AMENDED & RE-ISSUED RFP 26-2016

Children, Youth and Family System of Care
Adult and Older Adult Systems of Care
Substance Use Disorder Treatment Services RFP

DEPARTMENT OF PUBLIC HEALTH
SAN FRANCISO HEALTH NETWORK – BEHAVIORAL HEALTH SERVICES

Request for Proposals (RFP) - 26 - 2016

DEPARTMENT OF PUBLIC HEALTH
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Date Issued:	September 27, 2016
E-Question Period:	September 27 – October 14, 2016
Date Amended & Re-Issued	October 21, 2016
Bidder's Conference	October 24, 2016, 1:00 pm – 3:00 pm
Letter of Intent Due:	12:00 p.m., November 1, 2016
Proposals Due:	**12:00 p.m., November 22, 2016**

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I. RFP INTRODUCTION & SCHEDULE

A. Introduction

The San Francisco Department of Public Health (DPH), San Francisco Health Network – Behavioral Health Services (SFHN-BHS), is soliciting proposals from interested proposers to provide substance use disorder (SUD) treatment services, beginning in Fiscal Year (FY) 2017-2018, for the: 1) Children, Youth and Family (CYF) System of Care; and 2) Adult and Older Adult (A/OA) Systems of Care. This request for proposals (RFP) includes a wide range of SUD treatment levels of care that together will create an integrated continuum of treatment for patients. Both qualified new providers and qualified existing SFHN-BHS providers are eligible to apply for funds.

A projected total of $34,300,000 is available under this RFP for all SUD treatment levels of care for children, youth, transition age youth, adults and older adults served by the CYF and A/OA Systems of Care. This is estimated annual amount is subject to available funding and may increase or decrease depending on funding availability.

Individual SUD treatment level of care funding line item amounts will not be provided in the interest of funding the highest qualified and most cost effective proposals. Proposers are required to: 1) develop proposals that reflect their organizational treatment capacity and experience in providing the SUD treatment level of care for which a proposal is being submitted; and 2) justify costs within their budget narratives for providing all required services identified in the RFP and DMC-ODS pilot.

B. Contract Term

Contracts shall have an original term of five (5) years from **July 1, 2017** to **June 30, 2022**. In addition, the City shall have one (1) option to extend the term for a period of five (5) years, for a total of ten (10) year contract, subject to annual availability of funds and annual satisfactory contractor performance and the needs of the SFHN-BHS system. The City has the sole, absolute discretion to exercise this option.

C. Proposal Submission

Proposers may submit proposals to serve the CYFSOC and/or A/OA SOC. For those proposers submitting proposals to serve CYFSOC and A/OA Systems of Care age-group populations, a separate and complete proposal must be submitted for CYF age-group populations and A/OA age group populations by SUD treatment level of care.

Providers may propose to provide SUD treatment services for a single level of care or multiple levels of care and/or case management services. For those proposers submitting proposals for multiple levels of care, a separate and complete proposal must be submitted for each level of care for which funding is sought.

D. Schedule

The anticipated schedule for selecting contractors is:

Proposal Phase	Time	Date
RFP is issued by the City		September 27, 2016
Email Questions Begins	12:00 Noon	September 27, 2016
Email Questions Ends	12:00 Noon	October 14, 2016
Bidder's Conference 25 Van Ness Street, # 610, San Francisco	1:00 pm – 3:00 pm	October 24, 2016
Non-Binding Letter of Intent due	12:00 Noon	November 1, 2016
Proposals Due	**12:00 Noon**	**November 22, 2016**

Estimated Dates:

Technical Review Panel	*December, 2016*
Selection and Negotiations	*January - February2016*
Contract Development	*February - March 2017*
Contract Processing and Approvals	*April-June 2017*
Service Start Date	*July 1, 2017*

E. Drug-Medi-Cal Organized Delivery Systems Pilot

With the publication of this RFP, SFHN-BHS providers will meet new SUD treatment services requirements under the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot. The DMC-ODS Pilot seeks to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a substance use disorder. The DMC-ODS pilot will demonstrate how organized SUD care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS pilot include:

- Providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services;
- Increasing local control and accountability with greater administrative oversight;
- Creating utilization controls to improve care and efficient use of resources;
- Increasing program oversight and integrity;
- Providing more intensive services for the criminal justice population which are more challenging to treat;
- Expanding the SUD treatment workforce by including Licensed Practitioners of Healing Arts for the assessment of patients and other functions within the scope of their practice;
- Requiring evidence-based practices (EBPs) in substance abuse treatment; and
- Increasing coordination with other systems of care including primary care and mental health.

This approach will provide patients with access to the care and system coordination needed to achieve sustainable recovery. More information on San Francisco's DMC-ODS Pilot County Plan can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/Fact-Sheets-and-FAQs.aspx.

F. San Francisco DMC-ODS Pilot Goals

Through participation in the DMC-ODS Pilot, the City and County of San Francisco will transform the SFHN-BHS substance use disorder (SUD) continuum of care to promote the wellness and recovery of individuals with substance use and related disorders. This will be accomplished by improving access to high quality, cost effective, sustainable SUD treatment and transitional care services and supports.

San Francisco takes great pride in a deep and longstanding commitment to protect and promote the health of all residents through a comprehensive, integrated, consumer-driven system of care. Working in collaboration with community partners, the San Francisco Department of Public Health (DPH) is the lead public agency that safeguards and maintains the City's commitment to protect and promote the health of San Franciscans by providing a full array of services, supports, and resources to residents from prevention and early intervention to treatment and transition services.

As San Francisco's largest public agency, DPH has two major divisions: 1) Population Health; and 2) the San Francisco Health Network. The SFHN encompasses most of the services covered by the DMC-ODS Pilot including Ambulatory Care (Primary Care, Behavioral Health Services (BHS), Maternal, Child and Adolescent Health, and Jail Health Services), San Francisco General Hospital, Transitions, Managed Care, and Laguna Honda Hospital (long-term care). The SFHN is the City's only complete care system that includes primary care for all ages, dentistry, emergency & trauma treatment, medical & surgical specialties, diagnostic testing, skilled nursing & rehabilitation, and behavioral health services.

Under the DMC-ODS Pilot, the SFHN-BHS is responsible for the implementation of San Francisco's Implementation Plan in partnership with DPH Population Health, consumers, public agency partners, and the SFHN-BHS network of community-based primary care and behavioral health providers. The SFHN actively engages consumers with health and behavioral health disorders in pursuing optimal health, happiness, recovery, and a full and satisfying life in the community. The SFHN supports this goal in part by applying "Quadruple Aim" to behavioral health services through the lenses of cultural humility, wellness and recovery by:
1) improving the patient experience of care (including quality and satisfaction); 2) improving the health of populations; 3) reducing the per capita cost of care; and 4) improving the behavioral health workforce.

G. SUD Treatment Foundational Principles and New Practices

The SFHN values the following aspects of behavioral health care which are consistent with the DMC-ODS Pilot approach to care:

- A trauma-informed system of care that fosters wellness and resilience for everyone in the system, from our patients to the staff who serve them;
- The practice of cultural humility where we make a consistent commitment to understanding different cultures and focusing on self-humility, maintaining an openness to someone else's cultural identity, and acknowledging that each of us brings our own belief/value systems, biases, and privileges to our work;
- Whole Person Care that integrates both behavioral and physical care of a patient including assessing the needs of a patient's identified family and other significant relationships;

- Colleagues who have experienced behavioral health challenges and bring their empathy and empowerment to recovery in others, as well as inspire and share their experience to create a truly recovery-oriented system;
- Valuing all patients that seek our services; and
- Shared decision making in providing the best possible coordinated care, where patients and their providers collaborate as part of a team to make care decisions together.

In partnership with SUD treatment providers, the SFHN-BHS will fund a continuum of services for all eligible adolescent and adult patients modeled after **The ASAM Criteria** (www.asam.org). The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and the transfer and discharge of patients with addiction and co-occurring conditions.
Consistent with the ASAM Criteria, the SFHN-BHS SUD treatment system will be guided by a set of **foundational principles** and **best practices** that represent a shift in how SUD treatment patients are assessed, treated, and supported in their recovery.

San Francisco is moving from a one-dimensional assessment of patient needs to a **multi-dimensional assessment** using The ASAM Criteria. Diagnosis alone is not a sufficient justification for entering a certain modality or intensity of treatment; patient assessment will support treatment that is holistic and able to meet the multiple and changing needs a patient may have across six life domains or "dimensions" ("whole person" care).

San Francisco is moving from program-driven to **clinically-driven and outcomes-driven treatment**. Treatment will be **individualized, person-centered** and responsive to specific patient needs and progress toward recovery. This is a departure from focusing on "placement" in a program, often with a fixed length of stay, and a move toward treatment lengths of stay that are individualized and based on the **severity of a patient's illness and patient's level of functioning** at treatment entry and the patient's response to treatment, progress and outcomes.

San Francisco is moving from a limited number of discrete SUD treatment modalities to a **broad and flexible continuum of care**. Levels of care will represent intensities of services along the continuum of treatment and reflects the varying severity of illnesses treated and the intensity of services required. See tables in the following section of this RFP which provide a brief description of each level of care on the SFHN-BHS treatment continuum. Note that the intensity of treatment is split into "levels of care", and each of the levels connect to each other, acting more like "benchmarks" along a single continuum. Patients can move between levels, or benchmarks along the continuum, depending on their unique needs and response to treatment.

The ASAM Criteria uses separate criteria and levels of benchmarks for adult patients and adolescent patients due to the different stages of emotional, mental, physical, and social development adolescents may be in.

San Francisco is moving toward a treatment referral system where referrals to a specific level of care will be based on a **careful and comprehensive assessment of patient needs** across six dimensions with the primary goal of placing patients in the most appropriate level of care. The preferable level of care will be the least intensive, while still meeting treatment objectives and providing safety and security for the patient. The levels of care are ranked under The ASAM

Criteria and represent benchmarks or points along the continuum of treatment services that can be accessed depending on a patient's needs and responses to treatment. That is, a patient may **begin at one level of care but step up or step down to another level of care.** SFHN-BHS SUD treatment providers will be required to have capacity to transition patients across the treatment continuum either in-house or through formal partnerships with other providers along the continuum (written, approved MOUs). This also includes formal partnerships with service providers and systems outside the SUD treatment continuum including mental health providers, primary care providers, and the criminal and juvenile justice systems.

