

REQUEST FOR PROPOSALS (RFP)

for

ADDICTION SERVICE CONTINUUM

issued by

COMMUNITY BEHAVIORAL HEALTH

Date of Issue:

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Proposals must be received no later than 2:00 P.M., Philadelphia, PA, local time, on August 21, 2017

Questions related to this RFP should be submitted via E-mail by August 4, 2017 to: Mark.ODwyer@phila.gov

**EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER – MINORITY, WOMEN
AND DISABLED ORGANIZATIONS ARE ENCOURAGED TO RESPOND**

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I. Project Overview

A. Introduction; Statement of Purpose

To address to the need to expand access to high-quality addiction services in Philadelphia, as recommended in the Mayor's Task Force *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*¹, Community Behavioral Health (CBH) is seeking providers to develop the following services:

- **Medically managed and medically monitored stabilization and maintenance residential treatment** (4A/4B and 3A/3B/ American Society of Addiction Medicine [ASAM]² level 4-WM/ 3.7-WM) with a capacity to treat individuals age 18 and over of varying genders. Providers are encouraged to propose the maximum capacity of individuals they can serve. Programs should be able to flex beds and staffing to function as medically managed or monitored stabilization or maintenance (4A, 4B, 3A, or 3B) depending on individual need and acuity. This flexibility will minimize the disruption for individuals transitioning between these levels of care, promote induction and stabilization on medication-assisted treatment, and promote continuity of care. Integrated substance use and mental health treatment should be provided on site.

Programs must be additionally licensed to provide inductions and maintenance with all forms of medication-assisted treatment for opioid use disorder (methadone, buprenorphine, naltrexone XR), and also provide pharmacologic treatments for other substance use disorders, including alcohol and tobacco use disorders. Providers must be hospital-based in order to provide 4A/B levels of care, and be able to treat individuals with co-morbid medical and psychiatric conditions. Academic centers incorporating medication-assisted treatment as fundamental to the treatment of substance use disorders, with the ability to educate individuals, families, and the future health professional workforce on these and other evidenced-based treatments of addiction, are strongly encouraged to apply.

- **Medically monitored stabilization and maintenance residential treatment** (3A/3B/ ASAM 3.7-WM) with a capacity to treat 16 individuals age 18 and over of varying genders. Programs should be able to flex beds and staffing to function as medically monitored stabilization or maintenance (3A or 3B) depending on individual need and acuity. This flexibility will minimize the disruption for individuals transitioning between these levels of care, promote induction and stabilization on medication-assisted treatment, and promote continuity of care. Integrated substance use and mental health treatment should be provided on site. Applicants can propose multiple 3A/3B programs.

These programs must be additionally licensed to provide withdrawal management, inductions and maintenance with all forms of medication-assisted treatment for opioid use disorder (methadone, buprenorphine, naltrexone XR), and also provide other

¹ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017, http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

² David Mee-Lee, Gerald D. Shulman, Marc J. Fishman, David R. Gastfriend, Michael M. Miller, Scott M. Provence, *The American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd ed. (Carson City, NV: The Change Companies, 2013).

pharmacologic treatments for other substance use disorders, including alcohol and tobacco use disorders. Applicants must be able to articulate how these treatments will be incorporated into individual assessments, patient and family education, and the structure of the program. Preference will be given to providers with academic partnerships in order to advance the training of the future health professional workforce.

- **Co-occurring medically monitored long-term intensive residential treatment (3C/ASAM 3.5)** with a capacity to treat 16 individuals age 18 and over of varying genders. Individuals in the program are expected to be maintained on medication-assisted treatments while participating in the program. The program is also expected to provide integrated mental health treatment on site.
- **Journey of Hope (JOH) medically monitored residential treatment (JOH 3A/B/C/ASAM 3.7-WM/3.3)** with capacity to treat at least 45 males, age 18 and over. Programs should be able to flex beds and staffing (3A, 3B, or 3C) depending on individual need and acuity. This flexibility will minimize the disruption for individuals transitioning between these levels of care, promote induction and stabilization on medication-assisted treatment, and promote continuity of care. Short term (3A/3B) programming is needed for individuals without significant habilitation needs and those who previously completed a 3C JOH program and are experiencing a significant relapse. Longer term (3C) programming must be able to address habilitation needs including vocational and educational challenges.

Programs must be additionally licensed to provide inductions and maintenance for all forms of medication-assisted treatment (methadone, buprenorphine, naltrexone XR), and also provide other pharmacologic treatments for other substance use disorders, including alcohol and tobacco use disorders. Applicants must be able to articulate how these treatments will be incorporated into individual assessments, patient and family education, and the structure of the program.

- **Ambulatory Stabilization (ASAM 2-WM/1-WM)** programs located in 19111, 19114, 19115, 19116, 19122, 19125, 19135, 19136, 19149, 19152, 19154 19104, 19131, 19139, 19140, 19142, or 19143. Applicants should have outpatient drug and alcohol licensure and will be expected to serve as bridge clinics, accepting individuals actively using as walk-ins and transfers from emergency departments and crisis centers. These are expected to provide American Society of Addiction Medicine /Pennsylvania Client Placement Criteria ASAM/PCPC assessments for level of care determinations, withdrawal management, short term stabilization and induction with medications, including buprenorphine and Vivitrol for opioid use disorders. Programs are expected to ensure individuals are engaged in recommended treatments and effectively linked to appropriate services. They also are expected to provide short term stabilization of psychiatric co-morbidities. Priority will be given to hospital- based and academic-affiliated sites with on-site and/or proximate linkages with emergency departments and crisis centers. Protocols for expedited linkages with individuals from emergency departments must be in place. Extended hours are expected.

All services must be located within Philadelphia, and priority will be given to applicants with programs located in the Health Enterprise Zone³ (this does not apply to Ambulatory Stabilization; see zip codes above): 19120, 19121, 19122, 19123, 19124, 19125, 19126, 19130, 19132, 19133, 19134, 19138, 19140, 19141, 19144. Additional considerations will be given to providers in zip codes with high volume of emergencies related to opioid use, including 19104, 19148, and 19102. Providers can apply for one or multiple programs. All programs must be able to admit individuals 24 hours per day/ 7 days per week. Programs must be trauma-informed and culturally competent, with staff trained in evidence-based practices appropriate for the populations served and services provided. Programs must provide on-site integrated mental health treatment, to be able to address individuals with co-occurring mental health challenges. Programs must also be able to serve individuals with additional challenges including criminal justice involvement, homelessness, unemployment and lack of education/ training, and intellectual disabilities. Providers who submit timelines reflective of expedited program start-up and implementation will be given preference in this procurement.

As an additional response to the Mayor's Task Force Report and the need to expand and enhance addiction services, particularly regarding access to MAT, CBH will initiate an application process to designate in-network practitioners as MAT providers. The aim of this initiative is to expand availability of MAT providers throughout the city. Providers of the addiction services being procured here will be expected to partner with new MAT providers to ensure continuity of MAT access.

Applicants must develop addiction services in a manner that reflects the Philadelphia system emphasis on recovery transformation and population health as discussed in section II.I. In particular, treatment should promote wellness as well as symptom-management, address the social determinants of health and mental health, and empower individuals to maintain recovery and achieve successful community tenure. The addiction services should partner with community organizations to promote wellness in the community and to support reintegration of individuals discharged from these services. The Philadelphia system's population health approach assumes that services are provided in a manner which is also consistent with the system transformation of behavioral health services implemented over the last decade. The *DBHIDS Practice Guidelines for Recovery and Resilience Oriented Treatment* (<http://www.dbhids.org/practice-guidelines/>) provide a framework for the system transformation.

Applicants will be required to develop and maintain a continuous quality improvement plan for the services implemented. This will include tracking process and outcome measures related to the impact and effectiveness of the services delivered, as well as setting goals and engaging in improvement activities related to the goals. Measures to be tracked by all programs (except Ambulatory Stabilization -see Reporting section later in this RFP for requirements for those programs) must include:

- Reductions in Addiction Severity Index
- Percentage of individuals with opioid use disorder, tobacco use disorder, and/or alcohol use disorder provided a FDA-approved medication as part of treatment in the program
- Amount of program services delivered (individual, group, and family therapy, psychiatric consultation, etc.)

³ Health Enterprise Zone is a section of North Philadelphia identified by Pennsylvania Department of Human Services as high priority for treatment availability given health disparities and the high concentration of Medicaid recipients living in the identified zip codes. <http://www.dhs.pa.gov/citizens/hez/index.htm>

- 30 and 90 day recidivism to all bed-based levels of care
- 7 and 30 day follow-up rates to outpatient services

B. Organizational Overview

The City of Philadelphia contracts with the Commonwealth of Pennsylvania Department of Human Services (PA-DHS) for the provision of behavioral health services to Philadelphia's Medicaid recipients under Pennsylvania's HealthChoices behavioral health mandatory managed care program. Services are funded on a capitated basis through this contractual agreement. The City of Philadelphia, through the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), contracts with Community Behavioral Health to administer the HealthChoices program.

CBH was established as a non-profit organization by the City in 1997 to administer behavioral health care services for the City's approximately 600,000 Medicaid recipients. As a result, CBH manages a full continuum of medically necessary and clinically appropriate behavioral health services. CBH employs more than 400 people and has an annual budget of approximately \$800 million.

DBHIDS has been actively transforming Philadelphia's behavioral health system for the last twelve years. The department's system transformation is rooted in approaches that promote recovery, resilience, and self-determination and build on the strengths and resilience of individuals, family members and other allies in communities that take ownership for their sustained health, wellness, and recovery from behavioral health challenges. As a next wave of its transformative efforts, DBHIDS is putting emphasis on quality community-level health outcomes using a population health approach. A population health approach seeks to promote health and wellness in all, not just to diagnose and address challenges for some. DBHIDS's population health approach builds upon many years of focus on community health; thus, the approach is consistent with a public health framework. The essence of the DBHIDS population health approach is based on the following principles: attend to the whole population, not just to those seeking services; promote health, wellness and self-determination; provide early intervention and prevention; address the social determinants of health; and empower individuals and communities to keep themselves healthy.

C. Background

In May 2017, the Mayor's Task Force released its *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*⁴. Outlining the growing scope of the opioid crisis, the Report indicates that 907 individuals in Philadelphia died due to drug overdose in 2016, an increase from 702 in 2015. In 2015, Philadelphia's rate of 46.8 drug overdose deaths per 100,000 residents far outpaced other large cities such as Chicago (15.4) and New York City (11.2). Approximately 80 percent of drug overdose deaths in Philadelphia involve opioids, including prescription opioids, heroin, and fentanyl. According to the Report, the Drug Enforcement Agency and National Survey on Drug Use and Health estimated that between 122,000 and 150,000 Philadelphians are in need of substance use disorder treatment.

To address the epidemic, the Task Force provided recommendations for treatment providers and

⁴ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017, http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

community partners to expand treatment access and capacity across multiple levels of care. Specifically, the Report calls for an increase in the number of sites in Philadelphia offering addiction treatment services, expanding the hours of operation of facilities, improving assessments incorporating American Society of Addiction Medicine (ASAM) Criteria, embedding withdrawal management into multiple levels of care, and increasing the use of medication-assisted treatment. Medication-assisted treatments (MAT) are empirically supported as effective interventions to treat opioid addiction; nonetheless, MATs are significantly underutilized in part due to stigmatization and a lack of knowledge about them among treatment professionals and the community. The Report also calls for enhanced workforce for addiction services; as such, this RFP reflects an increase in standards for staff training and credentials and services provided.⁵

An additional impetus for expanding and enhancing addiction services in Philadelphia is the impending transition from PCPC to the ASAM Criteria as the PA Department of Drug and Alcohol Programs (DDAP) standard for providing addiction services. The ASAM service descriptions and criteria reflect an increasing emphasis on “unbundling” treatment modality and intensity from the treatment setting, thus any type of clinical service (such as psychiatric consultation, withdrawal management, etc.) can be provided in any setting (residential, outpatient, supportive living environment, etc.). The practice of unbundling allows for treatment to be based on the individual’s needs and not imposed or limited by the treatment setting.⁶ As such, this RFP seeks programs that can flex treatment capacity to provide multiple levels of addiction treatment, thus minimizing treatment interruption when individuals transition between programs. Applicants should consult the PCPC to develop programs, cross-walking expectations with the ASAM Criteria in anticipation of this transition to occur July 2018. Additionally, providers should have staff trained in ASAM assessment and placement criteria, and adopt standardized assessments aligned with the ASAM and PCPC.

D. Applicant Eligibility Requirements

To be eligible to respond to this RFP, applicants must appropriately licensed and credentialed as of date of program implementation. Capacity to expedite a start date will be prioritized in RFP selection. Applicants must not be on any of the three Federal and Commonwealth exclusion lists or on a Corporate Integrity Agreement (see III. K. for complete threshold requirements).

E. General Location/ Site Requirements

Each applicant must have current control of a site located in Philadelphia, with priority given to applicants who can develop programs in the Health Enterprise Zone: 19120, 19121, 19122, 19123, 19124, 19125, 19126, 19130, 19132, 19133, 19134, 19138, 19140, 19141, 19144. Additional considerations will be given to providers in zip codes with high volume of emergencies related to opioid use, including 19104, 19148, and 19102. Ambulatory Stabilization applicants should target Northeast Philadelphia/ Frankford, South Philadelphia, or West Philadelphia in zip codes: 19111, 19114, 19115, 19116, 19122, 19125, 19135, 19136, 19149, 19152, 19154 19104, 19131, 19139, 19140, 19142, or 19143. The applicant may own or lease the property directly. For the proposed

⁵ City of Philadelphia Mayor’s Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017. Available at http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

⁶ David Mee-Lee, Gerald D. Shulman, Marc J. Fishman, David R. Gastfriend, Michael M. Miller, Scott M. Provence, *The American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd ed. (Carson City, NV: The Change Companies, 2013).

facility, the applicant is required to provide information on the property's zoning and licensing status as well as describe how it can be configured as the proposed program. Applicants can propose converting an existing program site to the proposed program to expedite a start date. The site should be able to provide comfortable living/ sitting space for the proposed number of individuals, including both shared and private rooms, access to outdoor space, and treatment space to accommodate milieu activities, appointments/ sessions, and staff offices. All sites must have all Americans with Disabilities Act (ADA) provisions; no ADA exceptions will be permitted. A tobacco-free policy must be maintained throughout the premises.⁷

F. General Disclaimer

This RFP does not commit CBH to award a contract. This RFP and the process it describes are proprietary and are for the sole and exclusive benefit of CBH. No other party, including any respondent, is intended to be granted any rights hereunder. Any response, including written documents and verbal communication, by any applicant to this RFP, shall become the property of CBH and may be subject to public disclosure by CBH.

G. Evidence Based Practices

DBHIDS has a strong focus on the use of evidence-based practices (EBPs) for all levels of services throughout its provider network. The programs procured through this RFP must establish evidence-based approaches to treatment. Applicants should consider EBPs appropriate to the population and level of care, including cognitive behavior therapy (CBT), motivational interviewing (MI), and contingency management (CM). For each EBP, the applicant is expected to provide the following information, in addition to responding to the issues in the bullets following each service description.

- Training and implementation requirements for delivering the EBP
- Consultation and supervision in the use of the EBP
- Integration into program operations
- Quality assurance strategies to assure fidelity to EBP and competence in program delivery
- Sustainability planning to maintain the EBP after initial training and implementation

II. Scope of Work

A. MEDICALLY MANAGED AND MEDICALLY MONITORED STABILIZATION AND MAINTENANCE RESIDENTIAL TREATMENT (4A/4B and 3A/3B)

This section is for applicants who would like to develop a program to provide 4A/4B and 3A/3B levels of care.

1. Objective/ Purpose

This RFP is seeking one or more providers to develop medically managed and medically monitored stabilization and maintenance programs (4A/4B and 3A/3B) with capacity to treat individuals age 18 and over of varying genders. These programs are state-licensed acute care and treatment facilities that provide a continuum of care and treatment for individuals from the point of acute withdrawal management to discharge to halfway house or community living. The ability for a single

⁷ The Department of Behavioral Health and Intellectual disability Services (DBHIDS), "Tobacco Recovery Wellness Initiative (TRWI)," <http://dbhids.org/tobacco-free>

program to flex treatment capacity between 4A/4B and 3A/3B will minimize the disruption for individuals transitioning between these levels of care.

These programs should be able to address emergent and complex/ chronic medical conditions, mental health needs, and MAT regimen on site. The programs must have capacity to provide 24/7 medically-directed and medically-monitored withdrawal management, intensive residential treatment for addiction and co-occurring mental health conditions, and life skills coaching in preparation for community reintegration. The target length of stay for stabilization and maintenance programs is 21 days, though emphasis is placed on individual treatment needs, with some individuals requiring shorter or longer stays. Individuals must be engaged in treatment along the continuum of care after completion of the program, to promote continuous as opposed to episodic treatment. The provider is responsible for ensuring the individuals link to the next level of care along the continuum.

