Fund Raising Organizations	
United Way	
Allocated By Unassociated and Non Federated Fund Raising Orgs	
Membership Dues – Individuals	
Assessments and Dues – Local Member Units	
Intra – Agency Sales of Supplies and Services	
Sale of Production	
Sale of Property and Other Assets	
Sale of Staff Services	
Interest	
Dividends	
Other (SPECIFY):	
TOTAL ANTICIPATED REVENUE:	

ATTACHMENT C: FISCAL CRITERION EVALUATION FORM

CORPORATE NAME:	FEIN:
PROGRAM NAME:	MEDICAID NPI #:

***Please complete the following using information contained in your most recent financial audit (FY07)**

PROGRAM FINANCIAL MEASURE	RESULT
(%) Of Administrative Overhead Built Into Program Budget – (%)	
Organizations Unrestricted Fund Balance/Line of Credit – (% of Total Budget and \$)	
Current Ratio (Current Assets/Current Liabilities)	
Operating Cash Flow Ratio (Cash Flow From Operations/Current Liabilities)	
Net Working Capital Ratio (Net Working Capital/Current Assets – Current Liabilities)	
Debt To Equity Ratio	
LME Total Contract Amount As (%) Of Total Organization Budget – (%)	
Demonstrated Use of Sliding Fee Scale – (Y/N)	
Demonstrated Collections From 3 rd Party Payors – (Y/N)	

**APPLICATION FOR ALAMANCE CASWELL ROCKINGHAM LME
FORMAL PROVIDER NETWORK (2008-2009)**

Instructions: Please be sure to answer each question. Incomplete applications will not be considered. Your signature on this application and your submission of it signifies your intent to participate in our network if you are selected.

PART A

1. Is your organization licensed to do business in North Carolina? Yes No
2. How is your organization licensed to do business, i.e., sole proprietorship, corporation, etc.?
3. Is your agency non-profit or for-profit?
4. How many years have you or has your agency been in business under its present name?
5. How many years were you or your organization in business under a related and/or prior business name?
6. Has your organization ever had a business or facility license revoked or had a DFS investigation in which the complaint was substantiated? If yes, please explain briefly.
7. Have you or has your agency ever had a contract terminated for cause? If yes, please explain.
8. Please include a copy of your auditor's letter or other verification of financial solvency of organization (i.e. letter from accountant or bank, etc.).
9. Please list the services that you wish to provide for us. Please be very specific as to the type of service, the population (age and disability groups and level of severity). Include the number of years of experience your organization has in service to each specific population and your expected capacity (numbers) to serve Alamance, Caswell, Rockingham clients during a 12-month period.
10. Has your organization had a compliance verification review, or DFS Survey reflecting full compliance, for the services you wish to provide?
11. Are you currently providing services to any of the following (check as applicable)
 - Juvenile justice clients
 - Offenders (type of offenses _____)
 - Pregnant women with children; without children)
 - Opioid dependent individuals
 - Individuals with HIV/AIDS
 - Individuals with other communicable diseases
 - Individuals with physical limitations(type of limitations _____)
 - Deaf or Hard of Hearing individuals
 - (LEP)Limited English speaking individuals

12. If you checked any of the above in #11, please describe how you make the necessary accommodations to serve each. Please be brief but specific.

13. If licensure is required for the service(s) your agency wishes to provide, please include copies of licenses of facilities that would be available to us for referral.

14. Please include a copy of a current Certificate of Insurance that includes at least your general liability and your professional malpractice insurance (at least \$1 million per occurrence and \$3 million aggregate)

15. Provide a copy of your agency's Clients Rights Policy and procedures.

16. Please provide a brief summary of results of consumer satisfaction surveys.

17. Please list outcome tools that you use and describe how your organization uses these tools to evaluate your services.

18. Please list all relevant organizations with whom you currently contract and/or have contracted within the last 12 months, to provide services similar to those you wish to provide for us. Please include the organizations' name, address, contact person and phone number.

19. May we contact the organizations listed in # 18 for a reference? Yes No

20. Describe how your organization is implementing HIPAA privacy regulations.

21. Do you currently have, or plan to have, the ability to transmit claims electronically? If yes, describe how it will be HIPAA compliant?

22. Which of the following checks are routinely involved in your hiring process?

- Criminal Background check
- Health Care Registry
- Driver's License
- Educational credentials
- Federal government exclusion list

23. Does your organization have formal alliances with any other private providers that involve the sharing of costly administrative functions, or to directly facilitate referrals for related other services that may be needed by our clients that you accept for services? If yes, please list those with whom you have such formal alliances and describe briefly the nature of the alliance.

24. Is your organization nationally accredited? If so, please state which accrediting body and what the dates are of your current accreditation.

Part B

1. What is your agency's mission statement or service philosophy?
2. For residential services only, list all supportive services (transportation, community outings, etc.) that you include as a part of each service level that you wish to provide for us. Please be concise and specific.
3. For residential service providers, list the community outreach activities that will be provided, and how often will these activities take place?
4. For periodic service providers, list community supportive resources that you routinely interface with or to which you refer clients.
5. What procedures/steps do you follow before you begin providing services to a client?
6. List all positions to be involved with the service(s) to be provided, and include for each position: a brief description of the responsibilities, minimum experience and qualifications and level of supervision to be delivered for each position.
7. Other than English, list languages which your direct care staff can understand, speak, read and write well.
8. Describe the training you provide to your direct care staff. Include the type of training, length of training, qualifications of trainers, etc. Specify what training components your direct care staff need to complete before beginning to provide services to clients.
9. Describe how you monitor direct care staff and program operation. Please be specific.
10. Do you have an adequate pool of trained staff to cover unexpected absences? Describe how you have determined that you do or do not.
11. What does your organization do to retain qualified staff?
12. How often do you monitor and how do you evaluate whether or not progress is being made towards client goals?
13. Please write a service plan with a goal for a consumer for each of the services that you propose to provide for us, utilizing the attached state service plan form. Be sure to complete all items.

ORGANIZATION NAME: _____

BUSINESS ADDRESS: _____

APPLICATION CONTACT PERSON: NAME _____

PHONE _____

FAX _____

EMAIL _____

PERSON COMPLETING APPLICATION: _____

DATE APPLICATION SUBMITTED: _____