San Francisco is moving toward a treatment system that is tailored to the needs of each patient, guided by **individualized treatment** plans and developed in consultation with patients through the formation of **therapeutic alliances with patients**. The goal of interventions and treatment will determine the methods, intensity, frequency and types of services provided. Decisions about patient discharge from a level of care or a patient's transfer to another level of care will be based on how the treatment and duration both resolves a patient's presenting challenges and impacts a patient's prognosis for long-term recovery. Treatment services are expected to stabilize a patient's condition and promote patient wellness and recovery.

San Francisco is moving toward an **interdisciplinary team approach** to patient care. SUD treatment professionals will be required to collaborate with physicians, mental health clinicians, peers and peer supports, and other individuals important to a patient's recovery. An example of a current patient-centered care model implemented within the SFHN-BHS Adult/Older Adult Systems of Care is the Behavioral Health Home (BHH). The BHH embraces a team-based model of care where an interdisciplinary team is responsible for meeting the range of needs presented by behavioral health patients assigned to their care. While the SFHN-BHS will continue to fund SUD treatment provided outside a BHH model of care, this is a preferred model of care. All SUD treatment providers will be required to **collaborate and coordinate SUD treatment care with patient medical homes, behavioral health clinics** and other service providers such as housing, educational and vocational providers.

San Francisco is moving toward the integration of **peer support specialists** within multi-disciplinary teams. Peer support offers patients significant interpersonal relationships and a shared sense of community that offers a foundation for the process of healing. At its best, a peer relationship can facilitate and enhance a patient's wellness and recovery. It also can provide increased meaning and purpose in the life of peer support specialists. Peer support specialist are colleagues who have experienced behavioral health challenges and bring their empathy and empowerment to recovery.

San Francisco is moving toward an **outcomes-based treatment system**. SFHN-BHS SUD treatment providers are required to use **evidence-based practices**…apply **The ASAM Criteria** to patient assessment, treatment, transitions among levels of care and discharge…invest in **quality management** activities and processes…**actively engage patients** on their paths to wellness and recovery…and collect and **report patient and program outcomes**.
San Francisco is moving toward the development of a **robust array of patient supports and services**. This includes the integration within SUD treatment services **case management services** that proactively link patients to community-based **wellness and recovery services** that emphasize a patient's role in managing their health and teach them to use effective self-management support strategies that prevent relapse. This also includes the integration within SUD treatment services **Medication Assisted Treatment** to evaluate, administer, adjust and

monitor patient medication support services.

All SUD treatment proposers are expected to integrate within their proposals these SUD treatment foundational principles and practices.

II. MINIMUM AGENCY REQUIREMENTS

Please note: All agencies submitting proposals for funding must meet the following Minimum Agency Requirements. Any proposals failing to demonstrate how the proposing agency meets these minimum requirements will be considered non-responsive and will not be eligible for project proposal review or award of a contract. In addition to the required forms, up to **five (5) pages** summarizing how all of the following minimum proposal requirements have been met should be included within the *Minimum Requirements Narrative* detailed on pages 13-15 of this RFP.

A. Drug Medi-Cal Certification

Consistent with State DMC-ODS required elements of provider selection and termination policies and procedures, all proposers are required to be Drug Medi-Cal certified by July 1, 2017. Enhanced cost reimbursement rates will be incorporated into contract awards for qualified DMC certified providers to offset the increased costs of meeting higher DMC standards.

Proposers must include a copy of their DHCS DMC Certification Approval Letter or DHCS DMC Provisional Certification Letter or proof of submission for certification. This letter does not count against the *Minimum Requirements Narrative* five-page limit.

For more information about DMC certification, visit:

http://www.dhcs.ca.gov/services/adp/Pages/Drug_MediCal.aspx

B. Harm Reduction

All SUD treatment services are required to be offered consistent with the Harm Reduction Resolution of the Health Commission (September 2000) and recent DPH Harm Reduction Policy requirements that enhance the Health Commission's Policy with new requirements that demonstrate compliance with the intent of the policy. These new requirements include:

1. Post in common areas where they can be viewed by patients up-to-date referral information about Syringe Access & Disposal services and schedule;
2. Have an onsite overdose response policy;
3. Post in common areas where they can be viewed by patients up-to-date referral information about naloxone access and DOPE Project schedule; and
4. Program staff participate in at least one training with the Harm Reduction Training Institute either at the program site or at a Training Institute site.

Proposers must describe in the *Minimum Requirements Narrative* how provider policies, practices, procedures, and staff training fully have complied with the Health Commission Harm Reduction Policy and the new, recent DPH policy requirements.

C. Cultural & Linguistic Competency Requirements

All SUD outpatient treatment services must be offered consistent with the Culturally and Linguistically Appropriate Services (CLAS) National Standards and related DPH Cultural and Linguistic Competency Policy. Cultural and linguistic competence impacts access to treatment, program adherence, and successful recovery for SUD treatment patients. Positively engaging each patient through culturally and linguistically relevant services and effective communication

is essential to recovery. Effective communication requires, at a minimum, the provision of services and information in appropriate languages, at appropriate educational and literacy levels, and in the context of the individual's cultural identity. Cultural competency also requires a demonstrated respect, awareness and acceptance of and an openness to learn from the beliefs, practices, traditions, religions, history, languages, and current needs of each individual and communities.

Cultural competency and capacity must be reflected throughout all levels of the proposer's organization including organizational vision and mission statements, board and staff recruitment, planning and policy making, staff skills development and training, administrative and policy implementation, and service delivery and evaluation.

Proposers must address in the *Minimum Requirements Narrative* how their organization and SUD treatment services meet National CLAS Standards and related DPH policies and practices.
http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf
https://www.thinkculturalhealth.hhs.gov/

D. Financial Management Capacity & Fiscal Integrity

Proposers must demonstrate a consistent high standard of financial management and fiscal integrity as evidenced by citywide or DPH monitoring report, lack of corrective action plans, unqualified audit opinions, a reasonable level of cash reserves, management letters accompanied by audited financial statements that are relatively free of internal control comments, and stable and experienced fiscal and financial management staffing.

Proposers also provide their most recent financial audit under the proposal appendix. If there are any adverse or qualified opinions, a proposer may be subject to further reviews of past audits to determine status of recommendations or any corrective actions taken at the sole, absolute discretion of the City.

The Department will refer to and consider current Corrective Action Plans (as opposed to program review – related Plans of Correction) for existing Department Contractors.

In addition, proposers must indicate whether they are organized as a "non-profit" or "for profit" organization and meet the following requirements:

- **Non-profit proposers:** Proposers must provide ONE copy of each of the following: 1) management letters and accompanying audited financial statements for FY 2014-2015 and FY 2015-2016; 2) a listing of financial management staff and accounting staff who will be supporting the services applied for, including name, job title, length of service, and a brief bio-sketch; and 3) a current cash flow statement and projection for the period of July 1, 2016 through June 30, 2017, including available unencumbered operating revenue held in reserve.

- **For profit proposers**: Proposers must provide ONE copy of each of the following: 1) complete sets of federal and state tax returns for the 2014 and 2015 tax years; 2) a listing of financial management staff and accounting staff who will be supporting the services applied for, including name, job title, length of service and a brief bio-sketch; and 3) a current cash flow statement and projection for the period of July 1, 2016 through June 30, 2017, including unencumbered operating revenue held in reserve.

The following requested fiscal management capacity documents will not count toward the *Minimum Requirements Narrative* five-page limit: 1) citywide or DPH monitoring report and lack of corrective action plans, 2) most recent financial audit; 3) management letters accompanied by audited financial statements; 4) federal and state tax returns; 5) current cash flow statements and projections; and 5) listing of current financial management staff.

E. Prior Performance

Proposers must demonstrate that they have a record of consistent quality service delivery for five (5) prior fiscal years in providing the SUD treatment level of care treatment services to the proposed service populations for which funding is sought in an urban environment. This description should include a summary of public and private sector contracts for similar services and supports and DPH monitoring reports or Non DPH evaluation reports of the last two years of issued reports.

Proposers must include Contractual Record Form (**Appendix A-1a**) if they are current DPH providers or copies of actual contracts (for non DPH providers) to demonstrate proof of 5 years' experience. Copies of monitoring reports or Contractual Record Form, attached along with contract monitor contact information including name, title, agency, county, email address and phone number. Summaries must include a brief description of service populations, service location, specific services and supports provided, and program and client outcomes. This also should include a summary of prior performance of the proposer's subcontractors that have records of consistent quality service delivery for five (5) prior fiscal years in serving the target population(s). **The Department will refer to and consider current Corrective Action Plans (as opposed to program review – related Plans of Correction) for existing Department Contractors.**

F. Priority Service Populations

The Department of Public Health has identified seven (7) priority service populations for SUD treatment services under the A/OA Systems of Care and four (4) priority service populations under by the CYF System of Care. Proposers must include at least two (2) of the priority service populations for each system of care level of care treatment services for which a proposal is submitted.

G. Priority Geographic Service Areas

The Department of Public Health has identified five (5) priority geographic service areas in the City and County of San Francisco. Proposers must demonstrate include at least one (1) priority geographic service area for system of care level of care treatment services for which a proposal is submitted.

H. Americans with Disabilities Act and Access Requirements

Americans with Disabilities Act (ADA) compliance and implementation of access to persons with the broadest possible range of abilities is required. Proposers must demonstrate compliance with this requirement by describing in detail the proposer's access program, including specific physical, substance use and mental health disability accommodation strategies, policies and procedures. This should include a description of policies and practices that accommodate patient companion animals within SUD treatment settings as a protected ADA right.

I. Approved City Vendor

Proposers must be an existing, approved vendor with the City and County of San Francisco at

the time proposals are submitted. Proposers must provide their vendor number and proof of good standing to do business with the City including a current business tax license and required insurance.

J. Compliance with City and County Policies, Laws, Rules and Regulations

Proposed must demonstrate capacity and ability to comply with all contracting policies, laws, rules, and regulations of the City and County of San Francisco and DPH.