Applicants should consult the PCPC to develop 4A/4B and 3A/3B programs, cross-walking expectations with the ASAM Criteria in anticipation of DDAP adopting this as the standard for addiction programs beginning July 2018⁸. Applicants will be asked to discuss methods to be used and resources needed to update programs to ASAM standards.

2. Target Population

Programs providing the continuum of 4A/4B and 3A/3B levels of care must be able to treat individuals of varying genders, ages 18 and older with substance use disorders and psychosocial challenges including homelessness, incarceration/ justice involvement, and unemployment. Individuals often have co-occurring intellectual disabilities, physical and mental health diagnoses, with symptoms and behaviors that range from moderate to severe. Some individuals will enter the program in acute states of intoxication or withdrawal and may exhibit impulsive behavior. Some may have suicidal/ homicidal thinking (with no active plan or intent), irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety, and challenges with life skills and self care. Individuals may manifest stress behaviors related to trauma histories and recent or threatened losses in the work, family, or social arena. The PCPC should be consulted throughout an individual's length of stay to determine level of acuity and care required. Individuals selected for 4A/4B are expected to have a higher intensity of need for physical health stabilization, withdrawal management (i.e. alcohol, opioids, benzodiazepines) and/or monitoring than those who require 3A/3B programming.

It is important to emphasize the cultural competency of staff and programming to be able to sensitively and proficiently meet the needs of a diverse population, including lesbian, gay, bisexual, transgender, questioning, queer, intersex, and asexual (LGBTQIA) individuals, including using inclusive language and addressing medical needs of individuals who are transgender; individuals who are multilingual/ multicultural, including the ability to provide/procure interpretative services, for both deaf and non-English speaking individuals; and individuals of varying racial and socioeconomic backgrounds, with many having experienced living in circumstances of poverty/ low income. Applicants should describe plans (hiring, training, programming, etc.) to support these populations.

3. Location/ Site

⁸ PA Department of Drug and Alcohol Programs, "Frequently Asked Questions Regarding the Transition to ASAM from PCPC," http://www.ddap.pa.gov/treatment/Pages/ASAM_FAQ.aspx

In addition to the requirements in section I.E., programs providing the continuum of 4A/4B and 3A/3B levels of care must be a hospital-based, DDAP-licensed acute care setting, with intensive biomedical and/ or psychiatric services and a DDAP-licensed treatment unit. The environment will support the promotion of clean air and living spaces and noise control. Sites must be smoke-free campuses. Access to outdoor space is required. On-site maintenance of naloxone must be included in program protocols.⁹ In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use, and offer it via prescription to vulnerable individuals upon discharge.

4. Services to be Provided/Required Tasks

4A/4B and 3A/3B programs must provide comprehensive assessment, inpatient withdrawal management, stabilization, monitoring, residential treatment, peer support, and discharge planning for individuals 18 years and older. Programs should motivate individuals toward formal recovery plans at the earliest stage of treatment possible to minimize attrition. Staff must be able to address a myriad of presenting medical and behavioral challenges stemming from substance use, mental health needs, intellectual disabilities, medical complexities, psychosocial barriers, legal involvement, or a combination. Treatment for substance use and co-occurring mental health symptoms should be provided on-site. Well-established referral pathways and connection to community supports should be mobilized to ensure successful discharges. Services must be culturally competent, trauma-informed, and able to meet the special needs of individuals (including but not limited to LGBTQIA individuals and individuals who are multilingual/ multicultural). Given the social stigma this population faces, it is critical for programs to cultivate a nonjudgmental and supportive treatment environment, one which respects the dignity and value of each person who receives treatment. Emphasis must be placed on education of individuals and their families on MAT and the de-stigmatization of individuals prescribed it.

a) Admission

4A/4B and 3A/3B programs must conduct admissions 24 hours per day/ 7 days per week to ensure individuals do not wait for treatment in states of acuity/ intense need. A qualified staff member must be on site who can conduct admissions 24/7. The programs must establish working relationships with emergency departments (per the Mayor's Task Force, ensuring continuous treatment for individuals following overdose¹⁰), hospitals, crisis response centers, and other addiction and mental health services to ensure smooth referral and admissions processes. Staff should conduct a welcoming orientation process for newly placed individuals (following withdrawal management as applicable), which should include a site tour, staff introductions, and explanation of guidelines and expectations for individuals receiving services. Informed consents must be obtained to allow the program to coordinate care with CBH, the individual's physical health plan, and other stakeholders. Psychoeducation should be provided with an emphasis on the goals of treatment and the individual's role in recovery. Informed consent around MAT options, including risks and benefits of treatment, must be conducted. Individuals must be assessed for tobacco use upon admission and offered medications for withdrawal. Clinical protocols must be reviewed and approved by CBH prior to implementation.

b) Assessment

⁹ Community Behavioral Health (CBH), "Bulletin 16-04: On-site Maintenance, Prescription, and Administration of Naloxone," <http://dbhids.org/wp-content/uploads/1970/01/Bulletin-16-04-Naloxone.pdf>

¹⁰ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017. Available at http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

4A/4B and 3A/3B program staff should complete an inter-disciplinary assessment to determine all substance use, psychiatric, mental health, and medical interventions to be provided during the individual's course of stay. The state mandated substance use assessment tool (currently the PCPC) should be used to determine addiction treatment needs. The assessment process should be trauma-informed, strengths-based, and culturally competent. Family members and other support people should be engaged in their roles to promote the individual's recovery. Structured tools should be administered to aid diagnosis and determine baseline measures for tracking progress and outcomes. Psychological and neuropsychological testing should be arranged as appropriate. Coordination with prior treatment teams, including short and long-term rehabilitation, hospitals, residential settings, Assertive Community Treatment (ACT) programs, probation officers, as well as system partners (ID case managers, residential case managers) must occur and be documented. All relevant prior records should be obtained, reviewed, and such review documented. Informed consent regarding evidence-based treatment options, including MAT, must be included in the assessment. Assessment should occur initially and ongoing to determine appropriateness of continued stay and/ or any need for transition to another level of care.

c) Physical Health and Wellness

Acute care settings, 4A/4B and 3A/3B programs must have capacity to provide intensive biomedical intervention and treatment on site. It is expected that programs will be able to treat a broad range of medically complex needs, including the ability to accept individuals in need of intravenous therapies and wound care. Physicians and nursing staff must be available 24/7. Staff should provide health and wellness education, addressing symptom management, engagement in treatment, medication consistency, exercise, nutrition, weight management, and drug, alcohol, and/ or tobacco use as applicable. Specific assessments should be performed on an individualized basis. A physical examination must be completed for all individuals within 24 hours of admission. Laboratory service capacity is expected and will be bundled in rate. Programs are expected to provide ongoing medication management for physical health issues as needed. Individuals who are transgender and receiving hormone replacement therapy (HRT) must be continue to receive all related medical intervention on site or via partnership with outside provider. Additionally, 4A/4B programs must be able to assess chronic pain needs and develop a comprehensive approach to pain management including appropriate choice of MAT for those with chronic pain and opioid use disorder.

d) Substance Use Treatment

Substance use treatment should include evidence-based interventions delivered by culturally competent and trauma-informed staff. Interventions should address barriers to sustained recovery and community tenure and should assist the individual in moving through stages of change with intention and self-awareness. Increasing an individual's understanding of personal risks for substance use and the ability to use adaptive coping skills should be the focus of treatment, with staff supporting opportunities for skill practice in daily life. Emphasis should be placed on promoting wellness as well as managing triggers and symptoms. Family engagement as a key predictor of sustained recovery should be emphasized; family members, significant others, or other support people identified by the individual should be included in treatment. Treatment should include:

- Medication induction and management
- Nursing monitoring
- Group therapy
- Individual therapy
- Peer group meetings

- Individual peer support
- Family therapy
- Educational or instructional groups
- Other supports
- Discharge planning and case management

Programs must be able to provide a curriculum of treatment throughout the day that is appropriately comprehensive and intensive as dictated by individual needs. Applicants should propose schedules of treatment, to include frequency and duration of the above services each day for each level of care, with the option to flex the combination or amount of any modality depending on individual treatment needs. It is critical that providers have weekend staffing to enable clinical programming seven days per week; this requirement aligns with best practices and the recommendation from the Mayor’s Task Force Report to expand weekend and evening operations for facilities at multiple levels of care¹¹.

e) Milieu Therapy/ Skill Building

Milieu management comprises many of the activities that provide structure and an opportunity for stability during stays, including but not limited to the management and layout of the environment, efforts to maintain safety and security, promote cooperative living among residents, and the daily schedule. Recreational activities, including walks, exercises, games, creative arts and crafts, and leisure activities should complement traditional therapeutic modalities and increase an individual’s ability to identify personal interests and engage in healthy outlets. Programming can include on-site support groups from outside providers.

f) Psychiatric Care/ Mental Health Treatment

4A/4B and 3A/3B programs must meet the psychiatric and mental health needs of individuals. 4A/4B and 3A/3B programs provide on-site psychiatric evaluations and medication management, with 24/7 on call access for medication concerns or other acute issues. The psychiatrist may also provide MAT if appropriately trained and licensed to do so. The psychiatric providers are expected to be integrated and leading members of the treatment team.

If an individual has been recommended to receive mental health treatment (therapy), treatment must be provided by a licensed or licensed-eligible (i.e. actively working toward licensure) mental health professional. Staff should be aware of mental health treatment goals for all individuals so that they may incorporate these into other aspects of treatment. Mental health treatment staff must be integrated into the treatment team.

g) Medication-Assisted Treatment (MAT)

4A/4B and 3A/3B programs must accept individuals on all forms of MAT, including methadone, buprenorphine and extended-release naltrexone, and must maintain MAT through the individual’s stay. Individual assessment for MAT for opioid use disorder, alcohol use disorder, and tobacco use disorder must be conducted, informed consent about pharmacologic options must occur and be documented in the medical record. As previously noted, MATs are empirically supported as effective interventions to treat opioid addiction; nonetheless, MATs are significantly underutilized in part due to stigmatization and a lack of knowledge about them among treatment professionals and the community. Staff must be educated on the uses and effectiveness of MATs. Program applicants must develop and articulate plans to educate individuals about MAT in group and individual settings.

¹¹ City of Philadelphia Mayor’s Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017. Available at http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

MAT may be prescribed by a psychiatrist, a supervised advanced nurse practitioner, and/or a physician with board certification in addiction medicine.

h) Coordination/ Discharge

4A/4B and 3A/3B programs must develop collaborative relationships with community services to promote successful reintegration into the community upon discharge, ensuring individuals are connected to appropriate supports and levels of care when they leave the program. Coordination with past, current, and prospective providers is critical and required. Programs must establish working relationships with halfway house, partial hospitalization, intensive outpatient programs and CBH to ensure smooth referral/ discharge processes. Interagency meetings including CBH will occur at intervals to be determined by CBH based on clinical need. Successful transition into the community is of paramount importance. A discharge plan should be developed and signed by the individual and all involved agencies. Agencies will be responsible for outcomes related to 7 and 30 day treatment follow-up as well as recidivism; therefore ensuring participants' engagement in treatment post-discharge is paramount. Applicants should develop intervention designed to promote continuity of care. In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

5. Personnel Requirements

In addition to DDAP requirements, the staffing pattern for the 4A/4B and 3A/3B programs should be as listed below. Personnel requirements align with the recommendation in the Mayor's Task Force Report to expand and enhance addictions workforce capacity. Strong preference will be given to providers coordinating with academic/ teaching programs.

- Physician with addictions training, available 24/7 on-site. Physical health assessment must be provided by a board-certified physician or appropriately supervised advanced nurse practitioner.
- Psychiatrist with the capacity to treat co-occurring substance use and mental health disorders, with the ability to prescribe MAT and psychotropic medication when necessary. Psychotropic medication management may be provided by an appropriately supervised, psychiatric certified advanced nurse practitioner.
- Nursing staff available 24/7 on-site
- Counselors
 - 50% master's level, clinically licensed or licensed-eligible (i.e. actively working toward license) with two years addiction treatment experience
 - 50% bachelor's level certified as Certified Alcohol and Drug Counselor (CADC)
- Facility Director
- Clinical Supervisor who is clinically licensed with at least two years addiction treatment experience
- Peer Support (Certified Peer Specialist or Certified Recovery Specialist)
- Case Manager

6. Training

4A/4B and 3A/3B programs must have education and training that complies with standards in the Manual for Review of Provider Personnel Files (MRPPF)¹².

¹² CBH, *Manual for Review of Provider Personnel Files*, <http://dbhids.org/wp-content/uploads/2015/10/Manual-for-Review-of-Provider-Personnel-Files-v.1.1-August-2014.pdf>

- All non-clinical staff must be trained in Mental Health First Aid.
- All staff must be trained to administer naloxone.
- All staff must be trained in trauma-informed care.
- All staff must be trained ongoing in CBH-required safety trainings.
- All staff must have prior experience working with addiction.
- All staff must be trained in MAT.
- All staff must be trained in selected EBP(s).
- Clinical staff must be trained in structured tools and other quality measures as applicable.
- All staff must be culturally competent; applicants should describe hiring and training procedures to ensure culturally competent programming for populations as described in section 2. Target Population.

B. MEDICALLY MONITORED STABILIZATION AND MAINTENANCE PROGRAMS (3A/3B)

This section is for applicants who would like to develop one or more of the medically monitored residential stabilization and maintenance programs.

1. Objective/ Purpose

This RFP is seeking providers to develop medically monitored stabilization and maintenance programs with capacity to treat 16 individuals age 18 and over of varying genders. Programs should be able to flex beds and staffing to function as medically monitored stabilization or maintenance (3A or 3B) depending on individual need and acuity. This flexibility will minimize the disruption for individuals transitioning between these levels of care. Preference will be given to providers with academic partnerships. Applicants can propose multiple 3A/3B programs (though each must be located on a separate site). Medically monitored stabilization and maintenance (3A/3B) occurs in a DDAP-licensed residential non-hospital facility located in a freestanding or healthcare-specific environment. These programs include 24-hour evaluation, care, and treatment for individuals with addiction in acute distress. Addressing acuity and restoring an individual's capacity to live in the community are the goals of 3A/3B. Programs should be able to address medical conditions, mental health needs, and MAT regimen on site, with the understanding that some emergency and/ or chronic/ complex medical needs will require off-site treatment through partnerships/ MOAs and with minimal disruption to daily routine. The target length of stay for stabilization and maintenance programs is 21 days, though emphasis is placed on individual treatment needs, with some individuals requiring shorter or longer stays. Individuals must be engaged in treatment along the continuum of care after completion of the program, to promote continuous as opposed to episodic treatment.

Applicants should consult the Pennsylvania Client Placement Criteria (PCPC) to develop 3A/3B programs, cross-walking expectations with the American Society of Addiction Medicine (ASAM) Criteria in anticipation of DDAP adopting this as the standard for AOD programs beginning July 2018. Applicants will be asked to discuss methods to be used and resources needed to update programs to ASAM standards¹³.

2. Target Population

3A/3B programs must be able to treat individuals, ages 18 and older with substance use disorders in acute distress. Individuals are often in states of intoxication or dependence and/ or are in danger of

¹³ PA Department of Drug and Alcohol Programs, "Frequently Asked Questions Regarding the Transition to ASAM from PCPC," http://www.ddap.pa.gov/treatment/Pages/ASAM_FAQ.aspx

using alcohol or other drugs with attendant severe consequences and are in need of 24-hour short-term clinical intervention. They struggle with intensive substance use disorder symptomatology, including persistent drug or alcohol craving. Related psychosocial challenges include homelessness, incarceration/ justice involvement, and unemployment, and co-occurring intellectual disabilities and mental health diagnoses are common. Mental health symptoms and/ or stress behaviors are moderate to severe in this setting, including moderate risk of harm to self or others, history of violent or disruptive behaviors during intoxication, current verbal aggression, depression, high levels of anxiety, and challenges with life skills and self care. Individuals will have reached a level of withdrawal management per the PCPC admission criteria; some will receive MAT through the duration of their stay. The PCPC should be consulted throughout an individual's length of stay to determine level of acuity and care required.

It is important to emphasize the cultural competency of staff and programming to be able to sensitively and proficiently meet the needs of a diverse population, including lesbian, gay, bisexual, transgender, questioning, queer, intersex, and asexual (LGBTQIA) individuals, including using inclusive language and addressing medical needs of individuals who are transgender; individuals who are multilingual/ multicultural, including the ability to provide/procure interpretative services, for both deaf and non-English speaking individuals; and individuals of varying racial and socioeconomic backgrounds, with many having experienced living in circumstances of poverty/ low income. Applicants should describe plans (hiring, training, programming, etc.) to support these populations.