III. SFHN-BHS SUD TREATMENT LEVEL OF CARE

The Department of Public Health seeks proposals from qualified proposers to provide SUD treatment services for certain ASAM level of care. The table below lists by ASAM level of care the annual estimate of unduplicated clients to be served, the number residential treatment beds required, and other SUD treatment system requirements. The information is intended to assist proposers in developing their proposals and budget justification documents. The City has the sole, absolute discretion in determining how many clients for each level of care to serve and system capacity requirements.

ASAM Level of Care	Annual Estimated Number of Unduplicated Clients (UDC)/Number of Residential Beds by System of Care & Other SUD Treatment System Requirements
Level 1/Opioid Treatment Programs (formerly Narcotic Treatment Programs)	**A/OA SOC: 3,300 UDCs and:** • At least one (1) program serving pregnant and parenting women with dependent children; • At least one (1) program serving inmates in Jail Services/Sheriff's Department; • Minimum opioid addiction medications that must be available for dispensing: methadone, buprenorphine, naloxone, disulfiram; and • Minimum alcohol addiction medications that must be available for dispensing: acamprosate, disulfiram, off-label us of topiramate.
Level 1/Outpatient Services	**CYFSOC: 300 UDCs** **A/OA SOC: 1,350 UDCs**
Level 2/Intensive Outpatient Services	**CYFSOC: 120 UDCs** **A/OASOC: 300 UDCs**
Level 3.1/Residential Services	**A/OA SOC: 1,550 UDCs/500 Beds and:** • At least one (1) program to serve pregnant/parenting women with children.
Level 3.3/Residential Services	
Level 3.5/Residential Services	

ASAM Level of Care service descriptions and requirements follow.

ASAM Level of Care Descriptions

Level of Care	CYFSOC	A/OASOC	Service Description & Requirements
OTP (Level 1)		**Opioid Treatment Programs** (formerly called Narcotic Treatment Program)	Daily or several times weekly opioid agonist medication and counseling available for those with severe opioid disorder or alcohol use disorder including methadone, buprenorphine, naloxone, and disulfiram. Includes all of the following components: a) Intake; b) Individual & Group Counseling; c) Patient Education; d) Medication Services; e) Collateral Services; f) Crisis Intervention Services; g) Treatment Planning; h) Medical Psychotherapy: one-on-one counseling conducted by the Medical Director with patient; and i) Discharge Services.
1	**Outpatient Services**	**Outpatient Services**	Recovery or motivational enhancement therapies/strategies provided to patients less than 9 hours a week (adults) and less than 6 hours a week (adolescents) and includes all of the following components: a) Intake; b) Individual & Group Counseling; c) Patient Education; d) Family Therapy; e) Medication Services; f) Collateral Services; g) Crisis Intervention Services; h) Treatment Planning; and i) Discharge Services.

Level of Care	CYFSOC	A/OASOC	Service Description & Requirements
2.1	**Intensive Outpatient Services**	**Intensive Outpatient Services**	Structured programming services to treat multidimensional instability not requiring 24-hour care for a minimum of 9 or more hours with a maximum of 19 hours a week (adults) and 6 hours or more with a maximum of 19 hours (adolescents). See Level 1/Outpatient Services for Level 2.1 program service components.
3.1 Level of Care includes perinatal residential services.		**Clinically Managed Low Intensity Residential Services**	24-hour structure with available trained personnel and providing at least 5 hours of clinical service per week with the goal of preparing patient for outpatient treatment. Includes all of the following program service components: a) Intake; b) Individual & Group Counseling; c) Patient Education; d) Family Therapy; e) Safeguarding Medications; f) Collateral Services; g) Crisis Intervention Services; h) Treatment Planning; i) Transportation Services (to/from medically necessary treatment); and j) Discharge Services.
3.3 Level of Care includes perinatal residential services.		**Clinically Managed High-intensity Residential Services**	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. Goals is to prepare for outpatient treatment. See Level 3.1/Clinically Managed Low Intensity Residential Services for program service components.
3.5 Level of Care includes perinatal residential services.		**Clinically Managed High-intensity Residential Services**	24-hour care with trained counselors to stabilize multidimensional imminent danger with goal to prepare patients for outpatient treatment. Able to tolerate and use full milieu or therapeutic community. See Level 3.1/Clinically Managed Low Intensity Residential for program service components.

A. Priority Service Populations and Priority Geographic Service Areas

1. Priority Service Populations: Adult/Older Adult Systems of Care Priority

The Department of Public Health has identified seven Priority Service Populations under the Adult/Older Adult Systems of Care for all SUD treatment levels of care:

a) Persons Who Are Black/African American

While drug overdose (poisonings) deaths have remained stable in San Francisco through 2012, there were significant differences in death rates based on race, along with gender and age. The death rate among Black/African American residents was higher than others with 62.1, compared to White (25.2), Hispanic/Latino (10.3), and Asian persons (3.2).

b) Persons Who Are Homeless

The 2015 San Francisco's biennial homeless count showed there were 6,686 people without a place to live, or 3.8 percent more than in 2013. Based on survey responses, 37% of homeless people said they abused drugs or alcohol, up from 29% in 2013. Twenty-seven percent of homeless people said they had post-traumatic stress disorder, 10% said they had a traumatic brain injury, and 35% said they had psychiatric or emotional conditions.

c) Persons Who Are Incarcerated or Involved with the Criminal Justice System/Drug Courts

These represent priority service populations under the DMC-ODS Pilot and are longstanding priority populations SFHN-BHS.

d) Persons Who Are Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Ally or Two-Spirit (LGBTQQIA2S)

When compared with the general population, LGBTQQIA2S people are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life.

e) Transition Age Youth, Aged 18-24

Young adults, aged 18-24, had the highest prevalence for past month binge alcohol use and use of illicit drugs other than marijuana, past year cocaine and nonmedical prescription pain reliever use, and past year dependence or abuse of alcohol or illicit drugs.

f) Persons Whose Primary Substance is Alcohol

According to the National Institute on Drug Abuse August 2015 National Drug Early Warning System (NDEWS) Sentinel Community Site Profile for San Francisco, the most frequent cause of admissions to substance use disorder treatment is alcohol, reflecting a quarter of all treatment episodes. In addition, 12% of residents reported dependence or abuse of alcohol compared to 3% reporting dependence or abuse of illicit drugs; 61% of San Francisco residents reported past month use of alcohol; and 25% of residents reported binge alcohol use.

g) Pregnant Women or Parenting Women with Dependent Children

Targeted interventions to pregnant women and parenting women with dependent children with substance use disorders increase the incidence of prenatal visits, improve birth

outcomes, improve child development outcomes, and improve a mother's ability to parent in recovery.

Proposers must demonstrate in their proposals at least five (5) years of experience successfully engaging, treating, and transitioning patients in an urban environment for at least two (2) or more of the Priority Service Populations listed above.

2. <u>Priority Treatment Populations: Children, Youth and Family System of Care</u>

For the Children, Youth and Family System of Care (CYFSOC), DPH is seeking proposals to provide ASAM Level 1/Outpatient Services and Level 2/Intensive Outpatient Services for adolescents, aged 10 to 18. Adolescent Priority Service Populations include:

a) Persons Who Are Black/African American
While drug overdose (poisonings) deaths have remained stable in San Francisco through 2012, there were significant differences in death rates based on race along with gender and age. The death rate among Black/African American residents was higher than others with 62.1, compared to White (25.2), Hispanic/Latino (10.3), and Asian persons (3.2).

b) Persons Who Are Involved with the Child Welfare and Juvenile Justice System
These represent priority service populations under the DMC-ODS Pilot and are longstanding priority populations SFHN-BHS.

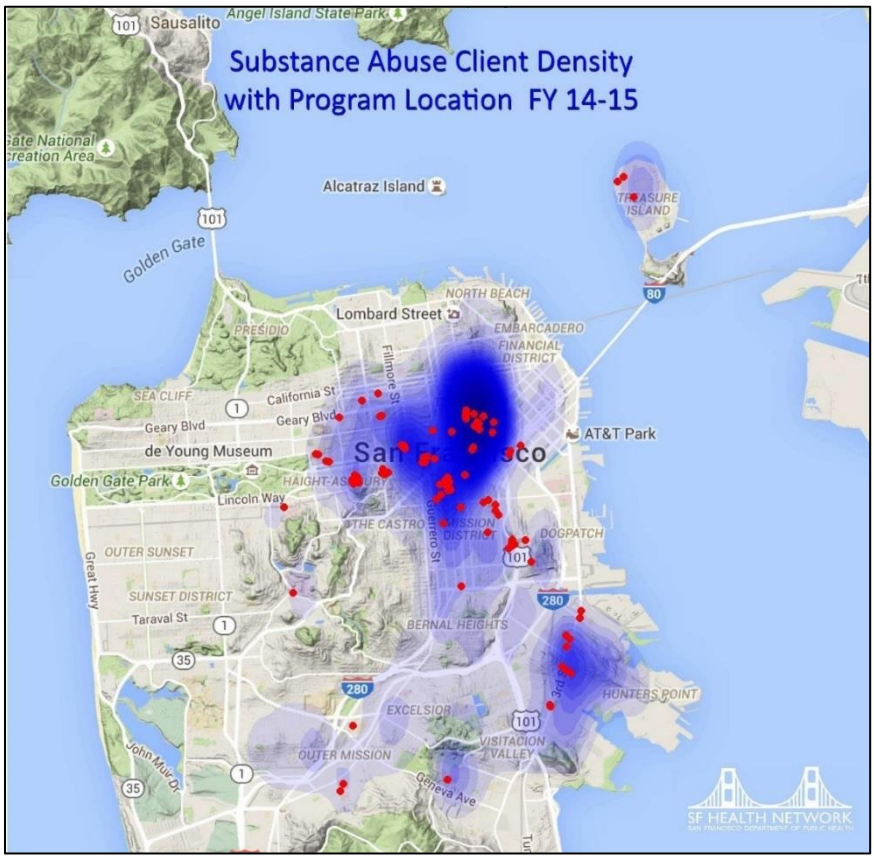
c) Persons Who Are Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Ally or Two-Spirit (LGBTQQIA2S)
When compared with the general population, LGBTQQIA2S people are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life.

d) Persons Whose Primary Substance is Alcohol
The 2015 San Francisco Unified School District Youth Risk Behavior Survey for middle school students showed 15.9% of middle students reported ever drinking alcohol, 7.5% reported alcohol use in the past 30 days and 2% reported episodic heavy drinking of alcohol (binge drinking). The same survey for high school students showed 43.5% of high school students reported ever drinking alcohol, 18.4% reported alcohol use in past 30 days, and 8.8% reported episodic heavy drinking of alcohol (binge drinking).

Proposers must demonstrate in their proposals <u>at least five (5) years of experience</u> successfully engaging, treating, and transitioning patients in an urban environment for at least <u>two (2) or more</u> of the Priority Service Populations listed above.

B. Priority Geographic Service Areas

As part of the DPH Quality Improvement Plan, DPH quality management staff produces Geomaps of the location of substance use treatment programs by modality, overlaying a patient residence density map. The FY 2014-15 Geomap follows and demonstrates that the SFHN-BHS has SUD treatment services (dark red) that are well aligned with the greatest patient residence density (medium blue).



Based on the Geomap analysis and other available data, DPH is seeking SUD treatment services in the following Priority Geographic Service Areas for both the Adult/Older Adult Systems of Care and the Children, Youth and Family System of Care:

1. Hayes Valley/Tenderloin/North of Market/94102
2. South of Market/94103
3. Bernal Heights/Inner Mission/94110
4. Bayview-Hunter's Point/94124
5. Southeast/Visitacion Valley/Sunnydale/94134

Proposers must demonstrate in their proposals experience and capacity in successfully engaging, treating, and transitioning Priority Service Population patients residing in at least one (1) of the Priority Geographic Service Areas. Proposals to serve Priority Service Populations in other San Francisco geographic service areas may be considered for contract awards, funds permitting, only when system capacity and patient needs are deemed met in all of the Priority Geographic Service Areas. The Department of Public Health has the sole, absolute discretion to determine system capacity and patient needs and which proposals will be funded, if any.

C. ASAM LEVEL OF CARE SERVICE COMPONENTS & REQUIREMENTS

Following is a summary of ASAM level of care treatment service components and requirements excerpted from *The ASAM Criteria, Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* (American Society of Addictive Medicine, Third Edition, 2013). Proposers must demonstrate capacity to meet all ASAM level of care service components and requirements in their proposals and all Drug Medi-Cal certification requirements. Where DMC and ASAM Criteria requirements differ, DMC certification requirements take precedence.

1. Level 1/Outpatient Services Requirements

Level 1/Outpatient Services are benchmarked at the lower end of the ASAM treatment continuum and include organized outpatient treatment services which can be delivered in a variety of settings such as addiction programs, behavioral health homes and clinics, and school-based service sites. Services are provided less than 9 hours per week for adults and less than 6 hours per week for adolescents.

In Level 1 programs, a multi-disciplinary team provides services. Members of the team include addiction, mental health treatment, peer support specialists, and general health care personnel, including addiction credentialed physicians. The team provides professionally directed screening, evaluation, treatment and ongoing recovery and disease management services.

Like all ASAM Levels of Care, Level 1 services are tailored to each patient's level of clinical severity and function and are designed to help the patient achieve changes in his or her alcohol and/or other drug use or addictive behaviors. Treatment addresses major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or impair the patient's ability to cope with major life tasks without the addictive use of alcohol and/or other drugs and/or addictive behaviors such as gambling.

These services provide greater access to care for patient with co-occurring substance use and physical and mental health conditions, individuals not interested in recovery that are mandated to treatment, and individuals in early stages of readiness to change. Level 1/Outpatient Services also provide access to needed care for parents in early recovery that need education about addiction and person-centered treatment, as well as patients in ongoing recovery who need monitoring and continuing disease management.

Some characteristics of patients in Level 1 include those who are able to complete professionally directed addiction and/or mental health treatment, those who are stepping down from a more intensive level of care, those who are in early stages of change and not yet ready to commit to full recovery, and those who have achieved stability in recovery.

Level 1/Outpatient Services Support Requirements

Level 1/Outpatient Services programs include the following supports:

1) Medical, psychiatric, psychological, laboratory and toxicology services available on-site or consultation or through closely coordinated referral; medical and psychiatric consultation is available within 24 hours by telephone or in person within a timeframe appropriate to the severity and urgency of the consultation requested;
2) Directly affiliated with or closely coordinated referral to more intensive levels of care and medication management;
3) Emergency services available by telephone 24 hours a day/7 days a week; and

4) Intensive case management for patients with co-occurring disorders.

Level 1/Outpatient Services Staffing Requirements

Level 1/Outpatient Services program are staffed by appropriately credentialed and/or licensed treatment professionals who assess and treat substance-related, mental, and addictive disorders. Professional peer support specialists with lived experience in substance use treatment also are integrated within this multi-disciplinary team to support patient wellness and recovery.

Professional staff are experienced in gathering and interpreting information regarding a patient's biopsychosocial needs and are knowledgeable about the biophysical dimensions of alcohol and other drug and addictive disorders including how to assess a patient's readiness for change. Professional staff also are capable of monitoring stabilized mental health challenges a patient may have and recognizing instability in patients with co-occurring mental health conditions. In addition, there is at least one professional staff member on the multi-disciplinary team with authority to prescribe medication either on-site or through closely coordinated consultation services.

Drug Medi-Cal certified outpatient sites must comply with DMC staffing requirements. All Level 1/Outpatient Services programs, regardless of DMC certification status, are expected to meet the following minimum staffing requirements:

1) Appropriately credentialed and/or licensed treatment professionals including addiction-credentialed physicians, counselors, psychologists, social workers, and others to assess and treat substance-related, mental, and addictive disorders;
2) Professional peer support specialists with lived experience in substance use treatment to support patient wellness and recovery as members of the multidisciplinary team;
3) Credentialed mental health professionals to assess, manage, and monitor patient mental health disorders for patients with co-occurring disorders preferably on-site or via closely coordinated referrals.

Level 1/Outpatient Services Required Therapies

Level 1/Outpatient Services involve skilled treatment services which are provided in an amount, frequency and intensity appropriate to a patient's needs, and include at a minimum:

1) Intake;
2) Individual and group counseling;
3) Motivational enhancement;
4) Family therapy;
5) Educational groups;
6) Occupational and recreational therapy;
7) Psychotherapy;
8) Medication management services;
9) Case managed services;
10) Mental health treatment (for patients with co-occurring disorders);
11) Other addictive disorders treatment (e.g. gambling); and
12) Primary care and other general medical care.

Level 1/Outpatient Services Assessment/Treatment Plan Review Requirements

For Level 1 programs, the assessment and treatment plan review must include:

1) Individualized, comprehensive biopsychosocial assessments of a comprehensive substance use and addictive behaviors history reviewed by a physician, and if determined needed by a patient's medical condition, a physical examination within a reasonable amount of time;
2) An individualized treatment plans developed in partnership with the patient that includes challenges, needs, strengths, skills, priority formulation and articulation of short-term, measurable treatment goals (including the patient's treatment goals), preferences and activities designed to achieve those goals;
3) Monitoring, including biomarkers and toxicology testing; and
4) A review of a patient's most recent psychiatric history and a mental status examination performed within a reasonable timeframe for patients with co-occurring mental disorders.

Level 1/Outpatient Services Adolescent-Specific Considerations

In addition to Outpatient Services practice expectations, proposers must demonstrate in their proposals experience successfully meeting all of the following requirements:

1) Staff knowledgeable about adolescent development and experience in working with and engaging adolescents;
2) Engagement and integration of families, caregivers and other important resources in treatment planning, services, and transition planning to support patient recovery;
3) Proactively transitioning adolescents in need of continued SUD treatment to the Adult/Older Adult Systems of Care including partnering with adolescents and their families in developing comprehensive transition plans that address the wide range of treatment and support needs such as housing, vocational services, and other community supports;
4) Collaborative working relationships with child welfare, mental health, court, schools, primary care, and juvenile justice to meet multi-system treatment goals and outcomes for adolescents; and
5) Serving adolescents placed out-of-county.

Level 1/Outpatient Services Scoring Preference

The Department of Public Health will provide a scoring preference for Outpatient Services that are organized in a Behavioral Health Home model or similar integrated care model where the needs of the "whole patient" are met either on-site or through closely coordinated and managed services off-site. This includes addiction, mental health, and primary care services.

2. Level 2.1/Intensive Outpatient Services Requirements

Intensive Outpatient Services offer a higher intensity of outpatient services with the goal of stepping patients down to Level 1/Outpatient Services or discharge. Examples of Level 2.1 programs are after school, day or evening and/or weekend intensive outpatient programs.

Generally, 9-19 hours of structured programming per week is provided to adults, and 6-19 hours a week for adolescents. Although programming consists primarily of counseling and education about addiction-related and mental health problems, providers must demonstrate capacity to provide all required Level 2.1 service components.

Patient psychiatric and medical service needs are provided through consultation and closely coordinated referrals if a patient is stable and requires only maintenance monitoring. Providers must demonstrate on-site capacity or formal partnerships with mental health and healthcare providers to meet the needs of patients with co-occurring mental disorders. Evidence of formal partnerships includes fully executed, written MOUs with these service providers identifying the specific roles and responsibilities of each partner are to be included as attachments in the proposal appendix.

Level 2.1 Support Requirements

Level 2.1 programs include all of the following:

1) Medical, psychological, psychiatric, laboratory, and toxicology services available through consultation or closely coordinated referral with psychiatric and other medical consultation, available 24 hours by telephone and within 72 hours in person;
2) Emergency services that are available by telephone 24 hours a day/7 days a week when the treatment program is not in session;
3) Direct affiliation with or close coordination through referral to more and less intensive levels of care and supportive housing services; and
4) Psychiatric services appropriate to a patient's mental health condition available by telephone or on-site or closely coordinated off-site.

Level 2.1 Staffing Requirements

Level 2.1 programs are staffed by an inter-disciplinary team of appropriately credentialed addiction treatment professionals including counselors, psychologists, social workers, and addiction-credentialed physicians who assess and treat substance use and other addictive disorders. Physicians treating patients in Level 2.1 should have specialty training and experience in addiction medicine or addiction psychiatry, and if treating adolescents, experience with adolescent medicine. Generalist physicians may provide physical exams and concurrent/integrated general medical care such as services for hepatitis, HIV disease, tuberculosis, or other co-occurring infectious diseases during addiction treatment.