3. Location/ Site

In addition to the requirements in section I.E., the 3A/B programs should be free-standing or located in a healthcare-specific setting. The environment will support the promotion of clean air and living spaces and noise control. Access to outdoor space is required in the 3A/3B environment. Sites must be smoke free campuses. On-site maintenance of naloxone must be included in program protocols.¹⁴ In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

4. Services to be Provided/Required Tasks

3A/3B must provide comprehensive assessment, inpatient withdrawal stabilization and monitoring, peer support, residential treatment, and discharge planning for individuals 18 years and older. Staff must be able to address a myriad of presenting challenges stemming from substance use, mental health needs, intellectual disabilities, medical complexities, psychosocial barriers, legal involvement, or a combination. Treatment for substance use and co-occurring mental health symptoms should be provided on-site. Applicants should describe how they will ensure medical care for individuals with chronic and complex needs. Well-established referral pathways and connections to outpatient treatment services and additional community supports should be mobilized to ensure successful discharges. Services should be culturally competent, trauma-informed, and able to meet the special needs of individuals (including but not limited to LGBTQIA individuals and individuals who are multilingual/ multicultural). Given the social stigma this population faces, it is critical for each 3A/3B program to cultivate a nonjudgmental and supportive treatment environment, one which respects the dignity and value of each person who receives treatment. Emphasis must be placed on education of individuals and their families on MAT and the de-stigmatization of individuals

¹⁴ Community Behavioral Health (CBH), "Bulletin 16-04: On-site Maintenance, Prescription, and Administration of Naloxone," <http://dbhids.org/wp-content/uploads/1970/01/Bulletin-16-04-Naloxone.pdf>

prescribed it.

a) Admission

3A/3B programs must conduct admissions 24 hours per day/ 7 days per week to ensure individuals do not wait for treatment in states of acuity/ intense need. The programs must establish working relationships with emergency departments (per the Mayor's Task Force, ensuring continuous treatment for individuals following overdose¹⁵) hospitals, crisis response centers, and other addiction and mental health services to ensure smooth referral and admissions processes. Staff should conduct a welcoming orientation process for newly placed individuals (following withdrawal management as applicable), which should include a site tour, staff introductions, and explanation of guidelines and expectations for individuals receiving services. Informed consents must be obtained to allow the program to coordinate care with CBH, the individual's physical health plan, and other stakeholders. Psychoeducation should be provided with an emphasis on the goals of treatment and the individual's role in recovery. Informed consent around MAT options, including risks and benefits of treatment, must be conducted. Individuals must be assessed for tobacco use upon admission and offered medications for withdrawal. Clinical protocols must be reviewed and approved by CBH prior to implementation. The programs must establish partnerships with crisis response centers, hospitals and other addiction and mental health services ensure smooth referral and admissions processes.

b) Assessment

3A/3B teams should complete an inter-disciplinary assessment to determine all substance use, psychiatric, mental health, and medical interventions to be provided during the individual's course of stay. The state mandated substance use assessment tool (currently PCPC) should be used to determine substance use treatment needs. The assessment process should be trauma-informed, strengths-based, and culturally competent. Family members and other support people should be engaged in their roles to promote the individual's recovery. Structured tools should be administered to aid diagnosis and determine baseline measures for tracking progress and outcomes (specific tools, frequencies, and related processes to be determined during contract negotiation). Psychological and neuropsychological testing should be arranged as appropriate. Coordination with prior treatment teams, medically managed programs, hospitals, residential settings, Assertive Community Treatment (ACT) programs, probation officers, as well as system partners (ID case managers, residential case managers) must occur and be documented. All relevant prior records should be obtained, reviewed, and such review documented. Informed consent regarding evidence-based treatment options must be included in the assessment. Coordination with prior treatment teams, including short and long-term rehabilitation, hospitals, residential settings, Assertive Community Treatment (ACT) programs, probation officers, as well as system partners (ID case managers, residential case managers) must occur and be documented. All relevant prior records should be obtained, reviewed, and such review documented. Informed consent regarding evidence-based treatment options, including MAT, must be included in the assessment. Assessment should occur initially and ongoing to determine appropriateness of continued stay and/ or any need for transition to other level of care to address relapse, risk behaviors, or other symptoms that exceed 3A/3B threshold.

c) Physical Health and Wellness

3A/3B programs should provide initial physical health screening and examination upon admission. Ongoing medical treatment as appropriate should utilize on site providers for basic medical care. MOUs can be used with outside providers to treat chronic and complex specialty medical conditions

¹⁵ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017. Available at http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

as needed. Staff should provide health and wellness education, addressing symptom management, engagement in treatment, medication consistency, exercise, nutrition, weight management, and drug, alcohol, and/ or tobacco use as applicable. Physical examination by a physician within 24 hours following admission, or a physical examination which was conducted within 7 days prior to admission, and was evaluated by the facility physician within 24 hours following admission, is required. Laboratory service capacity is expected and will be bundled in rate. Specific assessments should be performed on an individualized basis. Programs are expected to provide ongoing medication management for physical health issues as needed. Individuals who are transgender and receiving hormone replacement therapy (HRT) must be continue to receive all related medical intervention on site or via partnership with outside provider. Additionally, programs must be able to assess chronic pain needs and develop a comprehensive approach to pain management including appropriate choice of MAT for those with chronic pain and opioid use disorder.

d) Substance Use Treatment

Substance use treatment should include evidence-based interventions delivered by culturally competent and trauma-informed staff. Interventions should address barriers to sustained recovery and community tenure and should assist the individual in moving through stages of change with intention and self-awareness. Increasing an individual's understanding of personal risks for substance use and the ability to use adaptive coping skills should be the focus of treatment, with staff supporting opportunities for skill practice in daily life. Emphasis should be placed on promoting wellness as well as managing triggers and symptoms. Family engagement as a key predictor of sustained recovery should be emphasized; family members, significant others, or other support people indentified by the individual should be included in treatment. Treatment should include:

- Medication induction and management
- Nursing monitoring
- Group therapy
- Individual therapy
- Peer group meetings
- Individual peer support
- Family therapy
- Educational or instructional groups
- Other supports
- Discharge planning and case management

Programs must be able to provide a curriculum of treatment throughout the day that is appropriately comprehensive and intensive as dictated by individual needs. Applicants should propose schedules of treatment, to include frequency and duration of the above services each day for each level of care, with the option to flex the combination or amount of any modality depending on individual treatment needs. It is critical that providers have weekend staffing to enable clinical programming seven days per week; this requirement aligns with best practices and the recommendation from the Mayor's Task Force Report to expand weekend and evening operations for facilities at multiple levels of care¹⁶.

e) Milieu Therapy/ Skill Building

Milieu management comprises many of the activities that provide structure and an opportunity for stabilization during 3A/3B stays, including but not limited to the management and layout of the

¹⁶ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017. Available at http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

environment, efforts to maintain safety and security, promote cooperative living among residents, and the daily schedule. Skills coaching and other opportunities for independent growth and responsible community living should be built into daily life. Recreational activities, including walks, exercises, games, creative arts and crafts, and leisure activities should complement traditional therapeutic modalities and increase an individual's ability to identify personal interests and engage in healthy outlets. Programming can include on-site support groups from outside providers.

f) Psychiatric Care and Mental Health Treatment

3A/B programs must meet the psychiatric and mental health needs of individuals. Programs provide on-site psychiatric evaluations and medication management, with 24/7 on call access for medication concerns or other acute issues. The psychiatrist may also provide MAT if appropriately trained and licensed to do so. The psychiatric providers are expected to be integrated and leading members of the treatment team.

If an individual has been recommended to receive mental health treatment (therapy), treatment must be provided by a licensed or licensed-eligible (i.e. actively working toward licensure) mental health professional. Staff should be aware of mental health treatment goals for all individuals so that they may incorporate these into other aspects of treatment. Mental health treatment staff must be integrated into the treatment team.

g) Medication-Assisted Treatment (MAT)

3A/3B programs must accept individuals on all forms of MAT, including methadone, buprenorphine and extended-release naltrexone, and must maintain MAT through the individual's stay. Individual assessment for MAT for opioid use disorder, alcohol use disorder, and tobacco use disorder must be conducted, informed consent about pharmacologic options must occur and be documented in the medical record. As previously noted, MATs are empirically supported as effective interventions to treat opioid addiction; nonetheless, MATs are significantly underutilized in part due to stigmatization and a lack of knowledge about them among treatment professionals and the community. Staff must be educated on the uses and effectiveness of MATs. Program applicants must develop and articulate plans to educate individuals about MAT in group and individual settings. MAT may be prescribed by a psychiatrist, a supervised advanced nurse practitioner, and/or a physician with board certification in addiction medicine.

h) Coordination/ Discharge

In addition to the linkages required to address chronic and complex medical needs, programs must develop collaborative relationships with community services to promote successful reintegration into the community upon discharge, ensuring individuals are connected to appropriate supports and levels of care when they leave the program. Coordination with past, current, and prospective providers is critical and required. Programs must establish working relationships with halfway house programs and CBH to ensure smooth referral/ discharge processes. Interagency meetings including CBH will occur at intervals to be determined by CBH based on clinical need. Successful transition into the community is of paramount importance. A discharge plan should be developed and signed by the individual and all involved agencies. Agencies will be responsible for outcomes related to 7 and 30 day treatment follow-up as well as recidivism; therefore ensuring participants' engagement in treatment post-discharge is paramount. Applicants should develop intervention designed to promote continuity of care. In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

5. Personnel Requirements

In addition to DDAP requirements, the staffing pattern for the 3A/3B programs should be as listed below. Personnel requirements align with the recommendation in the Mayor's Task Force Report to expand and enhance addictions workforce capacity. Strong preference will be given to providers coordinating with academic/ teaching programs.

- Physician with addictions training, available 24/7 on-site. Physical health assessment must be provided by a board-certified physician or appropriately supervised advanced nurse practitioner.
- Psychiatrist with the capacity to treat co-occurring substance use and mental health disorders, with the ability to prescribe MAT and psychotropic medication when necessary. Psychotropic medication management may be provided by an appropriately supervised, psychiatric certified advanced nurse practitioner.
- Nursing staff available 24/7 on-site
- Counselors
 - 50% master's level, clinically licensed or licensed-eligible (i.e. actively working toward license) with two years addiction treatment experience
 - 50% bachelor's level with licensed as Certified Alcohol and Drug Counselor (CADC)
- Facility Director
- Clinical Supervisor who is clinically licensed with at least two years addiction treatment experience
- Peer Support (Certified Peer Specialist or Certified Recovery Specialist)
- Case Manager

6. Training

3A/3B programs must have education and training that complies with standards in the Manual for Review of Provider Personnel Files (MRPPF).

- All non-clinical staff must be trained in Mental Health First Aid.
- All staff must be trained to administer naloxone.
- All staff must be trained in trauma-informed care.
- All staff must be trained ongoing in CBH-required safety trainings.
- All staff must have prior experience working with addiction.
- All staff must be trained in MAT.
- All staff must be trained in selected EBP(s).
- Clinical staff must be trained in structured tools and other quality measures as applicable.
- All staff must be culturally competent; applicants should describe hiring and training procedures to ensure culturally competent programming for populations as described in section 2. Target Population.

C. CO-OCCURRING MEDICALLY MONITORED LONG-TERM INTENSIVE TREATMENT PROGRAM (3C)

This section is for applicants who would like to develop the co-occurring medically monitored long-term intensive treatment program with capacity to treat 16 individuals age 18 and over of varying genders.

1. Objective/ Purpose

This RFP is seeking providers to develop co-occurring medically monitored long-term intensive treatment program(s). Medically monitored long-term treatment (3C) occurs in a DDAP-licensed addiction residential treatment and rehabilitation facility located in a freestanding or healthcare-specific environment. These programs include 24-hour evaluation, care, and treatment for individuals with addiction in chronic distress. Habilitation is the goal of 3C level of care. Chronic and complex maladaptive and addictive behaviors are addressed through global changes in lifestyle, promoting the individual's recovery and ability to reside in the community. Programs should be able to address medical conditions, mental health needs, and MAT regimen on site, with the understanding that some chronic/ complex medical needs with require off-site treatment through partnerships/ MOUs and with minimal disruption to daily routine. Successful and timely integration into the community is prioritized. The target length of 3C treatment is 90 days, though some individuals may require shorter or longer stays.

Applicants should consult the Pennsylvania Client Placement Criteria (PCPC) to develop 3C programs, cross-walking expectations with the American Society of Addiction Medicine (ASAM) Criteria in anticipation of DDAP adopting this as the standard for AOD programs beginning July 2018. Applicants will be asked to discuss methods to be used and resources needed to update programs to ASAM standards¹⁷.

2. Target Population

3C must be able to treat individuals ages 18 and older with substance use disorders who are in chronic distress and have long histories of maladaptive and antisocial behavior patterns, leading to little or no history of self-sufficient functioning in the community. Individuals referred to 3C programs are in danger of using alcohol or other drugs and resorting to illicit behaviors, with attendant severe consequences, and are in need of 24-hour long-term clinical intervention. Individuals admitted to 3C struggle with substance use disorder symptomatology, including drug or alcohol craving. Related psychosocial challenges including homelessness, patterns of criminogenic thinking and behaviors, incarceration/ justice involvement, and unemployment, and co-occurring intellectual disabilities and mental health diagnoses are common. Mental health symptoms and/ or stress behaviors are moderate to severe in this setting, including moderate risk of harm to self or others, history of violent or disruptive behaviors, difficulty adhering to structure and boundaries, current verbal aggression requiring limit setting, depression, high levels of anxiety, and challenges with life skills and self care. Referrals to 3C may come from other addiction programs, the community, and community-based treatment. Individuals will have reached a level of withdrawal management per the PCPC admission criteria; some will receive MAT through the duration of their stay.

¹⁷ PA Department of Drug and Alcohol Programs, "Frequently Asked Questions Regarding the Transition to ASAM from PCPC," http://www.ddap.pa.gov/treatment/Pages/ASAM_FAQ.aspx

It is important to emphasize the cultural competency of staff and programming to be able to sensitively and proficiently meet the needs of a diverse population, including lesbian, gay, bisexual, transgender, questioning, queer, intersex, and asexual (LGBTQIA) individuals, including using inclusive language and addressing medical needs of individuals who are transgender; individuals who are multilingual/ multicultural, including the ability to provide/procure interpretative services, for both deaf and non-English speaking individuals; and individuals of varying racial and socioeconomic backgrounds, with many having experienced living in circumstances of poverty/ low income. Applicants should describe plans (hiring, training, programming, etc.) to support these populations.