All program staff should have access to and be able to interpret information regarding a patient's biopsychosocial needs. Some staff should have sufficient cross-training to understand the signs and symptoms of mental disorders and understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders.

Level 2.1 Required Therapies

Level 2.1 programs must provide the following therapies:

1) A minimum of 9 hours per week for adults and 6 hours per week for adolescents of skilled treatment services which may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and other therapies provided in amounts, frequencies, and intensities appropriate to the objectives of a patient's treatment plan;
2) Family therapy which involves family members, guardians, or significant others in the assessment, treatment and continuing care of the patient;
3) A planned format of therapies delivered on an individual or group basis and adapted to the patient's developmental stage and comprehension level;
4) Motivational interviewing, enhancement and engagement strategies; and
5) Capability to offer the above therapies for patients with co-occurring addictive and mental disorders who can benefit from the therapies; for those who are not able to benefit, intensive case management, assertive community treatment, medication management, and psychotherapy must be offered.

Level 2.1 Assessment/Treatment Plan Review Requirements

For Level 2.1 programs, patient assessment and treatment plan reviews include:

1) Individualized, comprehensive biopsychosocial assessment of a comprehensive substance use and addictive behaviors history reviewed by a physician and if determined needed by a patient's medical condition, a physical examination within a reasonable amount of time;
2) An individualized treatment plan developed in partnership with the patient that includes challenges, needs, strengths, skills, priority formulation and articulation of short-term, measurable treatment goals (including the patient's treatment goals), preferences and activities designed to achieve those goals;
3) Monitoring, including biomarkers and toxicology testing; and
4) A review of a patient's most recent psychiatric history and a mental status examination performed within a reasonable timeframe for patients with co-occurring mental disorders.

Level 2.1 Adolescent Specific Considerations

The ASAM Criteria recognize adolescent specific needs across the continuum of treatment. Level 2.1 programs serving adolescents must demonstrate capacity in their proposals to meet Level 2.1 adolescent-specific considerations including:

1) Staff knowledgeable about adolescent development and experience in working with and engaging adolescents;
2) Assessment and treatment staff experienced in recognizing adolescent needs for specialty evaluation and treatment for intoxication or withdrawal and that are able to arrange for these evaluation and treatment services in a timely manner;
3) Successful strategies for engaging parents, caregivers or other significant resources to obtain information for patient assessment and treatment planning and support patient recovery;
4) Assessment and support to address patient lingering subacute withdrawal symptoms such as severe insomnia (note: patients at risk or experiencing acute withdrawal symptoms

should not be treated in Level 2.1/Intensive Outpatient Services and should be treated by a Level 2-Withdrawal Management treatment provider); and

5) Serving adolescents placed out-of-county.

3. Residential Services/ASAM Level of Care 3.1, 3.3, and 3.5 Overview

The Department of Public Health is seeking proposals from qualified providers for Residential Services/ASAM Level 3, sublevels 3.1, 3.3, and 3.5 for adults and older adults. Level 3.1, 3.3, and 3.5

Residential Services must be authorized by The Howard Street Program Treatment Access Program (TAP). Proposers must describe a process for obtaining TAP approval to provide residential services to patients.

All Level 3 sublevels have 24-hour staff, with Level 3.1 providing a 24-hour supportive living environment, while Levels 3.3 and 3.5 provide 24-hour treatment settings. Each sublevel differs in intensity, but the defining differences between ASAM 3.1, 3.3, and 3.5 are based on the limitations patients have across the six ASAM dimensions and the services provided to address those limitations. Proposers must demonstrate an understanding of the range of intensities that make up ASAM Level 3 and patient placement in the appropriate sublevel of Residential Services.

Level 3 Residential Services create a positive recovery environment where patients are able to develop, practice, and demonstrate the recovery skills they need to prevent immediate relapse and not to continue substance use after transitioning. Level 3 programs promote continuity of care and community reintegration through seamless and overlapping intensities of outpatient services. Programs make admission, continued service and discharge decisions based on the clinical evaluation of a patient's assessed needs and treatment progress. When a patient has improved sufficiently to be ready for discharge or transfer to a lower level of care, staff are advocates for patient discharge and transition, including engagement with the courts if needed for patients under court order for mandatory lengths of stay in treatment.

All Level 3 providers must have capacity to provide case management services conducted by on-site staff, coordination of related addiction treatment, health care, mental health, and social, vocational, or housing services (provided concurrently) and the integration of services with other levels of care. Proposers must demonstrate capacity within their proposals to provide the required service, coordination and integration components of Residential Services.

In addition, DPH is requiring all Residential Services providers obtain approval from DHCS to offer Incidental Medical Services (IMS) that are provided by a health care practitioner to address medical issues associated with either detoxification or the provision of alcoholism or drug abuse recovery or treatment services to assist in the enhancement of treatment services (see *DHCS MHSUDS Information Notice No. 16-039*). IMS services include: a) obtaining medical histories; b) monitoring health status to determine whether the health status warrants transfer of the patient to receive urgent or emergent care; c) testing associated with detoxification from alcohol or drugs; d) providing alcoholism or drug abuse recovery or treatment services; e) overseeing patient self-administered medications; and f) treating substance use disorders including detoxification. Proposers must demonstrate capacity within their proposals to provide IMS services including evidence of state approval of or submission of a supplemental application

(DHCS 5255) requesting this additional service in the proposal appendix and describe components of their onsite IMS programs.

Level 3/Residential Services providers must demonstrate the capacity to:

1. Begin and continue treatment with prescription medications that are FDA approved for maintenance and ongoing craving, as indicated by patient needs;
2. Prescribe and adjust prescriptions for psychiatric or medical problems in order to facilitate a patient's continued participation in treatment services, as indicated by patient needs;
3. Provide closely coordinated access to medically-supervised WM services at 3.2-WM for alcohol withdrawal, and more complicated medical WM, as indicated by patient needs.

In addition to compliance with all federal, state and local laws, regulations and policies governing SUD treatment services, Level 3 Residential Services providers must have capacity to make required patient accommodations to comply with the Americans with Disabilities Act. This includes having in place practices, policies and procedures to allow patients to have companion animals in treatment facilities. Providers must describe their strategies for accommodating patient companion animals and ensuring the safety of all treatment patients and provider staff in the residential environment.

All Level 3/Residential Services licensed treatment facilities also must complete the *DHCS ASAM Residential Level of Care Designation Questionnaire.* For more info, please see:

http://www.dhcs.ca.gov/provgovpart/Documents/ASAM_Designation_Questionnaire_8-19-15.pdf

Level 3.1, 3.3 and 3.5 Requirements

Following is a description of The ASAM Criteria required components, staffing, support/collaborative partnerships, therapies, and assessment and treatment plan review for Levels 3.1, 3.3, and 3.5. Proposers must review requirements for each level of care carefully and demonstrate organizational and staffing capacity to meet all requirements for the Level 3/ Residential Service proposed to be provided.

Level 3.1/Residential Services Requirements

Level 3.1 program services usually are offered in a freestanding, appropriately licensed facility located in the community. The length of stay in Level 3.1 programs tend to be longer than in the more intensive residential levels of care (e.g. Level 3.3 or Level 3.5).

Examples of Level 3.1 programs are sobering centers, group homes and other supportive living environments with 24-hour staff and closely integrated clinical/treatment services. The residential component of Level 3.1 can be combined with Level 2.1 Intensive Outpatient Services for patients whose living situations or recovery environments are incompatible with their recovery goals if they otherwise meet the ASAM dimensional criteria for Level 2.1 placement.

Patients served in Level 3.1 programs typically experience challenges in applying recovery skills, self-efficacy or lack connections to work, education or family life. The 24-hour structure

under Level 3.1 provides patients the opportunity to develop and practice their interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and family, and begin or resume employment or academic pursuits. Patients placed in Level 3.1 also may not yet acknowledge that they have a substance use or other addictive challenge. They could be living in a recovery environment that is too unstable to permit treatment in an outpatient setting, needing residential services to minimize continued substance use and/or other addictive behavior. In addition, Level 3.1 patients are often at early stages of readiness to change, requiring monitoring and motivating strategies to prevent deterioration, engage them in treatment and facilities their progress through the stages of change to recovery.

Desired characteristics of recovery-focused, supportive residential treatment include:

1. Residential treatment provides a physically and emotionally safe, secure and respectful environment;
2. Sobriety requirements are supported by patients to support their wellness;
3. Residential treatment is located in the community, and patients are supported in connecting with services, supports, employment and social activities;
4. Providers and patients value the voice and experience of peers who have experienced addition challenges;
5. Patient rights and responsibilities are clear and consistent;
6. Patients are accountable for how their behaviors impact their residential stability and the wellness of others in housing;
7. Residential stability is a priority for recovery and to prevent relapse – if a patient is leaving treatment by choice or transitioning to another level of care, every effort is made to connect him or her to safe housing and recovery supports.

The Department of Public Health is interested in recovery residence models that provide short-term, 30-day intensive services (with up two, 30-day reauthorizations) that link patients to housing and job training, medication management services and a lower level of care, either Level 1/Outpatient Services or Level 2/Intensive Outpatient Services through case management services.

<u>Level 3.1 Required Components</u>
There are two primary components of Level 3.1 programs: a clinical services component and a recovery services component as follows:

1) <u>Clinical Services Component</u>
   Level 3.1 provides weekly clinical services with the intensity determined by a patient's clinical needs. Services are usually outpatient services but no less than 5 hours per week. Treatment services focus on improving a patient's readiness to change and/or functioning and coping skills. Services may include individual, group and family therapy, medication management and medication education, mental health evaluation and treatment, vocational rehabilitation, job placement and either introductory or remedial like skills workshops.
2) <u>Recovery Services Component</u>

The second component of Level 3.1 care is a structured recovery residence environment, staffed 24 hours a day, which provides support and stability to prevent or minimize relapse or continued use and continued problem potential. Patient interpersonal and group living skills generally are promoted through the use of community or house meetings of residents and staff to facilitate bonding and cohesion among recovering patients, reinforce recovery concepts and norms, and introduce patients to the larger recovery community and recovery-oriented resources.