3. Location/ Site

In addition to the requirements in section I.E., the 3C programs should be free-standing or located in a healthcare-specific setting. The environment will support the promotion of clean air and living spaces and noise control. Access to outdoor space is required in a 3C environment. The environment will support the promotion of clean air and living spaces and noise control. Sites must be smoke free campuses. On-site maintenance of naloxone must be included in program protocols.¹⁸ In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

4. Services to be Provided/Required Tasks

3C programs must provide comprehensive assessment, treatment, and discharge planning for individuals 18 years and older. Applicants can propose multiple 3C programs, provided they are located on different sites. Staff must be able to address a myriad of presenting challenges stemming from substance use, mental health needs, intellectual disabilities, medical complexities, psychosocial barriers, legal involvement, or a combination. Treatment for substance use and co-occurring mental health symptoms should be provided on-site. Applicants should describe how they will ensure access to medical care for individuals, including those with chronic and complex needs. Treatment for substance use and co-occurring mental health symptoms should be provided on-site. Well-established referral pathways and connection to community supports should be mobilized to ensure successful discharges. Services should be culturally competent, trauma-informed, and able to meet the special needs of individuals (including but not limited to LGBTQIA individuals and individuals who are multilingual/ multicultural). Given the social stigma this population faces, it is critical for programs to cultivate a nonjudgmental and supportive treatment environment, one which respects the dignity and value of each person who receives treatment. Emphasis must be placed on education of individuals and their families on MAT and the de-stigmatization of individuals prescribed it.

a) Admission

3C programs must establish working relationships with CBH, other addiction and mental health providers, and medically managed programs to ensure smooth referral and admissions processes. A qualified staff person must be available for intake/admission 24/7. Staff should conduct a welcoming orientation process for newly placed individuals, including a site tour, staff introductions, and explanation of program guidelines and expectations for individuals receiving services. Informed consents must be obtained to allow the program to coordinate care with CBH, the individual's physical health plan, and other stakeholders. Psychoeducation should be provided with an emphasis on the goals of treatment and the individual's role in recovery. Informed consent regarding MAT

¹⁸ Community Behavioral Health (CBH), "Bulletin 16-04: On-site Maintenance, Prescription, and Administration of Naloxone," <http://dbhids.org/wp-content/uploads/1970/01/Bulletin-16-04-Naloxone.pdf>

options, including risks and benefits of treatment, must be conducted. Individuals must be assessed for tobacco use upon admission and offered medications for withdrawal. Clinical protocols must be reviewed and approved by CBH prior to implementation.

b) Assessment

3C teams should complete an inter-disciplinary assessment to determine all substance use, psychiatric, mental health, and medical interventions to be provided during the individual's course of stay. The state mandated substance use assessment tool (currently the Pennsylvania Client Placement Criteria) should be used to determine substance use treatment needs. The assessment process should be trauma-informed, strengths-based, and culturally competent. Family members and other support people should be engaged in their roles to promote the individual's recovery. Structured tools should be administered to aid diagnosis and determine baseline measures for tracking progress and outcomes. Psychological and neuropsychological testing should be arranged as appropriate. Criminogenic risk should be assessed given the prevalence of both criminogenic and antisocial behavior patterns as behaviors to community living. Coordination with prior treatment teams, medically managed programs, hospitals, residential settings, Assertive Community Treatment (ACT) programs, probation officers, as well as system partners (ID case managers, residential case managers) must occur and be documented. All relevant prior records should be obtained, reviewed, and such review documented. Informed consent regarding evidence-based treatment options, including MAT, must be included in the assessment. Assessment should occur initially and ongoing to determine appropriateness of continued stay and/ or any need for transition to other level of care to address relapse, risk behaviors, or other symptoms that exceed 3C threshold.

c) Physical Health and Wellness

3C programs should provide on-site medical treatment as appropriate and should utilize partnerships/ MOUs with outside providers to treat chronic and complex medical conditions as needed. Individuals who are transgender and receiving hormone replacement therapy (HRT) must be continue to receive all related medical intervention on site or via partnership with outside provider. Staff should provide health and wellness education, addressing symptom management, engagement in treatment, medication consistency, exercise, nutrition, weight management, and drug, alcohol, and/ or tobacco use as applicable. Physical examination by a physician within 24 hours following admission, or a physical examination which was conducted within 7 days prior to admission, and was evaluated by the facility physician within 24 hours following admission, is required. Laboratory service capacity is expected and will be bundled in rate. Specific assessments should be performed on an individualized basis.

d) Substance Use Treatment

Substance use treatment should be provided on site and should use evidence-based interventions delivered by culturally competent and trauma-informed staff. Interventions should address barriers to sustained recovery and community tenure and should assist the individual in moving through stages of change with intention and self-awareness. Increasing an individual's understanding of personal risks for substance use and the interaction between substance use and criminogenic behaviors should be a focus of treatment. The ability to begin to use adaptive / prosocial coping skills should be emphasized, with staff supporting opportunities for skill practice in daily life. Family members or other support people indentified by the individual should be included in treatment. Treatment should occur as follow:

- Medication induction/ management
- Group therapy
- Individual therapy

- Nursing Monitoring
- Peer group meetings
- Family therapy, if indicated by the individual's recovery plan
- Educational or instructional groups
- Vocational and educational trainings (either in house or through MOUs with community agencies)
- Other supports
- Discharge planning and case management

Programs must be able to provide a curriculum of treatment throughout the day that is appropriately comprehensive and intensive as dictated by individual needs. Applicants should propose schedules of treatment, to include frequency and duration of the above services each day for each level of care, with the option to flex the combination or amount of any modality depending on individual treatment needs. It is critical that providers have weekend staffing to enable clinical programming seven days per week; this requirement aligns with best practices and the recommendation from the Mayor's Task Force Report to expand weekend and evening operations for facilities at multiple levels of care¹⁹.

e) Milieu Therapy/ Skill Building

Milieu management comprises many of the activities that provide structure and an opportunity for stabilization during 3C stays, which is critical for individuals who may struggle to adhere to limits and boundaries. Milieu activities include the management and layout of the environment, efforts to maintain safety and security and promote cooperative living among residents, and the daily schedule. Skills coaching and other opportunities for independent growth and responsible community living should be built into daily life. Recreational activities, including walks, exercises, games, creative arts and crafts, and leisure activities should complement traditional therapeutic modalities and increase an individual's ability to identify personal interests and engage in healthy outlets as part of recovery activities. Recreational activities should focus on promoting community tenure.

f) Psychiatric Care and Mental Health Treatment

3C programs must meet the psychiatric and mental health needs of individuals. Programs provide on-site psychiatric evaluations and medication management, with 24/7 on call access for medication concerns or other acute issues. The psychiatrist may also provide MAT if appropriately trained and licensed to do so. The psychiatric providers are expected to be integrated and leading members of the treatment team.

If an individual has been recommended to receive mental health treatment (therapy), treatment must be provided by a licensed or licensed-eligible (i.e. actively working toward licensure) mental health professional. Staff should be aware of mental health treatment goals for all individuals so that they may incorporate these into other aspects of treatment. In addition to medication management, individuals should receive a minimum of weekly individual therapy for their mental health treatment. Mental health treatment staff must be integrated into the treatment team.

g) Medication-Assisted Treatment (MAT)

3C programs must accept individuals on all forms of MAT, including methadone, buprenorphine and extended-release naltrexone, and must maintain MAT through the individual's stay. Individual

¹⁹ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017, http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

assessment for MAT for opioid use disorder, alcohol use disorder, and tobacco use disorder must be conducted, informed consent about pharmacologic options must occur and be documented in the medical record. As previously noted, MATs are empirically supported as effective interventions to treat opioid addiction; nonetheless, MATs are significantly underutilized in part due to stigmatization and a lack of knowledge about them among treatment professionals and the community. Staff must be educated on the uses and effectiveness of MATs. Program applicants must develop and articulate plans to educate individuals about MAT in group and individual settings. MAT may be prescribed by a psychiatrist, a supervised advanced nurse practitioner, and/or a physician with board certification in addiction medicine.

h) Coordination/ Discharge

In addition to the linkages required to address chronic and complex medical needs, programs must develop collaborative relationships with community services to promote successful reintegration into the community upon discharge, ensuring individuals are connected to appropriate supports and levels of care when they leave the program. Coordination with past, current, and prospective providers is critical and required. Programs must establish working relationships with halfway house programs and CBH to ensure smooth referral/ discharge processes. Interagency meetings including CBH will occur at intervals to be determined by CBH based on clinical need. Successful transition into the community is of paramount importance. A discharge plan should be developed and signed by the individual and all involved agencies. Agencies will be responsible for outcomes related to 7 and 30 day treatment follow-up as well as recidivism; therefore ensuring participants' engagement in treatment post-discharge is paramount. Applicants should develop intervention designed to promote continuity of care. In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

5. Personnel Requirements

In addition to DDAP requirements, the staffing pattern for the 3C programs should be as listed below. Personnel requirements align with the recommendation in the Mayor's Task Force Report to expand and enhance addictions workforce capacity. Strong preference will be given to providers coordinating with academic/ teaching programs.

- Physician with addictions training, available 24/7 on-site or on-call. Physical health assessment must be provided by a board-certified physician or appropriately supervised advanced nurse practitioner.
- Psychiatrist with the capacity to treat co-occurring substance use and mental health disorders, with the ability to prescribe MAT and psychotropic medication when necessary. Psychotropic medication management may be provided by an appropriately supervised, psychiatric certified advanced nurse practitioner.
- Nursing staff available 24/7 on-site, able to provide medical monitoring
- Counselors
 - 50% master's level, clinically licensed or licensed-eligible (i.e. actively working toward license) with two years addiction treatment experience
 - 50% bachelor's level certified as Certified Alcohol and Drug Counselor (CADC)
- Facility Director
- Clinical Supervisor who is clinically licensed with at least two years addiction treatment experience
- Peer Support (Certified Peer Specialist or Certified Recovery Specialist)
- Case Manager

6. Training

3C programs must have education and training that complies with standards in the Manual for Review of Provider Personnel Files (MRPPF).

- All non-clinical staff must be trained in Mental Health First Aid.
- All staff must be trained to administer naloxone.
- All staff must be trained in trauma-informed care.
- All staff must be trained ongoing in CBH-required safety trainings.
- All staff must have prior experience working with addiction.
- All staff must be trained in MAT.
- All staff must be trained in selected EBP(s).
- Clinical staff must be trained in structured tools and other quality measures as applicable.
- All staff must be culturally competent; applicants should describe hiring and training procedures to ensure culturally competent programming for populations described in section 2. Target Population.

D. JOURNEY OF HOPE (JOH) MEDICALLY MONITORED RESIDENTIAL TREATMENT PROGRAMS (3A/3B/3C)

This section is for applicants who would like to develop JOH 3A/3B/3C programs

1. Objective/ Purpose

This RFP is seeking providers to develop JOH medically monitored residential treatment programs (JOH 3A/3B/3C). JOH 3A/3B/3C is delivered in a DDAP-licensed addiction residential treatment and rehabilitation facility located in a freestanding or healthcare-specific environment. These programs include 24-hour evaluation, care, and treatment for individuals with addiction in acute and/ or chronic distress. Programs should be able to flex beds and staffing (3A, 3B, or 3C) depending on individual need and acuity. This flexibility will minimize the disruption for individuals transitioning between these levels of care. Applicants can propose multiple JOH 3A/B/C programs, provided they are located on different sites. Short term (3A/3B) programming is needed for individuals without significant habilitation needs and for individuals who previously completed a 3C JOH program and are experiencing a significant relapse. Longer term (3C) programming must be able to address habilitation needs including chronic and complex maladaptive and addictive behaviors leading to long-standing vocational and educational challenges. Programs should be able to address medical conditions, mental health needs, and MAT regimen on site. Successful and timely integration into the community is prioritized. The target length of stay will vary depending on acuity and habilitation needs. Individuals with chronic homelessness and habilitation needs may require longer than traditional 3C lengths of stay (three-six months); individuals who require short term programming without habilitation may require the standard 3A/3B length of stay (approximately 21 days).

Applicants should consult the Pennsylvania Client Placement Criteria (PCPC) to develop 3C programs, cross-walking expectations with the American Society of Addiction Medicine (ASAM) Criteria in anticipation of DDAP adopting this as the standard for AOD programs beginning July 2018. Applicants will be asked to discuss methods to be used and resources needed to update programs to ASAM standards²⁰.

²⁰ PA Department of Drug and Alcohol Programs, "Frequently Asked Questions Regarding the Transition
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2. Target Population

JOH 3A/B/C must be able to treat individuals ages 18 and older with substance use disorders and chronic homelessness, some of whom are in acute or chronic distress and have long histories of maladaptive and antisocial behavior patterns, leading to little or no history of self-sufficient functioning in the community. Individuals referred to JOH programs must be experiencing chronic homelessness according to the criteria of Department of Housing and Urban Development (HUD).⁸ This RFP seeks a provider to develop capacity to treat 45 men at a time. Individuals referred to JOH 3A/B/C programs are in danger of using alcohol or other drugs and resorting to illicit behaviors, with attendant severe consequences, and are in need of 24-hour clinical intervention. Individuals struggle with substance use disorder symptomatology, including drug or alcohol craving, and some enter the program needing withdrawal monitoring. Related psychosocial challenges including homelessness, patterns of criminogenic thinking and behaviors, incarceration/ justice involvement, and unemployment, and co-occurring intellectual disabilities and mental health diagnoses are common. Mental health symptoms and/ or stress behaviors are moderate to severe in this setting, including moderate risk of harm to self or others, history of violent or disruptive behaviors, difficulty adhering to structure and boundaries, current verbal aggression requiring limit setting, depression, high levels of anxiety, and challenges with life skills and self care. Referrals may come from other addiction programs, the community, and community-based treatment. Some individuals will receive MAT through the duration of their stay.

It is important to emphasize the cultural competency of staff and programming to be able to sensitively and proficiently meet the needs of a diverse population, including lesbian, gay, bisexual, transgender, questioning, queer, intersex, and asexual (LGBTQIA) individuals, including using inclusive language and addressing medical needs of individuals who are transgender; individuals who are multilingual/ multicultural, including the ability to provide/procure interpretative services, for both deaf and non-English speaking individuals; and individuals of varying racial and socioeconomic backgrounds, with many having experienced living in circumstances of poverty/ low income. Applicants should describe plans (hiring, training, programming, etc.) to support these populations.

3. Location/ Site

In addition to the requirements in section I.E., the JOH 3A/B/C programs should be free-standing or located in a healthcare-specific or hospital-based setting. The environment will support the promotion of clean air and living spaces and noise control. Access to outdoor space is required in a 3A/B/C environment. The environment will support the promotion of clean air and living spaces and noise control. Sites must be smoke free campuses. On-site maintenance of naloxone must be included in program protocols.²¹ In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

4. Services to be Provided/Required Tasks

JOH 3A/B/C programs must provide withdrawal monitoring, stabilization, comprehensive assessment, treatment, and discharge planning for individuals 18 years and older. Staff must be able to address a myriad of presenting challenges stemming from substance use, mental health needs, habilitation needs, chronic homelessness, intellectual disabilities, medical complexities, psychosocial barriers, legal involvement, or a combination. JOH programs provide treatment to individuals who

²¹ Community Behavioral Health (CBH), "Bulletin 16-04: On-site Maintenance, Prescription, and Administration of Naloxone," <http://dbhids.org/wp-content/uploads/1970/01/Bulletin-16-04-Naloxone.pdf>

have experienced chronic homelessness according to the criteria of Department of Housing and Urban Development (HUD).²² Programs provides case management, life skills coaching, coordination with HUD/other housing supports to target chronic homelessness. Recipients of JOH services receive priority status for housing, and status is protected even in cases of extended stays. Treatment for substance use, medical conditions, and co-occurring mental health symptoms should be provided on-site. Well-established referral pathways and connection to community supports should be mobilized to ensure successful discharges. Services should be culturally competent, trauma-informed, and able to meet the special needs of individuals (including but not limited to LGBTQIA individuals and individuals who are multilingual/ multicultural). Given the social stigma this population faces, it is critical for programs to cultivate a nonjudgmental and supportive treatment environment, one which respects the dignity and value of each person who receives treatment. Emphasis must be placed on education of individuals and their families on MAT and the de-stigmatization of individuals prescribed it.

a) Admission

JOH 3A/B/C programs must establish working relationships with CBH, other addiction and mental health providers, and medically managed programs to ensure smooth referral and admissions processes. A qualified staff person must be available for intake/admission 24/7. Staff should conduct a welcoming orientation process for newly placed individuals, including a site tour, staff introductions, and explanation of program guidelines and expectations for individuals receiving services. Informed consents must be obtained to allow the program to coordinate care with CBH, the individual's physical health plan, and other stakeholders. Psychoeducation should be provided with an emphasis on the goals of treatment and the individual's role in recovery. Informed consent regarding MAT options, including risks and benefits of treatment, must be conducted. Individuals must be assessed for tobacco use upon admission and offered medications for withdrawal. Clinical protocols must be reviewed and approved by CBH prior to implementation.

b) Assessment

JOH 3A/B/C teams should complete an inter-disciplinary assessment to determine all substance use, psychiatric, mental health, and medical interventions to be provided during the individual's course of stay. The state mandated substance use assessment tool (currently the PCPC) should be used to determine substance use treatment needs. The assessment process should be trauma-informed, strengths-based, and culturally competent. Family members and other support people should be engaged in their roles to promote the individual's recovery. Structured tools should be administered to aid diagnosis and determine baseline measures for tracking progress and outcomes. Psychological and neuropsychological testing should be arranged as appropriate. Criminogenic risk should be assessed given the prevalence of both criminogenic and antisocial behavior patterns as behaviors to community living. Coordination with prior treatment teams, medically managed programs, hospitals, residential settings, HUD, Assertive Community Treatment (ACT) programs, probation officers, as well as system partners (ID case managers, residential case managers) must occur and be documented. All relevant prior records should be obtained, reviewed, and such review documented. Informed consent regarding evidence-based treatment options, including MAT, must be included in the assessment. Assessment should occur initially and ongoing to determine appropriateness of

²² HUD defines chronic homelessness as follows:

- Has been continuously homeless for a year or more (HUD defines "homeless" as "a person sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter.)
- Has had four (4) episodes of homelessness in the last three (3) years. Details available at: <https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/>

continued stay and/ or any need for transition to other level of care.

c) Physical Health and Wellness

JOH 3A/3B/3C programs should provide initial physical health screening and examination upon admission. Ongoing medical treatment as appropriate should utilize on site providers for basic medical care. MOUs can be used with outside providers to treat chronic and complex specialty medical conditions as needed. Staff should provide health and wellness education, addressing symptom management, engagement in treatment, medication consistency, exercise, nutrition, weight management, and drug, alcohol, and/ or tobacco use as applicable. Physical examination by a physician within 24 hours following admission, or a physical examination which was conducted within 7 days prior to admission, and was evaluated by the facility physician within 24 hours following admission, is required. Laboratory service capacity is expected and will be bundled in rate. Specific assessments should be performed on an individualized basis. Programs are expected to provide ongoing medication management for physical health issues as needed. Individuals who are transgender and receiving hormone replacement therapy (HRT) must be continue to receive all related medical intervention on site or via partnership with outside provider. Additionally, programs must be able to assess chronic pain needs and develop a comprehensive approach to pain management including appropriate choice of MAT for those with chronic pain and opioid use disorder.

d) Substance Use Treatment

Substance use treatment should be provided on site and should use evidence-based interventions delivered by culturally competent and trauma-informed staff. Interventions should address barriers to sustained recovery and community tenure and should assist the individual in moving through stages of change with intention and self-awareness. Increasing an individual’s understanding of personal risks for substance use and the interaction between substance use and criminogenic behaviors should be a focus of treatment. The ability to begin to use adaptive / prosocial coping skills should be emphasized, with staff supporting opportunities for skill practice in daily life. Family members or other support people indentified by the individual should be included in treatment. Treatment should occur as follow:

- Medication induction/ management
- Group therapy
- Individual therapy
- Nursing monitoring
- Peer group meetings
- Family therapy, if indicated by the individual’s recovery plan
- Educational or instructional groups
- Vocational and educational trainings (either in house or through MOUs with community agencies)
- Other supports
- Discharge planning and case management

Programs must be able to provide a curriculum of treatment throughout the day that is appropriately comprehensive and intensive as dictated by individual needs. Applicants should propose schedules of treatment, to include frequency and duration of the above services each day for each level of care, with the option to flex the combination or amount of any modality depending on individual treatment needs. It is critical that providers have weekend staffing to enable clinical programming seven days

per week; this requirement aligns with best practices and the recommendation from the Mayor's Task Force Report to expand weekend and evening operations for facilities at multiple levels of care²³.

e) Milieu Therapy/ Skill Building

Milieu management comprises many of the activities that provide structure and an opportunity for stabilization during JOH 3A/B/C stays, which is critical for individuals who may struggle to adhere to limits and boundaries. Milieu activities include the management and layout of the environment, efforts to maintain safety and security and promote cooperative living among residents, and the daily schedule. Skills coaching and other opportunities for independent growth and responsible community living should be built into daily life. Recreational activities, including walks, exercises, games, creative arts and crafts, and leisure activities should complement traditional therapeutic modalities and increase an individual's ability to identify personal interests and engage in healthy outlets. Recreational activities should promote learning and occur off-site, in the community for identified individuals with the focus of promoting community tenure. Programming can include on-site support groups from outside providers.

f) Psychiatric Care and Mental Health Treatment

JOH 3A/B/C programs must meet the psychiatric and mental health needs of individuals. Programs provide on-site psychiatric evaluations and medication management, with 24/7 on call access for medication concerns or other acute issues. The psychiatrist may also provide MAT if appropriately trained and licensed to do so. The psychiatric providers are expected to be integrated and leading members of the treatment team.

If an individual has been recommended to receive mental health treatment (therapy), treatment must be provided by a licensed or licensed-eligible (i.e. actively working toward licensure) mental health professional. Staff should be aware of mental health treatment goals for all individuals so that they may incorporate these into other aspects of treatment. Mental health treatment staff must be integrated into the treatment team.

g) Medication-Assisted Treatment (MAT)

JOH 3A/B/C programs must accept individuals on all forms of MAT, including methadone, buprenorphine and extended-release naltrexone, and must maintain MAT through the individual's stay. Individual assessment for MAT for opioid use disorder, alcohol use disorder, and tobacco use disorder must be conducted, informed consent about pharmacologic options must occur and be documented in the medical record. As previously noted, MATs are empirically supported as effective interventions to treat opioid addiction; nonetheless, MATs are significantly underutilized in part due to stigmatization and a lack of knowledge about them among treatment professionals and the community. Staff must be educated on the uses and effectiveness of MATs. Program applicants must develop and articulate plans to educate individuals about MAT in group and individual settings. MAT may be prescribed by a psychiatrist, a supervised advanced nurse practitioner, and/or a physician with board certification in addiction medicine.

h) Coordination/ Discharge

In addition to the linkages required to address chronic and complex medical needs, programs must develop collaborative relationships with community services to promote successful reintegration into

²³ City of Philadelphia Mayor's Task Force, *Final Report and Recommendations to Combat the Opioid Epidemic in Philadelphia*, May 17, 2017, http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf

the community upon discharge, ensuring individuals are connected to appropriate supports and levels of care when they leave the program. Coordination with past, current, and prospective providers is critical and required. Programs must establish working relationships with halfway house programs and CBH to ensure smooth referral/ discharge processes. Interagency meetings including CBH will occur at intervals to be determined by CBH based on clinical need. Successful transition into the community is of paramount importance. A discharge plan should be developed and signed by the individual and all involved agencies. Agencies will be responsible for outcomes related to 7 and 30 day treatment follow-up as well as recidivism; therefore ensuring participants' engagement in treatment post-discharge is paramount. Applicants should develop intervention designed to promote continuity of care. In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge.

5. Personnel Requirements

In addition to DDAP requirements, the staffing pattern for the JOH 3A/3B/3C programs should be as listed below. Personnel requirements align with the recommendation in the Mayor's Task Force Report to expand and enhance addictions workforce capacity. Strong preference will be given to providers coordinating with academic/ teaching programs.

- Physician with addictions training, available 24/7 on-site. Physical health assessment must be provided by a board-certified physician or appropriately supervised advanced nurse practitioner.
- Psychiatrist with the capacity to treat co-occurring substance use and mental health disorders, with the ability to prescribe MAT and psychotropic medication when necessary. Psychotropic medication management may be provided by an appropriately supervised, psychiatric certified advanced nurse practitioner.
- Nursing staff
- Counselors
 - 50% master's level, clinically licensed or licensed-eligible (i.e. actively working toward license) with two years addiction treatment experience
 - 50% bachelor's level with licensed as Certified Alcohol and Drug Counselor (CADC)
- Facility Director
- Clinical Supervisor who is clinically licensed with at least two years addiction treatment experience
- Peer Support (Certified Peer Specialist or Certified Recovery Specialist)
- Housing Case Manager

6. Training

JOH 3A/B/C programs must have education and training that complies with standards in the Manual for Review of Provider Personnel Files (MRPPF). Staff must be trained in issues related to chronic homelessness and must be knowledgeable of housing programs and systems in Philadelphia.

- All non-clinical staff must be trained in Mental Health First Aid.
- All staff must be trained to administer naloxone.
- All staff must be trained in trauma-informed care.
- All staff must be trained ongoing in CBH-required safety trainings.
- All staff must have prior experience working with addiction.
- All staff must be trained in MAT.
- All staff must be trained in selected EBP(s).

- Clinical staff must be trained in structured tools and other quality measures as applicable.
- All staff must be culturally competent; applicants should describe hiring and training procedures to ensure culturally competent programming for populations described in section 2. Target Population.

E. AMBULATORY STABILIZATION BRIDGE PROGRAM

This section is for applicants who would like to develop Ambulatory Stabilization, which includes the following components:

- 23-hour Observation (optional)
- Ambulatory Withdrawal Management
- Comprehensive assessment for level of care placement
- Warm hand off to next level of care
- Ongoing medication management and intervention until individuals' link to the appropriate level of care

1. Objective/ Purpose

This RFP is seeking providers to develop Ambulatory Stabilization in Northeast Philadelphia/ Frankford, North, South Philadelphia, and West Philadelphia (see zip codes below) to increase access to substance use assessment and withdrawal management. The goals of the program are to provide urgent and timely access to emergency substance use intervention, followed by outpatient withdrawal management as appropriate, for individuals who may otherwise be at risk for overdose or continued use. Programs can be DDAP licensed, mental health licensed, or medical clinics with licensed staff who can be individually enrolled in Medicaid.

Extended hours of operation are required. Capacity to operate 24/7 is preferred. The program must actively coordinate with emergency departments and their providers. Protocols for rapid buprenorphine and other withdrawal management inductions should be well-defined and articulated in the proposal, in order to ensure individuals receive minimal delay in care from the time of presentation to the emergency department. It is understood that the stages of recovery often start with an individual seeking relief from withdrawal, while not yet feeling ready to enroll in addiction treatment. Ambulatory Stabilization aims to meet individuals where they are (i.e. providing the relief they seek) and includes components of peer support and clinical intervention to encourage motivation toward next steps in recovery. Providers may apply for Ambulatory Stabilization and other addiction services in this RFP.

2. Target Population

The Ambulatory Stabilization programs must be able to treat individuals of varying genders, ages 18 and older with substance use disorders who may present in acute stages of intoxication or withdrawal. Like target populations for other addiction levels of care, individuals have psychosocial challenges including homelessness, incarceration/ justice involvement, and unemployment. Individuals often have co-occurring intellectual disabilities, physical health and mental health diagnoses, with symptoms and behaviors that range from moderate to severe. Individuals will be accepted for treatment from emergency departments once medically cleared.

It is important to emphasize the cultural competency of staff and programming to be able to sensitively and proficiently meet the needs of a diverse population, including lesbian, gay, bisexual, transgender, questioning, queer, intersex, and asexual (LGBTQIA) individuals, including using

inclusive language and addressing medical needs of individuals who are transgender; individuals who are multilingual/ multicultural, including the ability to provide/procure interpretative services, for both deaf and non-English speaking individuals; and individuals of varying racial and socioeconomic backgrounds, with many having experienced living in circumstances of poverty/ low income. Applicants should describe plans (hiring, training, programming, etc.) to support these populations.

3. Location/ Site

In addition to the requirements in section I.E., Ambulatory Stabilization programs should be free-standing or located in a healthcare-specific or hospital-based setting; close proximity to emergency departments is preferred. Physical space must function as a walk-in site, with reception, waiting area, and space for face-to-face treatment. Sites must be smoke free campuses. On-site maintenance of naloxone must be included in program protocols.²⁴ In accordance with CBH policy, staff must be trained in the administration of naloxone, must educate participants and their families about its use and offer it via prescription to vulnerable individuals upon discharge. CBH seeks applicants to deve

4. Services/ Required Tasks

a) 23-Hour Observation

23-hour observation is a preferred (not required) component of Ambulatory Stabilization. It is designed to serve as a 24/7 access point, make a level of care determination, safely begin the induction process, and create a seamless transition to next level of care. 23-hour observation includes a comprehensive level of care assessment by a medical team and peer specialists. If the individual exhibits symptoms of withdrawal (as assessed through observation and structured tools), medical intervention, including MAT induction if appropriate, can begin. It is critical that the 23-hour observation service is equipped to address most substance use and co-occurring mental health and medical needs, diverting a need for transfer to a Crisis Response Center or Emergency Department when appropriate. Once a level of care assessment is made, staff must mobilize linkages to ensure expeditious transfers to next levels of care, including withdrawal management on-site for individuals for whom this is deemed appropriate. It is possible for Ambulatory Stabilization applicants to develop programs without 23-hour observation, provided the other components of programming are offered via extended hours.

b) Withdrawal Management

Withdrawal management is the second component of Ambulatory Stabilization, designed to provide immediate and less intensive follow-up treatment for individuals deemed appropriate for this level of care. Individuals receive medical services, including vitals, urine drug analysis (to ensure compliance with management program), daily dosing of MAT, and assessment of response to intervention. Physicians or nurse practitioners must be available 24/7 to respond to any medical complications. Individuals must also participate in clinical intervention, and programs must have the availability of group therapy daily and individual therapy twice weekly (individuals can participate in some or all of these supports depending on need and recommendations of the program). Nursing support and medication management should also be available daily. Target duration for withdrawal management and stabilization is 10-28 days before supported transition to appropriate level of care.

²⁴ Community Behavioral Health (CBH), "Bulletin 16-04: On-site Maintenance, Prescription, and Administration of Naloxone," <http://dbhids.org/wp-content/uploads/1970/01/Bulletin-16-04-Naloxone.pdf>

c) Comprehensive Level of Care Assessment

Individuals must receive an inter-disciplinary comprehensive level of care assessment, using the state-mandated placement criteria (currently the PCPC) to determine services needed. Individual assessment for continued MAT for opioid use disorder, alcohol use disorder, and tobacco use disorder must be conducted, informed consent about pharmacologic options must occur and be documented in the medical record. As previously noted, MATs are empirically supported as effective interventions to treat opioid addiction; nonetheless, MATs are significantly underutilized in part due to stigmatization and a lack of knowledge about them among treatment professionals and the community. Level of care assessment should also provide psychoeducation about addiction continuum, including evidence-based therapies, and should ensure appropriate linkage to services.

d) Transition to Next Level of Care/Ongoing Medication Management and Intervention

It is critical that individuals continue to receive medication management and interventions until next level of care begin; interrupted treatment during transition between levels of care creates life-threatening risk for individuals with substance use disorders; therefore Ambulatory Stabilization programs must closely manage the transition to next services, ensuring no barriers exist to individuals being placed or attending first appointment (this includes individual ambivalence). Staff should follow up to ensure first appointment attendance in cases of referrals to non-bed services.

5. Personnel

- Psychiatrist with the ability to prescribe MAT and psychotropic medication when necessary. Psychotropic medication management may be provided by an appropriately supervised, psychiatric certified advanced nurse practitioner.
- Physician with capacity to treat co-occurring substance use and mental health disorders (round-the-clock on-site coverage)
- Nursing staff (round-the-clock on-site coverage)
- Counselors
 - 50% master's level, clinically licensed or licensed-eligible (i.e. actively working toward license) with two years addiction treatment experience
 - 50% bachelor's level with licensed as Certified Alcohol and Drug Counselor (CADC)
- Facility Director
- Clinical Supervisor who is clinically licensed with at least two years addiction treatment experience
- Peer Support (Certified Recovery Specialist)
- Case Manager

6. Training

Staff must have education and training that complies with standards in the MRPPF.

- All non-clinical staff must be trained in Mental Health First Aid.
- All staff must be trained to administer Naloxone.
- All staff must be trained in trauma-informed care.
- All staff must be trained ongoing in CBH-required safety trainings
- All staff must have prior experience working with Alcohol and Other Drugs (AOD).
- All staff must be trained in selected EBP(s).
- Clinical staff must be trained in structured tools and other quality measures as applicable.
- All staff must be culturally competent; applicants should describe hiring and training procedures to ensure culturally competent programming for populations described in section 2. Target Population.

F. Timetable

It is expected that all services requested through this RFP will be fully operational as soon as possible, and applicants should include timetable for projected start date with target dates for phases of start-up (hiring, training, etc.).

G. Monitoring

Programs selected will be subject to evaluation, program, compliance and budgetary monitoring by DBHIDS and CBH. On site reviews including participation in treatment teams may occur as deemed necessary by CBH.

H. Reporting Requirements

By accepting an award under this RFP, applicants agree to comply with all data reporting requirements of CBH. Awardees agree to supply all the required data necessary for outcome evaluation and Performance Evaluation, Analytics, and Research (PEAR) purposes and to participate in required assessments. To fulfill the data reporting requirements, successful applicants must work with CBH and, where applicable, the CBH Claims, Information Services and PEAR Departments to ensure the quality and completeness of data. Reporting requirements may be modified prior to or during the contract award period.