Level 3.1 Support Systems

Level 3.1 Residential Services must demonstrate capacity for the following supports either provided on-site or through formal partnerships with service providers as documented by written, approved MOUs that identify roles and responsibilities:

1) 24/7 telephone or in person consultation with physicians and emergency services;
2) Access to other levels of care that are directly affiliated or closely coordinated referrals to more or less intensive levels of care, such as ASAM 2.1/Intensive Outpatient Services, as well as other services such as adult education;
3) Incidental Medical Services (see *Department of Health Care Services MHSUDS Information Notice No. 16-039*) including Medication Assisted Treatment; laboratory testing, toxicology services, and medication management services;
4) Arrangement of pharmacotherapy for psychiatric or anti-addiction medications;
5) Capacity to provide appropriate mental health services, including medication evaluation and laboratory services, on-site or closely coordinated off-site via formal partnerships for patients with co-occurring disorders.

Level 3.1 Staffing Requirements

Level 3.1 programs are staffed by:

1) Allied health professional staff such as counselor aides or group living workers who are available onsite 24 hours a day or as required by licensing regulations;
2) Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment and are able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation;
3) A multi-disciplinary team comprised of appropriately trained and credentialed medical, addiction and mental health professionals;
4) On-site or closely coordinated referrals to appropriately credentialed medical staff to assess and treat co-occurring patient biomedical disorders and monitor patient administration of medications;
5) On-site or closely coordinated referrals to appropriately credentialed mental health professionals to assess and treat co-occurring disorders in consultation with addiction-trained psychiatrists.

While physicians, advanced registered nurse practitioners, and physician assistants are not involved in direct services as staff, an addiction physician is desired to review admission decisions to confirm clinical necessity of services.

Level 3.1 Therapy Requirements

Level 3.1 programs include the following therapies:

1) Services designed to improve the patient's ability to structure and organize tasks of daily living and recovery such as personal responsibility, personal appearance and punctuality;
2) Planned clinical program activities (at least 5 hours per week of professionally directed treatment) to stabilize and maintain the stability of patient substance use disorder symptoms and to develop and apply recovery skills such as relapse prevention, exploring interpersonal choices, and development of social network for recovery;
3) Addiction pharmacotherapy;
4) Random drug screening to monitor and reinforce treatment progress;
5) Motivational enhancement and engagement strategies tailored to the patient's stage of readiness to change; and
6) Counseling and clinical monitoring to support successful initial involvement or reinvolvement in regular, productive daily activity and reintegration into family living, if appropriate, including health education services;
7) Regular monitoring of patient medication adherence;
8) Recovery support services;
9) Services for the patient's family and significant others; and
10) Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage addictive disorders.

Level 3.1 Assessment/Treatment Plan Review Components

In addition to providing required case management, service coordination and integration with other Level 3 services and ASAM levels of care, Level 3.1 programs must demonstrate capacity for assessment and treatment plan review as follows:

1) Individualized, comprehensive biopsychological assessment of each patient's substance use disorder, conducted or updated by staff who are knowledgeable about addiction treatment, to confirm the appropriateness of placement in Level 3.1 and to help guide the individualized treatment planning process;
2) An individualized treatment plan developed in partnership with the patient that involves challenges, needs, strengths, skills, priority formulation, and articulation of short-term, measurable treatment goals, preferences and activities designed to achieve those goals;
3) A biopsychosocial assessment, treatment plan, and updates that reflect a patient's clinical progress;
4) A physical examination performed within a reasonable time as defined by a program's policy or Drug Medi-Cal requirements, and as determined by a patient's medical condition; and
5) A review of recent psychiatric and mental status examination for patients with co-occurring disorders.

Level 3.3/Residential Services Requirements

Level 3.3 programs are licensed therapeutic rehabilitation facilities located in a community setting that offer a high-intensity structured clinical services with 24-hour staff.

Patients admitted to Level 3.3 programs usually have significant cognitive impairments as a result of the effects of substance use or other addictive disorders that present challenges in interpersonal relationships, emotional coping skills, or comprehension. These impairments make outpatient motivational and/or relapse prevention strategies infeasible and ineffective and make it unlikely that other levels of residential care would be of benefit. Some patients may have such severe limitations in interpersonal and coping skills that the treatment process is one of habilitation rather than rehabilitation where treatment becomes directed at overcoming a patient's lack of awareness or ambivalence about the effects of substance-related problems or addiction on their lives, as well as enhancing their readiness to change. Treatment also focuses on relapse prevention, continued problems and/or continued use, and promoting the eventual reintegration of the patient into the community.

Level 3.3 Required Components

Level 3.3 is generally considered as providing high-intensity services (daily clinical services) which may be provided in a deliberatively repetitive way to address the special needs of patients for whom a Level 3.3 program is considered medically necessary. This includes patients who are elderly, cognitively impaired, or developmentally delayed or those with chronic, intense primary diseases that require allowing for sufficient time to integrate lessons into their daily lives. Typically, these patients require a slower pace of treatment and may be homeless, though homelessness alone is not a sufficient indication for Level 3.3 admission.

Level 3.3 Support Systems

Level 3.3 Residential Services must demonstrate capacity to provide the following supports either by the provider or through formal partnerships with service providers as documented by written, approved MOUs that identify roles and responsibilities:

1. 24/7 telephone or in person consultation with physicians, physician assistants or nurse practitioners, and emergency services;
2. Access to other levels of care that are directly affiliated or closely coordinated referrals to more or less intensive levels of care, as well as other services such as adult education;
3. Incidental Medical Services (see *Department of Health Care Services MHSUDS Information Notice No. 16-039*) including Medication Assisted Treatment; laboratory testing, toxicology services, and medication management services;
4. Arrangement of pharmacotherapy for psychiatric or anti-addiction medications;
5. Medical, psychiatric, and psychological service available via consultation or closely coordinated referrals; and
6. Mental health services by telephone consultation within 8 hours and on-site or closely coordinated referrals offsite within 24 hours through formal partnerships.

Level 3.3 Staffing Requirements

Level 3.3 programs must demonstrative sufficient levels of staffing capacity including:

- Physicians, physician assistants, and nurse practitioners and appropriately credentialed mental health professionals;
- Allied health professional staff such as counselor aides or group living workers who are available on-site 24-hours a day or as required by licensing regulations including one or

more clinicians with competence in SUD treatment available on-site 24 hours or available by phone;

- Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment, are able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation, and have specialized training in behavior management techniques;
- Appropriately credential medical staff to assess and treat co-occurring biomedical disorders and monitor patient appropriate administration of medications; and
- Appropriately credentialed psychiatrists and mental health professionals who have specialized training in behavioral health techniques and can assess and treat co-occurring mental health disorders for patients with co-occurring mental disorders.

Level 3.3 Required Therapies

In addition to providing required case management, service coordination and integration with other Level 3 services and ASAM levels of care, Level 3.3 programs must demonstrate capacity to offer the following therapies:

1. Daily clinical services to improve the patient's ability to structure, organize the tasks of daily living and recovery;
2. Planned clinical program activities designed to stabilize and maintain the stability of patient addiction symptoms and develop/apply recovery skills such as relapse prevention, provide guidance about good choices a patient makes about interpersonal and social relationships, and develop a social network supportive of recovery;
3. Random drug screening to monitor progress and reinforce treatment progress as appropriate to the patient's treatment plan;
4. A range of cognitive, behavioral, and other evidence-based therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreational activities adapted to the patient's developmental stage and level of comprehension;
5. Counseling and clinical monitoring to assist patient with successful initial involvement or reinvolvement in regular, productive daily activities and reintegration into family living, if appropriate, and health education services;
6. Regular monitoring of patient adherence to taking prescribed medications;
7. Daily scheduled professional addiction and mental health treatment services designed to develop and apply recovery skills which include medical services, nursing services, individual and group counseling, family therapy, educational groups, occupational and recreational therapies, art, music or movement therapies, physical therapy and vocational rehabilitation activities;
8. Clinical and didactic motivational interventions appropriate to patient stages of readiness to change, designed to facilitate patient understanding of the relationship between substance use disorder and attendant life issues;
9. Services for patient families and significant others; and
10. Clinical activities for patients with co-occurring mental disorders designed to stabilize a patient's mental health challenges and psychiatric symptoms and to maintain a patient's stability.

Level 3.3 Assessment/Treatment Plan Review Requirements

Level 3.3 programs must demonstrate capacity to support regular assessment of patient needs and progress on treatment goals including:

1. Individualized, comprehensive biopsychological assessment of each patient's substance use disorder to on, conducted or updated by staff who are knowledgeable about addiction treatment, to confirm the appropriateness of placement in Level 3.1 and to help guide the individualized treatment planning process;
2. An individualized treatment plan developed in partnership with the patient that involves challenges, needs, strengths, skills, priority formulation, and articulation of short-term, measurable treatment goals, preferences and activities designed to achieve those goals;
3. A biopsychosocial assessment, treatment plan, and updates that reflect a patient's clinical progress, reviewed by a multi-disciplinary treatment team;
4. A physical examination performed within a reasonable time as defined by a program's policy or Drug Medi-Cal requirements, and as determined by a patient's medical condition;
5. Ongoing transition and continuing care planning; and
6. A review of recent psychiatric and mental status examination for patients with co-occurring disorders.

Level 3.5/Residential Services Requirements

Level 3.5 programs serve patients who need 24-hour safe and stable living environments to gain recovery skills to prevent immediate relapse or continued use in an imminently dangerous manner upon transfer to a lower level of care.

Patients in Level 3.5 have addiction challenges that have escalated to the point that they need a 24-hour supportive environment to either begin or continue a recovery process that has not progressed. Patient needs across the ASAM Dimensions are of such severity that they cannot be treated safely in less intensive levels of care and require comprehensive, multi-faceted treatment approaches to address the interrelated challenges patient have. Defining characteristics of patients needing Level 3.5 services: a) are having emotional, behavioral and cognitive conditions (ASAM Dimension 3); and b) their living environments (ASAM Dimension 6).

Patients needing Level 3.5 services also have multiple limitations that may include substance use and addictive disorders, criminal activity, psychological challenges, impaired functioning, and disaffiliation from mainstream values. Mental health challenges usually involve serious and chronic mental health disorders, such as schizophrenia, bipolar disorders, and major depressive disorders, and personality disorders.