Applicants will be required to develop and maintain a continuous quality improvement plan for the services implemented. This will include tracking process and outcome measures related to the impact and effectiveness of the services delivered, as well as setting goals and engaging in improvement activities related to the goals. Measures to be tracked by all programs (except for Ambulatory Stabilization) must include:

- Reductions in Addiction Severity Index
- Percentage of individuals with opioid use disorder, tobacco use disorder, and/or alcohol use disorder provided a FDA approved medication as part of treatment in the program
- Amount of program services delivered (individual, group, and family therapy, psychiatric consultation, etc)
- 30 and 90 day recidivism to all bed-based levels of care
- 7 and 30 day follow-up rates to outpatient services

Ambulatory Stabilization programs must report on the following measures:

- Number of individuals seen
- Average time spent in assessment center from walk-in to first contact with program staff
- Percent of referrals to various levels of care: Addictions Intensive Outpatient (1B) and Addictions Outpatient (1B), Acute Inpatient (AIP), Sub-acute Inpatient (SAIP), Inpatient Detox (4A), Non-Hospital Detox (3A), Inpatient Short Term Rehab (4B), Non-Hospital Short Term Rehab (3B), Non-Hospital Long Term Rehab (3C), Non-Hospital Halfway House
- Number/percent of discharges against medical advice (AMA)
- Basic demographics of population served
 - Age (in single years)
 - Gender
 - Race/Ethnicity

- Insurance status (CBH, BHSI, Medicare primary, other)
- Homelessness/housing status
- Forensic history/involvement
- Primary Diagnosis (DSM 5)
- Referral sources (i.e. how did individual know to come to Ambulatory Stabilization?)
- Primary drug of choice (Etoh, Benzodiazepines, Crack/Cocaine, Heroin, Marijuana, PCP, Rx opioids, Synthetics, other)
- Secondary drug of choice
- Tertiary drug of choice
- 7 and 30 day follow-up rates to outpatient services

To ensure immediate and accurate assessment of network capacity and in alignment with CBH policy and the Mayor’s Task Force Report to maintain a database to identify treatment slots in real time, providers of all bed-based programs will be required to submit treatment openings on a daily basis via the Open Bed Registry.²⁵

I. Performance Standards

The selected applicant will be required to meet CBH credentialing, compliance, and performance standards. All successful bidders will be expected to have a compliance plan along with all other required documents for initial credentialing.

J. Compensation/Reimbursement

For each program, you must submit a separate detailed budget in excel using the budget expenditure summary forms attached. All tabs must be completed. Your budget should incorporate all the requirements of the RFP.

Please use the miscellaneous item detail tab for any category not included on the form. Please provide information for all the categories in the miscellaneous item detail form. For the personnel roster, please provide actual staffing detail where available. Please note that the administrative staff should not be included on the personnel roster. These costs are part of administration. Do not alter the form in any way. Be sure to label clearly the start-up and ongoing operations budgets. The following are the expected range of per diem rates for these services:

Programs	Rate Range		
Withdrawal management for medically managed residential rehabilitation (3&4 A/B)	\$300	to	\$425
Withdrawal management for medically monitored residential rehabilitation (3 A/B)	\$275	to	\$400
Journey of Hope withdrawal management and residential rehabilitation (3 A/B/C)	\$275	to	\$400
Dual diagnosis long term residential rehabilitation (3C)	\$275	to	\$350
Ambulatory Stabilization	\$225	to	\$325

²⁵ Community Behavioral Health, “Bulletin 16-06 Daily Psychiatric and Substance Abuse Open Bed Registry,” <http://dbhids.org/wp-content/uploads/1970/01/Bulletin-16-06-Daily-Psychiatric-and-Substance-Abuse-Open-Bed-Registry.pdf>

Your budget should incorporate all the requirements of this RFP. Any deviations from the requirements and expectations of this RFP must be clearly stated along with supporting justification. Appropriate budget data must be submitted in order to be considered for the right to negotiate.

The right to negotiate will also include discussions regarding length of stay and may result in a value-based funding model that includes a reduction in the rate after the targeted length of service.

K. Technology Capabilities

Applicants must have the technology capabilities required to perform the proposed activities in this RFP. At a minimum, applicants must have electronic claims submission and an electronic health record (EHR) ready for use.

L. Available Information

Because of the successful DBHIDS transformation initiative over the last decade (2005-2015), people with behavioral health conditions and intellectual disabilities now not only live in communities but are a part of their communities. As the natural continuation of the transformation of Philadelphia's behavioral health and intellectual disability service system, DBHIDS has now adopted a population health approach.

Population health refers to the health of an entire community. Traditional approaches to health care center around individuals who are already experiencing a health-related condition. Population health approaches take a much broader view, seeking to improve the health status of everyone in a community, not just those who are sick. By providing excellent clinical care as well as community-level interventions and services, population health approaches help to create communities in which every member—not just those who seek out health services—can thrive.

As DBHIDS worked in communities to help them better support people in its system, it became clear that many communities are themselves distressed, grappling with violence, poverty, inadequate housing, and other threats to health, well-being, and self-determination. It also has become clear that many people in need of support are not being reached or being reached too late. As a result, DBHIDS has initiated a population health approach to increase capacity within the community to deliver highly effective clinical care supports and services so that over time, communities experience less illness and its associated consequences.

The current national attention to population health confirms that Philadelphia's population health approach is appropriate. The U.S. healthcare environment is already moving in this direction in an effort to contain costs and achieve better outcomes. Acknowledgement is growing locally, nationally, and internationally that promoting optimum health among a whole population can't be achieved within a narrow paradigm built primarily to manage diagnosed conditions. To break the cycle of escalating costs, health systems are increasingly focusing resources on prevention and early intervention. Because of DBHIDS' longstanding commitment to promoting recovery, resilience, and self-determination, Philadelphia is well positioned to be a leader in the nation's next health transformation. The thrust of Philadelphia's behavioral health initiatives are shifting from addressing illness and disability one person at a time to promoting optimum health, wellness, and self-determination throughout the population.

The population health approach challenges us to continue to enhance efforts to improve the health of all Philadelphians. This approach challenges us to expand our efforts beyond pilot projects and special initiatives and embed these principles into the culture of our entire system. It challenges us to consistently broaden our scope to include all people in a population, not just those seeking our services. It challenges us to prevent behavioral health conditions and developmental delays from developing or progressing, to equip individuals with the skills and opportunities to make their own choices and build meaningful lives in their communities, and to move even more out of program settings and deeper into the community to address the social and environmental circumstances that have shaped people's lives. We must learn from the innovative work the city has already started and be even bolder, shifting the intention of our work from addressing illness and disability one person at a time to promoting optimum health, wellness, and self-determination throughout the whole population.

Health providers and payers use a variety approaches to improve the health of a population. Some approaches, known as population health management, prioritize identifying and providing services to members of a population who have complex, chronic, or very costly conditions. A key goal of population health management efforts is to control costs, often through existing managed care strategies such as reducing avoidable emergency department visits. Other population health approaches are more akin to public health interventions in that they include broad-based interventions (such as flu shots) that benefit all members of a defined population, not just those seeking health services. These two major population health frameworks both use data-driven decision making and focus on health outcomes. DBHIDS's approach to population health builds on many years of focus on community health; thus, our approach is consistent with a public health framework.

The essence of the DBHIDS population health approach is as follows:

- 1. Attend to the needs of the whole population, not just those seeking services.** Population health approaches emphasize community-level outcomes, not just outcomes for individuals with particular diagnoses. A key benefit of a population health approach is its focus on keeping people well so that, over time, communities experience less illness and its associated consequences.
- 2. Promote health, wellness and self-determination.** Health is much more than the absence of illness or management of symptoms. There is a fundamental difference between providing targeted interventions to address illness versus promoting wellness and quality of life.
- 3. Provide early intervention and prevention.** There will always be a need for access to high – quality clinical care, supports, and services. A population health approach provides such care and also works to screen for and prevent the onset or progression of conditions which improves outcomes and better utilizes resources.
- 4. Address the social determinants of health.** Poor health and health disparities don't result from medical conditions alone. Chronic stress, toxic environments, limited access to nutritious foods, inadequate housing, social isolation, and numerous other nonmedical factors contribute to poor outcomes. A population health approach seeks to address these factors to reduce health disparities and safeguard everyone's right to optimum health and self-determination.
- 5. Empower individuals and communities to keep themselves healthy.** Healthcare providers can't shoulder the entire responsibility for healthy communities. A population health approach not only educates but also empowers and motivates people to take responsibility for promoting their own

health and wellness.

III. Proposal Format, Content and Submission Requirements; Selection Process

A. Required Proposal Format

1. Format Structure

Applicants must submit separate proposals for each program they would like to develop. Each proposal should include:

- Cover Sheet (Appendix A). Indicate which program is covered in the application.
- Table of Contents: A table of contents must be included as the second page of the proposal with each section of the proposal included and with a page number for the first page of each section.
- Responses to questions one (1) through five (5). CBH understands that applicants submitting multiple proposals may include some repeated content in their responses to these questions.
- Response to the program in section six (6) for which they are applying.
- Responses to questions one (1) through six (6) should not exceed **15 pages**.
- Treatment Curriculum (Appendix B)
- Budget Forms (Appendix F/ posted on website under RFP)

The following responses and attachments are also required; applicants can submit once even if submitting multiple applications:

- Responses / documentation required in question seven (7)
- City of Philadelphia Tax and Regulatory Status and Clearance Statement for Applicants (Appendix C)
- CBH Disclosure of Litigation Form (Appendix D)
- City of Philadelphia Disclosure Forms (Appendix E/ posted on website under RFP)

Proposals must be prepared simply and economically, providing a straightforward, concise description of the applicant's ability to meet the requirements of the RFP. The narrative portion of the proposal must be presented in print size of 12, using a Times New Roman font, single spaced on 8.5" by 11" sheets of paper with minimum margins of 1". For each section where it is required, the applicant must fully answer all of the listed questions. Answers to each question must be numbered/lettered and correspond to the numbered/lettered questions in this RFP. Failure to number and letter the questions or to respond to all questions may result in the proposal's being considered non-responsive. Each attachment, appendix, or addendum must reference the corresponding section or subsection number.

Applicants are required to limit their General Narrative Description (questions one (1) through six (6)) to 15 (fifteen) single spaced pages. As a general comment, if you have responded to a requirement in another part of your narrative, make reference to that section and do not repeat your response. Applicants whose narrative exceeds the page limits may have their proposals considered non-responsive and be disqualified.

B. Proposal Content

1. Introduction/Executive Summary

Prepare a very brief introduction including a general description of your understanding of the scope and complexity of the proposed project. Indicate which programs you intend to develop, indicating proposed capacity for each and anticipated timeframe for startup projected start date with target dates for phases of start-up (hiring, training, etc.).

2. Statement of Qualifications/Relevant Experience

Provide information on the continuum of services offered by the applicant agency and the length of time the agency has been in existence. Describe previous work with similar target populations and experience providing services similar to those requested in this RFP. This should include experience working with adults with serious addiction challenges. Also describe experience working with adults with co-occurring mental health and substance use issues.

The applicant must also be able to provide documentation of the availability of an appropriate facility for the program(s), ensuring site meets highest quality accreditation standards. Documentation of availability of the facility must be through ownership or lease documents that are included in the response to this RFP.

3. Corporate Status

Please indicate your corporate status, including whether you are a for-profit or not-for-profit organization and provide legal documentation of that status as an attachment to your proposal (documentation can be provided once, even if submitting multiple applications).

4. Governance Structure

Describe the governing body of your organization. Each applicant must provide a list of the names, gender, race, and business addresses of all members of its Board of Directors. Please indicate which, if any, board members are self-disclosed service recipients or are family members of people who have received services.

5. Program Philosophy

This section provides the opportunity to describe the vision, values and beliefs that will be evident in the design and implementation of the proposed services. The applicant should explain how the values of the Philadelphia System Transformation and the Practice Guidelines, including being strengths-based and recovery and resilience focused, are evident in the operations of the applicant organization, particularly as this pertains to program philosophy that focus on successful and sustained community reintegration. This section should also include a description of how person-first (culturally competent) and trauma-informed practices and approaches are incorporated into the applicant organization.

6. Program Design

Applicants should complete each portion of section 6 that correlates to the program(s) they are proposing.

a. MEDICALLY MANAGED AND MEDICALLY MONITORED STABILIZATION AND MAINTENANCE RESIDENTIAL TREATMENT (4A/4B and 3A/3B)

Applicants who wish to develop 4A/4B/3A/3B should address each component listed below, with detailed responses that reflect an understanding and an ability to address the requirements described in correlating sections in the RFP (sections are noted next to each component).

- 1) Objective (see I.A. & II.A.1.)
- 2) Target Population (II.A.2.)
- 3) Location/ Site (I.E. & II.A.3.)
- 4) Services to be Provided/ Required Tasks (II.A.4)
 - a) Admission (II.A.4.a.)
 - b) Assessment (II.A.4.b.)
 - c) Physical Health and Wellness (II.A.4.c.)
 - d) Substance Use and Treatment (II.A.4.d.) Applicants should address this section in narrative form here and via Attachment B
 - e) Milieu Therapy/ Skill Building (II.A.4.e.)
 - f) Psychiatric Care/ Mental Health Treatment (II.A.4.f.)
 - g) Medication-Assisted Treatment (II.A.4.g.)
 - h) Coordination/ Discharge (II.A.4.h.)
- 5) Personnel Requirements (II.A.5.) Proposed staffing patterns, with ratios to proposed treatment capacity, should be addressed in narrative form here and by completing the Budget Form.
- 6) Training (II.A.6. and address plan to provide EBPs per I.G.)
- 7) Reporting (II.H.)
- 8) Discuss methods to be used and resources needed to update programs to ASAM standards.

b. MEDICALLY MONITORED STABILIZATION AND MAINTENANCE RESIDENTIAL TREATMENT (3A/3B)

Applicants who wish to develop 3A/3B should address each component listed below, with detailed responses that reflect an understanding of and an ability to address the requirements described in correlating sections in the RFP (sections are noted next to each component).

- 1) Objective (see I.A. & II.B.1.)
- 2) Target Population (II.B.2.)
- 3) Location/ Site (I.E. & II.B.3.)
- 4) Services to be Provided/ Required Tasks (II.B.4)
 - a) Admission (II.B.4.a.)
 - b) Assessment (II.B.4.b.)
 - c) Physical Health and Wellness (II.B.4.c.)
 - d) Substance Use and Treatment (II.B.4.d.) Applicants should address this section in narrative form here and via Attachment B
 - e) Milieu Therapy/ Skill Building (II.B.4.e.)
 - f) Psychiatric Care/ Mental Health Treatment (II.B.4.f.)
 - g) Medication-Assisted Treatment (II.B.4.g.)
 - h) Coordination/ Discharge (II.B.4.h.)
- 5) Personnel Requirements (II.B.5.) Proposed staffing patterns, with ratios to proposed

treatment capacity, should be addressed in narrative form here and by completing the Budget Form.

- 6) Training (II.B.6. and address plan to provide EBPs per I.G.)
- 7) Reporting (II.H.)
- 8) Discuss methods to be used and resources needed to update programs to ASAM standards.

c. CO-OCCURRING MEDICALLY MONITORED LONG-TERM INTENSIVE TREATMENT PROGRAM (3C)

Applicants who wish to develop 3C should address each component listed below, with detailed responses that reflect an understanding of and an ability to address the requirements described in correlating sections in the RFP (sections are noted next to each component).

- 1) Objective (see I.A. & II.C.1.)
- 2) Target Population (II.C.2.)
- 3) Location/ Site (I.E. & II.C.3.)
- 4) Services to be Provided/ Required Tasks (II.C.4)
 - a) Admission (II.C.4.a.)
 - b) Assessment (II.C.4.b.)
 - c) Physical Health and Wellness (II.C.4.c.)
 - d) Substance Use and Treatment (II.C.4.d.) Applicants should address this section in narrative form here and via Attachment B
 - e) Milieu Therapy/ Skill Building (II.C.4.e.)
 - f) Psychiatric Care/ Mental Health Treatment (II.C.4.f.)
 - g) Medication-Assisted Treatment (II.C.4.g.)
 - h) Coordination/ Discharge (II.C.4.h.)
- 5) Personnel Requirements (II.C.5.) Proposed staffing patterns, with ratios to proposed treatment capacity, should be addressed in narrative form here and by completing the Budget Form.
- 6) Training (II.C.6. and address plan to provide EBPs per I.G.)
- 7) Reporting (II.H.)
- 8) Discuss methods to be used and resources needed to update programs to ASAM standards.

d. JOURNEY OF HOPE (JOH) MEDICALLY MONITORED RESIDENTIAL TREATMENT PROGRAMS (JOH 3A/3B/3C)

Applicants who wish to develop JOH 3A/3B/3C should address each component listed below, with detailed responses that reflect an understanding of and an ability to address the requirements described in correlating sections in the RFP (sections are noted next to each component).

- 1) Objective (see I.A. & II.D.1.)
- 2) Target Population (II.D.2.)
- 3) Location/ Site (I.E. & II.D.3.)
- 4) Services to be Provided/ Required Tasks (II.D.4)
 - a) Admission (II.D.4.a.)
 - b) Assessment (II.D.4.b.)
 - c) Physical Health and Wellness (II.D.4.c.)
 - d) Substance Use and Treatment (II.D.4.d.) Applicants should address this section in narrative form here and via Attachment B.
 - e) Milieu Therapy/ Skill Building (II.D.4.e.)
 - f) Psychiatric Care/ Mental Health Treatment (II.D.4.f.)