The main treatment goals of Level 3.5/Residential Services are to promote abstinence from substance use, reduce other addictive and antisocial behaviors, and support change in patient lifestyles, attitudes and values. Substance-related and other addictive problems are viewed as disorders of the "whole person" that are reflected in problems with conduct, attitudes, moods, values, and emotional management. Treatment is tailored to the patient's level of readiness for change which for some patients could include becoming aware for the first time of the nature of

their substance use or addictive disorder and/or mental health challenges, and for others, could include a focus on maintaining abstinence and preventing relapse.

Level 3.5 Clinical Services Component

Level 3.5 is generally considered as providing high-intensity services (daily clinical services) which may be provided in a deliberatively repetitive way to address the special needs of patients for whom a Level 3.5 program is considered medically necessary. This includes patients who are elderly, cognitively impaired, or developmentally delayed or those with chronic, intense primary diseases that require allowing for sufficient time to integrate lessons into their daily lives. Typically, these patients require a slower pace of treatment and may be homeless, though homelessness alone is not a sufficient indication for Level 3.5 admission.

Level 3.5 Support Systems

Level 3.5 Residential Services must demonstrate capacity for the following supports either provided by the provider or through formal partnerships with service providers as documented by written, approved MOUs that identify roles and responsibilities:

1. 24/7 telephone or in person consultation with physicians, or a physician assistant or nurse practitioner and emergency services;
2. Access to other levels of care that are directly affiliated or closely coordinated referrals to more or less intensive levels of care, as well as other services such as adult education;
3. Incidental Medical Services (see *Department of Health Care Services MHSUDS Information Notice No. 16-039*) including Medication Assisted Treatment; laboratory testing, toxicology services, and medication management services;
4. On-site medical, psychiatric, and psychological services or access to these services through closely coordinated referral (as documented by written, approved MOUs that identify roles and responsibilities) as appropriate to the severity and urgency of a patient's condition; and
5. Psychiatric services, medication evaluation and laboratory services for patients with co-occurring disorders by telephone consultation within 8 hours and on-site or closely coordinated offsite within 24 hours (through formal partnerships as documented by written, approved MOUs).

Level 3.5 Staffing Requirements

Level 3.5 programs must demonstrative sufficient levels of staffing capacity including:

1. Licensed or credentialed clinical staff such as addiction counselors, social workers, or licensed professional counselors working in multi-disciplinary teams with allied health/medical professionals;
2. Allied health professional staff such as counselor aides or group living workers who are available on-site 24-hours a day or as required by licensing regulations including one or more clinicians with competence in SUD treatment available on-site 24 hours or available by phone;
3. Clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment, are able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation, and have specialized training in behavior management techniques; and

4. Appropriately credentialed medical staff who are available to assess or treat co-occurring biomedical disorders and monitor patient medications in accordance with physician prescriptions.

Level 3.5 Required Therapies

In addition to provide required case management, service coordination and integration with other Level 3 services and levels of care, Level 3.5 programs must demonstrate capacity to offer the following therapies:

1. Daily clinical services to improve the patient's ability to structure and organize the tasks of daily living and recovery and develop and practice prosocial behaviors;
2. Planned clinical program activities designed to stabilize and maintain the stability of patient addiction symptoms and develop/apply recovery skills such as relapse prevention, exploration of interpersonal and choices, and development of a social network supportive of recovery;
3. Counseling and clinical monitoring to assist patient with successful initial involvement or reinvolvement in regular, productive daily activities and reintegration into family living, if appropriate, and health education services;
4. Random drug screening to monitor progress and reinforce treatment progress as appropriate to the patient's treatment plan;
5. A range of cognitive, behavioral, and other evidence based therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreational activities adapted to the patient's developmental stage and level of understanding;
6. Regular monitoring of patient adherence to taking prescribed medications and/or any permitted over-the-counter medications or supplements;
7. Motivational enhancement and engagement strategies appropriate to a patient's stage of readiness and desire to change;
8. Counseling and clinical interventions to facilitate teaching a patient the skills needed for productive daily activity and successful reintegration into family living, if indicated, and health education services;
9. Daily scheduled professional addiction and mental health treatment services designed to develop and apply recovery skills which include medical services, nursing services, individual and group counseling, family therapy, educational groups, occupational and recreational therapies, art, music or movement therapies, physical therapy and vocational rehabilitation activities;
10. Planned clinical activities to enhance a patient's understanding of his or her substance use and/or mental health disorders;
11. Services for patient families and significant others; and
12. Planned clinical activities designed to stabilize a patient's mental health challenges and psychiatric symptoms and maintaining stabilization for patients with co-occurring disorders.

Level 3.5 Assessment/Treatment Plan Review Requirements

Level 3.5 programs must demonstrate capacity to support regular assessment of patient needs and progress on treatment goals including:

1. Individualized, comprehensive biopsychological assessment of each patient's substance use disorder to on, conducted or updated by staff who are knowledgeable about addiction treatment, to confirm the appropriateness of placement in Level 3.1 and to help guide the individualized treatment planning process;
2. An individualized treatment plan developed in partnership with the patient that involves challenges, needs, strengths, skills, priority formulation, and articulation of short-term, measurable treatment goals, preferences and activities designed to achieve those goals;
3. A biopsychosocial assessment, treatment plan, and updates that reflect a patient's clinical progress, reviewed by a multi-disciplinary treatment team;
4. A physical examination performed within a reasonable time as defined by a program's policy or Drug Medi-Cal requirements, and as determined by a patient's medical condition; and
5. A review of a patient's recent psychiatric history and a mental status examination for patients with co-occurring disorders.

Level 3 Special Population: Requirements for Pregnant Women and Parenting Women with Dependent Children

The Department of Public Health is seeking proposals to provide a Level 3/Residential Services program for pregnant and parenting women with young children, birth to age five, where women receive addiction treatment, the parent-child relationship is supported and the age appropriate developmental and treatment needs of the child are supported. The Department acknowledges that the addition of children to a residential setting presents a number of challenges to creating a supportive environment for increasing parenting skills, supporting parent-child bonding, and promoting child development. At the same time, DPH recognizes that motivating parents to engage with and remain treatment strengthens the parent-child relationship and healthy outcomes for families.

Special treatment service requirements for serving pregnant women and parenting women with dependent children include capacity to:

1. Compliance with the Fiscal Year 2016-17 Perinatal Services Network Guidelines (see http://www.dhcs.ca.gov/services/adp/Documents/PSNG%20FY%202016-17.pdf);
2. Primary medical care for women, including referral for prenatal care and child care while women are receiving such services;
3. Primary pediatric care, including immunization for children;
4. Gender specific substance use treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care for women receiving these services;
5. Therapeutic interventions for children in custody of women in treatment which address at a minimum their developmental needs, their issues of sexual and physical abuse, and neglect;

6. Sufficient case management and transportation to ensure that women and their children have access to services;
7. Assessments of child-parent relationship and needs of the child including facilitating access to age-appropriate treatment for the child;
8. Trained staff in child development and positive parenting, trauma-informed care, and gender-specific treatment and staff skills required to establish and maintain recovery while parenting;
9. Trained staff in couples and family therapy to support patients in their interaction with the other parent of the child and/or with their current partner including caregivers and any supportive family members;
10. Connections with supportive resources early in treatment to support patient recovery and transitions to other levels of care;
11. Engagement of patient family members including significant others; and
12. Collaborative partnerships with family and child serving agencies to put into place supports and services that support patient transitions and recovery, including Medi-Cal, TANF, vocational rehabilitation, and housing.

Level 3 Residential Services Scoring Preference

There are two scoring preferences that will be awarded to qualified proposals that meet the following desired service components:

1. Level 3.1, 3.3, and 3.5 Scoring Preference – Continuity of Care/10 Preference Points
   Longer exposure to treatment interventions may be necessary for patients to acquire basic living, coping and recovery skills. The State has placed limitations on reimbursement beyond two non-continuous 90-day treatment periods for ASAM Level 3 programs (*see DHCS MHSUDS Notice No. 16-042 at www.dhcs.ca.gov*). While DPH will support Level 3 treatment with County General Fund beyond the State limits when a review of a patient's assessed needs and treatment plan progress indicates the need for a longer treatment period, funds permitting, a scoring preference of 10 points will be awarded to qualified Level 3 proposals that demonstrate capacity to provide recovery residences/environments with ongoing Outpatient or Intensive Outpatient Services (depending on the patient's continued needs) after the state imposed reimbursement limits.

2. Level 3.3 Scoring Preference – On-Site Medical Monitoring/10 Preference Points
   Qualified providers that demonstrate capacity to offer biomedical enhanced services on-site will receive ten (10) preference points added to the proposal base score. Biomedical enhanced services must be delivered by appropriate medical staff to assess and treat co-occurring biomedical disorders and to monitor the administration of medications in accordance with a physician's prescription. This includes nursing care and sufficient observation to meet patient needs.

4. Opioid Treatment Programs (OTP) Overview

Opioid Treatment Programs (formerly Narcotic Treatment Programs) encompass a variety of pharmacological and non-pharmacological treatment that include medication used to treat opioid use disorders including methadone, buprenorphrine, disulfiram, and naloxone and alcohol use disorders including acamprosate, disulfiram, and off-label use of topiremate.

There are two models for OTP: 1) Opioid Treatment Programs that directly administer medication on a daily basis without prescribing medications; and 2) Office-Based Opioid Treatment (OBOT) where clinics prescribe outpatient supplies of buprenorphine. Opioid Treatment Programs that directly administer medication on a daily basis are heavily regulated by federal agencies, while under the OBOT model, a program clinic site is not regulated per se; the practice of the individual physician at the clinic site is regulated by federal regulations.

OBOT Model

A physician at a clinic receives a federal waiver to prescribe buprenorphine up to 275 patients which is dispensed by a pharmacy. OBOT clinics must maintain logs of all patients that include dosage, start date, number of doses authorized, other data (including the run-out date for the last authorized prescription), and a notation whether the patient is no longer under the physician's care.

The clinic also must demonstrate capacity for a multi-disciplinary approach to patient care including having formal relationships to refer patients to psychosocial counseling for patient addiction across all ASAM levels of care, depending on the patient's needs, and providing medication management services.