- g) Medication-Assisted Treatment (II.D.4.g.)
- h) Coordination/ Discharge (II.D.4.h.)
- 5) Personnel Requirements (II.D.5.) Proposed staffing patterns, with ratios to proposed treatment capacity, should be addressed in narrative form here and by completing the Budget Form.
- 6) Training (II.D.6. and address plan to provide EBPs per I.G.)
- 7) Reporting (II.H.)
- 8) Discuss methods to be used and resources needed to update programs to ASAM standards.

e. AMBULATORY STABILIZATION PROGRAMS

Applicants who wish to develop Ambulatory Stabilization should address each component listed below, with detailed responses that reflect an understanding of and an ability to address the requirements described in correlating sections in the RFP (sections are noted next to each component).

- 1) Objective (see I.A. & II.E.1.)
- 2) Target Population (II.E.2.)
- 3) Location/ Site (I.E. & II.E.3.)
- 4) Services to be Provided/ Required Tasks (II.E.4)
 - a) 23 Hour Observation (II.E.4.a.) If applicants intend to develop Ambulatory Stabilization without this component, this section should describe methods to ensure frequent (preferred 24/7) appointment and walk-in access.
 - b) Withdrawal Management (II.E.4.b.)
 - c) Comprehensive Level of Care Assessment (II.E.4.c.)
 - d) Transition to Next LOC and Ongoing Medication Management and Intervention (II.E.4.d.)
- 5) Personnel Requirements (II.E.5.) Proposed staffing patterns, with ratios to proposed treatment capacity, should be addressed in narrative form here and by completing the Budget Form.
- 6) Training (II.E.6. and address plan to provide EBPs per I.G.)
- 7) Reporting (II.H.)
- 8) Discuss methods to be used and resources needed to update programs to ASAM standards.

7. Operational Documentation and Requirements

Applicants must demonstrate the financial capability and fiscal solvency to do the work described in this RFP, and as described in their proposal. At a minimum, applicants must meet the financial threshold requirements described below for their proposal to be considered for further review. The following documentation is required at the time of proposal submission and should be submitted as an Attachment to the proposal. This documentation is required once, even if submitting multiple proposals:

- Tax Identification Number
- An overview of your agency’s financial status, which will include submission of a certified corporate audit report (with management letter where applicable). If this is not available, please explain, and submit a review report by a CPA firm. If neither a certified corporate audit report nor review report is available, please explain and submit a compilation report by a CPA firm. Any of these submissions must be for the most recently ended corporate fiscal year. If the report is not yet available, submit the report for the prior corporate fiscal year. Please note, the most recent report must be submitted

prior to any potential contract negotiations.

- Federal Income Tax returns for for-profit agencies, or IRS Form 990, Return of Organization Exempt from Income Tax for non-profit agencies. Either of these submissions must be for the most recently ended corporate fiscal year. If the tax return is not yet available, submit the return for the prior corporate fiscal year. Please note, the most recent tax return must be submitted prior to any potential contract negotiations.
- Proof of payment of all required federal, state and local taxes (including payroll taxes) for the past twelve (12) months.
- Proof of an adequate Line of Credit demonstrating funds available to meet operating needs. If not available, please explain.
- Disclosure of any Bankruptcy Filings or Liens placed on your agency over the past five years. Please include an explanation of either. If there were no Bankruptcy Filings or Liens placed on your agency over the past five years, please include an attestation indicating that this is the case, signed by either your Chief Executive Officer or Chief Financial Officer.
- Certificates of insurance. Certificates of insurance with the named insured entity being the same name and address as the provider contracting with CBH. The insurance company providing coverage must be certified to do business in Pennsylvania or be otherwise acceptable to CBH. The insurances certificate must include the following coverage: General Liability with a minimum of \$2,000,000 aggregate and a minimum of \$2,000,000 per occurrence. Professional Liability with a minimum of \$1,000,000 aggregate and a minimum of \$3,000,000 per occurrence. Professional liability policy may be per occurrence or claims made, if claims made, a two-year tail is required. Automobile Liability with a minimum combined single limit of \$1,000,000. Workers Compensation/Employer Liability with a \$100,000 per Accident; \$100,000 Disease-per Employee; \$500,000 Disease Policy Limit. CBH, City of Philadelphia and Commonwealth of Pennsylvania Department of Public Welfare must be named as an additional insured with respect to your General Liability Policy. The certificate holder must be Community Behavioral Health. Further, for applicants that have passed all threshold review items and are recommended by the Review Committee to be considered for contract negotiations for this RFP, each applicant will be required to provide a statement from an independent CPA attesting to the financial solvency of the applicant agency.

C. Terms of Contract

The contract entered into by CBH as a result of this RFP will be designated as a Provider Agreement. Negotiations will be undertaken only with the successful applicants whose applications, including all appropriate documentation (e.g., audits, letters of credit, past performance evaluations, etc.) shows them to be qualified, responsible and capable of performing the work required in the RFP.

The selected applicants shall maintain full responsibility for maintenance of such insurances as may be required by law of employers, including but not limited to Worker's Compensation, General Liability, Unemployment Compensation and Employer's Liability Insurance, and Professional Liability and Automobile Insurance.

D. Health Insurance Portability and Accountability Act (HIPAA)

The work to be provided under any contract issued pursuant to this RFP is subject to the federal Health Insurance Portability and Accountability Act (HIPAA), as amended, and/or other state or federal laws or regulations governing the confidentiality and security of health information. The selected applicant(s) will be required to comply with CBH confidentiality standards identified in any contractual agreement between the selected applicant and CBH.

E. Minority/Women/People with Disabilities Owned Business Enterprises

CBH is a city-related agency and as such its contracted providers must cooperate with the intent of the local municipality regarding minority/women/disabled-owned business enterprises. It is the expectation of CBH that the selected applicants will employ a “Best and Good Faith Efforts” approach to include certified minority, women and disabled businesses (M/W/DSBE) in the services provided through this RFP where applicable and meet the intent of M/W/DSBE legislation.

The purpose of M/W/DSBE state legislation is to provide equal opportunity for all businesses and to assure that CBH funds are not used, directly or indirectly, to promote, reinforce or perpetuate discriminatory practices. CBH is committed to fostering an environment in which all businesses are free to participate in business opportunities without the impediments of discrimination and participate in all CBH contracts on an equitable basis.

- For-profit applicants should indicate if their organization is a Minority (MBE), Woman (WBE), and/or Disabled (DSBE) Owned Business Enterprise and certified as such by an approved certifying agency and/or identified in the City of Philadelphia Office of Economic Opportunity (OEO) Certification Registry. If the applicant is M/W/DSBE certified by an approved certifying agency, a copy of certifications should be included with the proposal. Any certifications should be submitted as hard copy attachments to the original application and copies that are submitted to CBH.
- Not-for-profit applicants cannot be formally M/W/DSBE certified. CBH does utilize adapted state definitions to determine the M/W/DSBE status. Criteria are applied to not-for-profit entities to determine M/W/DSBE status in the CBH provider network, as follows (all criteria must be satisfied):
 - At least 51% of the board of directors must be qualified minority individuals and/or women and/or people with disabilities.
 - A woman or minority individual or person with a disability must hold the highest position in the company.
 - Minority groups eligible for certification include African Americans, Hispanic Americans, Native Americans, and Asian Americans.
 - Citizenship and legitimate minority group membership must be established through birth certificates, military records, passports, or tribal cards.
- Not-for-profit organizations may have sub-contracting relationships with certified M/W/DSBE for-profit organizations. Not-for-profits should include a listing of their M/W/DSBE certified sub-contractors, along with their certification information.
- For additional information regarding the Commonwealth of Pennsylvania’s M/W/DSBE certification process, go to the following website:
www.dgs.state.pa.us/portal/server.pt/community/bureau_of_minority_and_women_business_opportunities/1358

a. City of Philadelphia Tax and Regulatory Status and Clearance Statement

As CBH is a quasi-governmental, city-related agency, prospective applicants must meet certain City of Philadelphia requirements. It is the policy of the City of Philadelphia to ensure that each contractor and subcontractor has all required licenses and permits and is current with respect to the payment of City taxes or other indebtedness owed to the City (including, but not limited to, taxes collected by the City on behalf of the School District of Philadelphia), and is not in violation of other regulatory provisions contained in The Philadelphia Code. To assist the City, through its Department of Revenue and Department of Licenses and Inspections, in determining this status, each applicant is required to complete and return with its proposal, a City of Philadelphia Tax and Regulatory Status and Clearance Statement Form (see Appendix B).

If the applicant is not in compliance with the City's tax and regulatory codes, an opportunity will be provided to enter into satisfactory arrangements with the City. If satisfactory arrangements cannot be made within a week of being notified of their non-compliance, applicants will not be eligible for award of the contract contemplated by this RFP.

All selected applicants will also be required to assist the City in obtaining the above information from its proposed subcontractors (if any). If a proposed subcontractor is not in compliance with City Codes and fails to enter into satisfactory arrangements with the City, the non-compliant subcontractor will be ineligible to participate in the contract contemplated by this RFP and the selected Applicant may find it necessary to replace the non-compliant subcontractor with a compliant subcontractor. Applicants are advised to take these City policies into consideration when entering into their contractual relationships with proposed subcontractors.

Applicants need not have a City of Philadelphia Business Privilege Tax Account Number and Business Privilege License Number to respond to this RFP, but will, in most circumstances, be required to obtain one or both if selected for award of the contract contemplated by the RFP. Proposals for a Business Privilege Tax Account Number or a Business Privilege License may be made on line by visiting the City of Philadelphia Business Service site- <http://business.phila.gov/Pages/Home.aspx> and clicking on "Register Your Business." If you have specific questions, call the Department of Revenue at 215-686-6600 for questions related to City of Philadelphia Business Privilege Tax Account Number or the Department of Licenses and Inspections at 215-686-2490 for questions related to the Business Privilege License.

F. Compliance with Philadelphia 21st Century Minimum Wage and Benefits Ordinance

Applicants are advised that any contract awarded pursuant to this RFP is a "Service Contract," and the successful applicant under such contract is a "Service Contractor," as those terms are defined in Chapter 17-1300 of the Philadelphia Code ("Philadelphia 21st Century Minimum Wage and Benefits Standard Ordinance"). Any Subcontractor and any sub-subcontractor at any tier proposed to perform services sought by this RFP is also a "Service Contractor" for purposes of Chapter 17-1300. If any such Service Contractor (i.e. applicant and subcontractors at any tier) is also an "Employer," as that term is defined in Section 17-1302 (more than five employees), and is among the Employers listed in Section 17-1303 of the Code, then during the term of any resulting contract, it is subject to the minimum wage and benefits provisions set forth in Chapter 17-1300 unless it is granted a waiver or partial waiver under Section 17-1304. Absent a waiver, these minimum wage and benefits provisions, which include a minimum hourly wage that is adjusted annually based on the CPI, health care and sick leave benefits, are mandatory and must be provided to applicant's

employees or the employees of any subcontractor at any tier who perform services related to the City contract resulting from this RFP. Applicants and any subcontractors at any tier proposed by Applicants are strongly encouraged to consult Chapter 17-1300 of the Philadelphia Code,¹ the General Provisions, and the About/Minimum Wage and Equal Benefits Ordinances Impacting Some City Contractors links on the eContract Philly home page for further details concerning the applicability of this Chapter to, and obligations it imposes on certain City contractors and subcontractors at any tier. In addition to the enforcement provisions contained in Chapter 17-1300, the successful applicant's failure or the failure of any subcontractor at any tier to comply (absent an approved waiver) with the provisions of Chapter 17-1300, or any discrimination or retaliation by the successful applicant or applicant's subcontractors at any tier against any of their employees on account of having claimed a violation of Chapter 17-1300, shall be a material breach of any Service Contract resulting from this RFP. By submitting a proposal in response to this RFP, applicants acknowledge that they understand, and will comply with the requirements of Chapter 17-1300, and will require the compliance of their subcontractors at any tier if awarded a contract pursuant to this RFP. Applicants further acknowledge that they will notify any subcontractors at any tier proposed to perform services related to this RFP of the requirements of Chapter 17-1300.

G. Certification of Compliance with Equal Benefits Ordinance

If this RFP is a solicitation for a "Service Contract" as that term is defined in Philadelphia Code Section 17-1901(4) ("A contract for the furnishing of services to or for the City, except where services are incidental to the delivery of goods. The term does not include any contract with a governmental agency."), and will result in a Service Contract in an amount in excess of \$250,000, pursuant to Chapter 17-1900 of the Philadelphia Code (1 A link to the Philadelphia Code is available on the City's official web site, www.phila.gov. Click on "City Code and Charter," located to the bottom right of the Welcome page under the box "Transparency."), the successful Applicant shall, for any of its employees who reside in the City, or any of its employees who are non-residents subject to City wage tax under Philadelphia Code Section 19-1502(1)(b), be required to extend the same employment benefits the successful applicant extends to spouses of its employees to life partners of such employees, absent a waiver by the City under Section 17-1904. By submission of their Proposals in response to this RFP, all applicants so acknowledge and certify that, if awarded a Service Contract pursuant to this RFP, they will comply with the provisions of Chapter 17-1900 of the Philadelphia Code and will notify their employees of the employment benefits available to life partners pursuant to Chapter 17-1900. Following the award of a Service Contract subject to Chapter 17-1900 and prior to execution of the Service Contract by the City, the successful applicant shall certify that its employees have received the required notification of the employment benefits available to life partners and that such employment benefits will actually be available, or that the successful applicant does not provide employment benefits to the spouses of married employees. The successful applicant's failure to comply with the provisions of Chapter 17-1900 or any discrimination or retaliation by the successful applicant against any employee on account of having claimed a violation of Chapter 17-1900 shall be a material breach of the any Service Contract resulting from this RFP. Further information concerning the applicability of the Equal Benefits Ordinance, and the obligations it imposes on certain City contractors is contained in the About/Minimum Wage and Equal Benefits Ordinances Impacting Some City Contractors links on the eContract Philly home page.

H. City of Philadelphia Disclosure Forms

Applicants and subcontractors are required to complete the City of Philadelphia Disclosure Forms

(see Appendix C and separate website Attachment) to report campaign contributions to local and state political candidates and incumbents; any consultants used in responding to the RFP and contributions those consultants have made; prospective subcontractors; and whether applicant or any representative of applicant has received any requests for money or other items of value or advice on particular firms to satisfy minority-, woman- or disabled-owned business participation goals. These forms must be completed and returned with the proposal. The forms are attached as a separate PDF on the website posting.

I. CBH Disclosure of Litigation Form

The applicant shall describe any pending, threatened, or contemplated administrative or judicial proceedings that are material to the applicant's business or finances including, but not limited to, any litigation, consent orders or agreements between any local, state, or federal regulatory agency and the applicant or any subcontractor the applicant intends to use to perform any of the services described in this RFP. Failure to disclose any of the proceedings described above may be grounds for disqualification of the applicant's submission. Complete and submit with your proposal the CBH Disclosure of Litigation Form (see Appendix D).

J. Selection Process

An application review committee will review all responses to this RFP. Based on the criteria detailed below, the committee will make recommendations concerning the submissions that are best able to meet the goals of the RFP.

Submissions will be reviewed based upon the merits of the written response to the RFP.

K. Threshold Requirements

Threshold requirements provide a baseline for all proposals, which means they provide basic information that all applicants must meet. Failure to meet all of these requirements may disqualify an applicant from consideration through this RFP. Threshold requirements include timely submission of a complete proposal with responses to all sections and questions outlined in Section II.A., Project Details. In addition, all required attachments must be submitted. Threshold requirements include having the requisite experience and licenses to implement the program and being a service provider in good standing with the City and CBH (as applicable).

CBH will determine if a provider is in good standing by reviewing information gathered through various departments across the DBHIDS. A determination is based on, but not limited to, the following criteria: re-credentialing status history, compliance error rate history, quality improvement plan status, and financial solvency. When applicable, state licensure status will also be reviewed and taken into consideration and discussed with PA Department of Human Services.

Neither the provider nor its staff, contractors, subcontractors, or vendors may be on any of the three Excluded Individuals and Entities lists:

- List of Excluded Individuals and Entities (LEIE) <http://oig.hhs.gov/fraud/exclusions.asp>;
- System for Award Management (SAM) (*formerly Excluded Parties List System (EPLS)*) <https://www.sam.gov>;
- Department of Human Services' Medichex List <http://www.dhs.state.pa.us/publications/medichexsearch/>

For this RFP, the applicant must include an attached statement that the provider and its staff, subcontractors, or vendors have been screened for and are not on any of the three Excluded Individuals and Entities lists. Ongoing, the provider must conduct monthly screening of its own staff, contractors, subcontractors, and vendors for excluded individuals on the three Excluded Individuals and Entities lists.

L. RFP Responses

A review committee will review all responses to this RFP. Based on the criteria detailed below, the committee will make recommendations concerning the submissions that are best able to meet the goals of the RFP.

IV. Application Administration

A. Procurement Schedule

The anticipated procurement schedule is as follows:

RFP Event	Deadline Date
RFP Issued	July 14, 2017
Deadline to Submit Questions	August 4, 2017
Answers to Questions on Website	August 9, 2017
Application Submission Deadline	August 21, 2017
Applicants Identified for Contract Negotiations by	October 13, 2017

CBH reserves the right to modify the schedule as circumstances warrant.

This RFP is issued on **July 14, 2017**. In order to be considered for selection, all applications must be delivered to the address below no later than 2:00 PM **on August 21, 2017**.

Community Behavioral Health
 801 Market Street
 7th Floor
 Philadelphia, PA 19107
 ATTN: Mark O’Dwyer

- Application packages should be marked “Addiction Services.” Applications submitted by any means other than mailing, courier, or hand delivery will not be accepted.
- Applicants must submit an electronic version of the application prepared as a PDF document placed onto a compact disc or flash drive with one clearly marked signed original application and seven (7) copies of the application.
- Applications submitted after the deadline date and time will be returned unopened.

- The individual Applicant or an official of the submitting agency, authorized to bind the agency to all provisions noted in the application, must sign the cover sheet of the application.

B. Questions Relating to the RFP

All questions concerning this RFP must be submitted in writing via email to Mark O'Dwyer at mark.odwyer@phila.gov by **August 4, 2017**. CBH will respond to questions it considers appropriate to the RFP and of interest to all applicants, but reserves the right, in its discretion, not to respond to any question. Responses will be posted on the DBHIDS website. Responses posted on this website become part of the RFP upon posting. CBH reserves the right, in its discretion, to revise responses to questions after posting, by posting the modified response. No oral response to any applicant question by any CBH employee or agent shall be binding on CBH or in any way considered to be a commitment by CBH. Contact with other CBH staff, or other related staff, regarding this RFP is not permitted and failure to comply with this restriction could result in disqualification.

C. Interviews/Presentations

Applicants may be required to make an oral presentation concerning various aspects of their application to CBH. Such presentations provide an opportunity for applicants to clarify their application to insure a thorough and mutual understanding. CBH will schedule such presentations on an as needed basis.

D. Term of Contract

CBH reserves the right to set the rates for this service, budgets and rates notwithstanding. Continuation of funding is contingent upon the availability of funds, quality of service being provided and contract compliance. CBH reserves the right to continue subsequent yearly contracts. All contracts become binding on the date of signature by the provider agency's chief executive officer and Community Behavioral Health's chief executive officer. CBH reserves the right to re-issue all or part of the RFP if it is not able to establish acceptable providers for any or all services. CBH also reserves the right to amend contracts throughout the contract period, and to renegotiate the contract length as needed.

V. General Rules Governing RFPs/Applications; Reservation of Rights; Confidentiality and Public Disclosure

A. Revisions to RFP

CBH reserves the right to change, modify or revise the RFP at any time. Any revision to this RFP will be posted on the DBHIDS website with the original RFP. It is the applicant's responsibility to check the website frequently to determine whether additional information has been released or requested.

B. City/CBH Employee Conflict Provision

City of Philadelphia or CBH employees and officials are prohibited from submitting an application in response to this RFP. No application will be considered in which a City or CBH employee or official has a direct or indirect interest. Any application may be rejected that, in CBH's sole

judgment, violates these conditions.

C. Proposal Binding

By signing and submitting its proposal, each applicant agrees that the contents of its proposal are available for establishment of final contractual obligations for a minimum of 180 calendar days from the proposal deadline for this RFP. An applicant's refusal to enter into a contract which reflects the terms and conditions of this RFP or the applicant's proposal may, in the sole discretion of CBH, result in rejection of applicant's proposal.

D. Reservation of Rights

By submitting its response to this notice of Request for Proposals as posted on the DBHIDS website, the applicant accepts and agrees to this Reservation of Rights. The term "notice of request for proposals," as used herein, shall mean this RFP and include all information posted on the DBHIDS website in relation to this RFP.

1. Notice of Request For Qualifications (RFP)

CBH reserves the right, and may, in its sole discretion, exercise any one or more of the following rights and options with respect to this notice of contract opportunity:

- (a)** to reject any and all applications and to reissue this RFP at any time;
- (b)** to issue a new RFP with terms and conditions substantially different from those set forth in this or a previous RFP;
- (c)** to issue a new RFP with terms and conditions that are the same or similar as those set forth in this or a previous RFP in order to obtain additional applications or for any other reason CBH determines to be in their best interest;
- (d)** to extend this RFP in order to allow for time to obtain additional applications prior to the RFP application deadline or for any other reason CBH determines to be in its best interest;
- (e)** to supplement, amend, substitute or otherwise modify this RFP at any time prior to issuing a notice of intent to develop a provider agreement or consultant contract to one or more applicants;
- (f)** to cancel this RFP at any time prior to the execution of a final provider agreement whether or not a notice of intent to develop a provider agreement has been issued, with or without issuing, in CBH's sole discretion, a new RFP for the same or similar services;
- (g)** to do any of the foregoing without notice to applicants or others, except such notice as CBH, in its sole discretion, elects to post on the DBHIDS website.

2. Proposal Selection and Contract Negotiation

CBH may, in its sole discretion, exercise any one or more of the following rights and options with respect to application selection:

- (a)** to reject any application if CBH, in its sole discretion, determine the application is incomplete, deviates from or is not responsive to the requirements of this RFP, does not comply with applicable law, is conditioned in any way, or contains ambiguities, alterations or items of work not called for by this RFP, or if CBH determines it is otherwise in their best interest to reject the application to reject any application if, in CBH's sole judgment, the applicant has been delinquent or unfaithful in the performance of any contract with CBH or with others; is delinquent, and has not made arrangements satisfactory to CBH, with respect

- to the payment of City taxes or taxes collected by the City, or other indebtedness owed to the City; is not in compliance with regulatory codes applicable to applicant; is financially or technically incapable; or is otherwise not a responsible applicant;
- (b)** to waive any defect or deficiency in any application, including, without limitation, those identified in subsections 1) and 2) preceding, if, in CBH's sole judgment, the defect or deficiency is not material to the application;
 - (c)** to require, permit or reject, in CBH's sole discretion, amendments (including, without limitation, information omitted), modifications, clarifying information, and/or corrections to their applications by some or all of the applicants at any time following application submission and before the execution of a final provider agreement or consultant contract;
 - (d)** to issue a notice of intent to develop a provider agreement or consultant contract and/or execute a provider agreement and/or consultant contract for any or all of the items in any application, in whole or in part, as CBH, in its sole discretion, determine to be in CBH's best interest;
 - (e)** to enter into negotiations with any one or more applicants regarding price, scope of services, or any other term of their applications, and such other agreement or contractual terms as CBH may require, at any time prior to execution of a provider agreement or consultant contract, whether or not a notice of intent to develop a provider agreement or consultant contract has been issued to any applicant and without reissuing this RFP;
 - (f)** to enter into simultaneous, competitive negotiations with multiple applicants or to negotiate with individual applicants, either together or in sequence, and to permit or require, as a result of negotiations, the expansion or reduction of the scope of services or changes in any other terms of the submitted applications, without informing other applicants of the changes or affording them the opportunity to revise their applications in light thereof, unless CBH, in its sole discretion, determine that doing so is in and CBH's best interest;
 - (g)** to discontinue negotiations with any applicant at any time prior to the execution of a provider agreement or consultant contract, whether or not a notice of intent to develop a provider agreement or consultant contract has been issued to the applicant, and to enter into negotiations with any other applicant, if CBH, in its sole discretion, determine it is in the best interest of CBH to do so;
 - (h)** to rescind, at any time prior to the execution of a provider agreement or consultant contract, any notice of intent to develop a provider agreement or consultant contracted to an applicant, and to issue or not issue a notice of intent to develop a provider agreement or consultant contract to the same or a different applicant and enter into negotiations with that applicant, if CBH, in its sole discretion, determine it is in the best interest of CBH to do so;
 - (i)** to elect not to enter into any provider agreement or consultant contract with any applicant, whether or not a notice of intent to develop a provider agreement or consultant contract has been issued and with or without the reissuing this RFP, if CBH determines that it is in CBH's best interest to do so;
 - (j)** to require any one or more applicants to make one or more presentations to CBH at CBH's offices or other location as determined by CBH, at the applicant's sole cost and expense, addressing the applicant's application and its ability to achieve the objectives of this RFP;
 - (k)** to conduct on-site investigations of the facilities of any one or more applicants (or the facilities where the applicant performs its services);
 - (l)** to inspect and otherwise investigate projects performed by the applicant, whether or not referenced in the application, with or without consent of or notice to the applicant;
 - (m)** to conduct such investigations with respect to the financial, technical, and other qualifications of each applicant as CBH, in its sole discretion, deem necessary or appropriate;

- (n) to permit, at CBH's sole discretion, adjustments to any of the timelines associated with this RFP, including, but not limited to, extension of the period of internal review, extension of the date of provider agreement or consultant contract award and/or provider agreement or consultant contract execution, and extensions of deadlines for implementation of the proposed project; and
- (o) to do any of the foregoing without notice to applicants or others, except such notice as CBH, in its sole discretion, elects to post on the DBHIDS website.

3. Miscellaneous

(a) Interpretation; Order of Precedence. In the event of conflict, inconsistency or variance between the terms of this Reservation of Rights and any term, condition or provision contained in any RFP, the terms of this Reservation of Rights shall govern.

(b) Headings. The headings used in this Reservation of Rights do not in any way define, limit, describe or amplify the provisions of this Reservation of Rights or the scope or intent of the provisions, and are not part of this Reservation of Rights.

E. Confidentiality and Public Disclosure

The successful Applicant shall treat all information obtained from CBH that is not generally available to the public as confidential and/or proprietary to CBH. The successful Applicant shall exercise all reasonable precautions to prevent any information derived from such sources from being disclosed to any other person. The successful applicant agrees to indemnify and hold harmless CBH, its officials and employees, from and against all liability, demands, claims, suits, losses, damages, causes of action, fines and judgments (including attorney's fees) resulting from any use or disclosure of such confidential and/or proprietary information by the successful applicant or any person acquiring such information, directly or indirectly, from the successful applicant.

By preparation of a response to this RFP, applicants acknowledge and agree that CBH, as a quasi-public corporation, is subject to state and local public disclosure laws and, as such, is legally obligated to disclose to the public documents, including applications, to the extent required hereunder. Without limiting the foregoing sentence, CBH's legal obligations shall not be limited or expanded in any way by an applicant's assertion of confidentiality and/or proprietary data.

F. Incurring Costs

CBH is not liable for any costs incurred by applicants for work performed in preparation of a response to this RFP.

G. Prime Contractor Responsibility

The selected contractor will be required to assume responsibility for all services described in their applications whether or not they provide the services directly. CBH will consider the selected contractor as sole point of contact with regard to contractual matters.

H. Disclosure of Proposal Contents

Information provided in applications will be held in confidence and will not be revealed or discussed with competitors. All material submitted as part of the RFP process becomes the

property of CBH and will only be returned at CBH's option. Applications submitted to CBH may be reviewed and evaluated by any person other than competing applicants. CBH retains the right to use any/all ideas presented in any reply to this RFP. Selection or rejection of an application does not affect this right.

I. Selection/Rejection Procedures

The applicants whose submission is selected by CBH will be notified in writing as to the selection, and their selection will also be posted on the DBHIDS website. Information will be provided in this letter as to any issues within the application that will require further discussion or negotiation with CBH. This letter should not be considered as a letter of award. A formal letter of award will be forthcoming at such time when mutual agreement has been reached by the parties on all issues pertaining to the application. Applicants whose submissions are not selected will also be notified in writing by CBH.

J. Non-Discrimination

The successful applicant, as a condition of accepting and executing a contract with CBH through this RFP, agrees to comply with all relevant sections of the Civil Rights Act of 1964, the Pennsylvania Human Relations Act, Section 504 of the Federal Rehabilitation Act of 1973, and the Americans with Disabilities Act, hereby assuring that:

The contractor does not and will not discriminate against any person because of race, color, religious creed, ancestry, national origin, age, sex, sexual orientation, handicap or disability in providing services, programs or employment or in its relationship with other contractors.

K. Life of Proposals

CBH expects to select the successful applicants as a result of this RFP within approximately 90 days of the submission deadline. However, proposals that are submitted may be considered for selection up to 180 days following the submission deadline of this RFP. By submission of a proposal, respondents agree to hold the terms of their proposal open to CBH for up to 180 days following the submission deadline.

**APPENDIX A
RFP RESPONSE COVER SHEET
COMMUNITY BEHAVIORAL HEALTH
ADDICTION SERVICE CONTINUUM**

CORPORATE NAME OF APPLICANT ORGANIZATION _____

CORPORATE ADDRESS _____

CITY _____ STATE _____ ZIP _____

PROGRAM SITE LOCATION _____

CITY _____ STATE _____ ZIP _____

Please note which program is proposed in this application. Please submit one cover sheet for each program.

___ **Medically managed and medically monitored stabilization and maintenance residential treatment (4A/4B and 3A/3B)**

___ **Medically monitored stabilization and maintenance residential treatment (3A/3B)**

___ **Co-occurring medically monitored long-term intensive residential treatment (3C)**

___ **Journey of Hope (JOH) medically monitored residential treatment (3A/B/C)**

___ **Ambulatory Stabilization**

MAIN CONTACT PERSON _____

TITLE _____ TELEPHONE # _____

E-MAIL ADDRESS _____ FAX # _____

SIGNATURE OF OFFICIAL AUTHORIZED TO BIND APPLICANT TO A PROVIDER AGREEMENT TITLE

TYPED NAME OF AUTHORIZED OFFICIAL IDENTIFIED ABOVE

DATE SUBMITTED _____

APPENDIX C

**CITY OF PHILADELPHIA TAX AND REGULATORY
STATUS AND CLEARANCE STATEMENT
FOR APPLICANTS**

THIS IS A CONFIDENTIAL TAX DOCUMENT NOT FOR PUBLIC DISCLOSURE

This form must be completed and returned with Applicant’s proposal in order for Applicant to be eligible for award of a contract with the City. This form needs to be submitted once, even if applying for multiple programs. Failure to return this form will disqualify Applicant’s proposal from further consideration by the contracting department. Please provide the information requested in the table, check the appropriate certification option and sign below:

Applicant Name	
Contact Name and Title	
Street Address	
City, State, Zip Code	
Phone Number	
Federal Employer Identification Number or Social Security Number:	
Philadelphia Business Income and Receipts Tax Account Number (f/k/a Business Privilege Tax) (if none, state “none”)*	
Commercial Activity License Number (f/k/a Business Privilege License) (if none, state “none”)*	

____ I certify that the Applicant named above has all required licenses and permits and is current, or has made satisfactory arrangements with the City to become current with respect to the payment of City taxes or other indebtedness owed to the City (including, but not limited to, taxes collected by the City on behalf of the School District of Philadelphia), and is not in violation, or has made satisfactory arrangements to cure any violation, or other regulatory provisions applicable to Applicant contained in The Philadelphia Code.

____ I certify that the Applicant named above does not currently do business, or otherwise have an economic presence in Philadelphia. If Applicant is awarded a contract with the City, it promptly will take all steps necessary to bring it into compliance with the City’s tax and other regulatory requirements.

Authorized Signature

Date

Print Name and Title

* You can apply for a City of Philadelphia Business Income and Receipts Tax Account Number or a Commercial Activity License on line after you have registered your business on the City’s Business Services website located at <http://business.phila.gov/Pages/Home.aspx>. Click on “Register” or “Register Now” to register your business.

APPENDIX D

CBH Disclosure of Litigation Form

The Applicant shall describe in the space below any pending, threatened, or contemplated administrative or judicial proceedings that are material to the Applicant's business or finances including, but not limited to, any litigation, consent orders or agreements between any local, state, or federal regulatory agency and the Applicant or any subcontractor the Applicant intends to use to perform any of the services described in this RFP.

Not Applicable

Signature

Print Name

Date

Company or Agency Name

APPENDIX E

CITY OF PHILADELPHIA DISCLOSURE FORMS

The City of Philadelphia Disclosure Forms may be found on the DBHIDS Website along with this posted RFP. Applicants need to complete just one set of disclosure forms even if submitting multiple applications.

APPENDIX F

BUDGET FORM

The Budget Form and Instructions may be found on the DBHIDS Website along with this posted RFP. Applicants must complete one budget form for each program they are proposing. Please reference section II.J. in this RFP for per diem reimbursement figures.