Please note that a newly enacted federal law will allow nurse practitioners and physician assistants with a Drug Enforcement Agency license to become prescribers of buprenorphine with training and within appropriate patient census limits. Until federal regulations are finalized to allow nurse practitioners and physician assistants to prescribe buprenorphine for the treatment of SUD disorders, waivered physicians at the clinic must see a patient and write a prescription at each visit.

OBOT clinics must demonstrate capacity to admit, stabilize and transition MAT patients to primary care by describe their processes, practices and procedures to support this requirement.

OTP Model

Opioid Treatment Programs are ambulatory addiction treatment services for patients with an opioid or alcohol use disorder. Programs use a multi-disciplinary team approach to treatment that includes, at a minimum, physicians, nurses, licensed or certified addiction counselors, and mental health therapists who provide patient-centered, recovery-oriented individualized treatment, case management, and health education.

Services such as dosing, level of care, length of services, and frequency of visits are tailored to the needs of patients, though federally-mandated program components include regularly scheduled psychosocial treatment sessions, random urine drug tests, and scheduled medication visits within a program structure. Opioid Treatment Programs must meet federal admission, discharge, and continued service criteria under 42 CFR 8.12 and California law.

Treatment is designed to address a patient's need to achieve changes in his or her level of function including the elimination/reduction in the use of any drugs that could compromise recovery. Patient-centered treatment plans address major lifstyle, attitudinal, and behavioral issues that may undermine a patient's recovery-oriented goals and impact his or her ability to cope with major life tasks.

While the duration of treatment varies with the severity of a patient's illness, response to treatment and desire to continue treatment, most studies show high rates of relapse to opioid use when participation in Opioid Treatment Programs is discontinued. Proposers should include in their proposals strategies to engage patients in appropriate level of care treatment that supports patient recovery and prevent relapse.

Required Level 1/OTP Model Supports
Level 1/OTP must include the following supports at a minimum:

1. Formal linkages with or access to psychological, medical, and psychiatric consultation;
2. Access to emergency medical and psychiatric care through affiliations with more intensive levels of care;
3. Access to evaluation and ongoing primary medical care;
4. Ability to conduct or arrange for appropriate laboratory and toxicology tests; and
5. Availability of physicians to evaluate, order, and monitor the use of medications and of pharmacists and nurses to dispense and administer medications.

Required Level 1/OTP Model Staffing
Level 1/OTP staff must include an interdisciplinary team of staff trained in treatment of opioid use disorder, including, at a minimum, a medical director, counselors, and a physician, or his/her appropriately licensed supervisee, who is available for medication dispensing and clinic operating hours in person or via telephone. The team can include social workers, professional counselors, and licensed psychologists depending on patient needs.

All staff members must be knowledgeable in the assessment, interpretation and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders and receive supervision appropriate to their level of training and experience.

Required Level 1/OTP Model Therapies
Leve1 1/OTP therapies must include at a minimum:

1. Individualized, patient-centered assessment and treatment;
2. Assessment, ordering, administration, reassessment, and regulation of medication and dose levels appropriate to the patient and supervision of withdrawal management from opioid methadone and buprenorphine;
3. Provision of medication for other physical and mental health disorders provided on-site or closely coordinator with other providers;
4. Monitored drug testing to be done at least 8 times per year;
5. A range of cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches provided to patients on an individual, group or family basis;
6. Case management including medical monitoring and coordination of on- and off-site treatment services and linkage to educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care, and other services; and

7. Psychoeducation including HIV/AIDS education and other health education services.

Required Level 1/OTP Model Assessment/Treatment Plan Review Elements
Level 1/OTP assessment and treatment plan review elements must include at a minimum the following:

1. A comprehensive medical history, physical examination, and laboratory tests in accordance with federal regulations;
2. An individual biopsychosocial assessment;
3. An appropriate regimen of medication at a dose established by a physician, or his/her appropriately licensed supervisee, at the time of admission and monitored carefully until the patient is stable and an adequate does has been established which is reviewed as indicated by a patient's course of treatment;
4. Continuing evaluation and referral for care of any serious biomedical problems; and
5. An individualized, patient-centered and recovery-focused treatment plan including patient challenges and short-term, measurable treatment goals and activities designed to achieve the goals developed in collaboration with the patient.

D. ASAM Withdrawal Management Services Overview

ASAM Withdrawal Management (WM) services represent one of the first priorities in treatment planning and can be provided at the same time as SUD treatment services. Though historically provided in an inpatient setting, current medication protocols allow for all but the most severe withdrawal syndromes to be managed safely within SUD treatment programs. WM services stabilize and resolve acute symptoms and minimize the potential for readmission to more intensive levels of care. This requires an understanding for the chronic disease nature of addiction and supporting care transitions to ongoing post-withdrawal services to meet patient addiction, general medical and mental health treatment needs.

It is the expectation that all DPH SUD treatment services provide the appropriate level of withdrawal management services for patients. For 3.2-WM services, there is an added expectation that WM for alcohol be provided for a period of three to six days, depending on a patient's detoxification needs. Beyond six days, SUD treatment providers will not be able to bill for WM services at WM billing rates. The Department of Public Health strongly encourages Level 3.1, 3.3, and 3.5 Residential Service providers to obtain required facility licensure with authorization to offer 3.2-WM Services.

WM services include the following service components:

1. Intake: Evaluation and analysis of a patient's SUD, the diagnosis of SUD, and the assessment of treatment needs and may include a physical examination and laboratory testing;
2. Observation: Monitoring a patient's course of withdrawal including a patient's health status;
3. Medication Services: Prescription or administration of medication related to SUD treatment and/or the assessment of the side effects and results of medications;

4. Discharge Services: Preparing patient for referral to another level of care, post treatment return, transition into the community, and/or case managed linkage of patients to community treatment, housing and human services.

Depending on the level of WM services to be offered, state facility licensure is required. Please see the following table.

ASAM Level	Description	Provider	Certification/ License Required
1 – WM Ambulatory Withdrawal Management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility	• AOD Certification with a non-residential detox service authorization • DMC Outpatient Certification
2 – WM Ambulatory Withdrawal Management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night, patients have supportive family or living situation.	DHCS Certified Outpatient Facility	• AOD Certification with a non-residential detox service authorization • DMC Outpatient Certification
3.2 – WM Residential/Inpatient Withdrawal Management	Moderate withdrawal, but patient needs 24-hour support to complete withdrawal management and to increase patient likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility	• DHCS Residential License with detox service authorization • DMC Residential Certification

Level 1-WM and Level 2-WM Requirements
Required Level 1-WM and Level 2-WM Supports include all of the following:

1. Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive challenges as indicated;
2. Ability to obtain a comprehensive medical history and physical examination of the patient at admission;
3. Linkages to other levels of care, including other levels of SUD treatment and general and psychiatric services;
4. Ability to conduct and/or arrange for appropriate laboratory and toxicology tests with a preference for point-of-care testing;
5. 24-hour access to emergency medical consultation services if needed; and
6. Ability to provide or assist in accessing transportation services for patients who do not have safe transportation.

In addition, for Level 2-WM, access to psychological and psychiatric consultation is required.

Required Level 1-WM and Level 2-WM staffing includes:

1. Physicians and nurses on-site or off-site but readily available to evaluate and confirm that WM in a less supervised setting is safe. Physicians do not need to be certified as addiction specialist physicians and nurses do not need to be certified as addiction nurses but training and experience in assessing and managing intoxication and withdrawal states is required; and
2. Counselors, psychologists, and social workers must be available. All clinicians who

assess and treat patients must have knowledge about interpreting information on the needs of patients going through withdrawal services. Staff also must be knowledgeable about the signs and symptoms of alcohol and other drug intoxication and withdrawal, appropriate treatment and monitoring these conditions and supporting a patient's entry into ongoing care.

Required Level 1-WM and Level 2-WM therapies include:

- Individual assessment
- Medication or non-medication WM strategies
- Patient Education
- Non-pharmacological clinical support
- Engagement of family or significant others in WM process
- Discharge or transition planning including treatment service and community recovery support group referrals
- Physician and/or nurse monitoring, assessment, and management of signs/symptoms of intoxication/withdrawal.

Level 1-WM and Level 2-WM Assessment/Treatment Plan Review includes the following elements:

1. An addiction-focused patient history, obtained as part of the initial assessment and conducted by or reviewed by a physician during the admission process;
2. A physical examination by a physician, physician assistant, or nurse practitioner performed within a reasonable time frame as part of the initial assessment;
3. Sufficient biopsychosocial screening assessments to determine the level of care placement and for the individualized treatment plan to address treatment priorities identified for ASAM Dimensions 2 through 6;
4. Individualized treatment plan that includes problem identification in ASAM Dimensions 2 through 6, development of treatment goals and measurable treatment objectives and activities to meet objectives related to withdrawal management;
5. Daily assessment of progress during withdrawal management and any treatment changes;
6. Discharge/transfer planning beginning at the admission to WM services; and
7. Referral and linkage to counseling, medical, psychiatric and continuing care.

In addition, for Level 2-WM services, serial medical assessments are required, using the appropriate measures of withdrawal.

Proposers for Level 1-WM and Level 2-WM services must describe their length of service and continued service and discharge criteria in their proposals. These criteria must be consistent Level 1-WM and Level 2-WM criteria which include:

- Withdrawal signs and symptoms are sufficiently resolved so that patients can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing WM monitoring; or
- Patient signs and symptoms of withdrawal have failed to respond to treatment and have intensified, requiring a transfer to a more intensive level of WM service; or
- A patient is unable to complete withdrawal management at Level 1-WM despite an adequate effort to participate.

Level 3.2-Clinically Managed Residential Withdrawal Management Requirements

Level 3.2-Clinically Managed Residential WM is an organized service delivered by appropriate trained staff that provide 24-hour supervision, observation and support for patients experiencing withdrawal with an emphasis on peer and social support. Patients have severe intoxication and withdrawal signs and symptoms that require a 24-hour structure and support not requiring inpatient services.

Required Level 3.2/Clinically Managed Residential WM Supports include:

1. Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive challenges;
2. Protocols that allow for medical and nursing interventions if a patient's condition deteriorates and require such interventions – proposers of Level 3.2 WM services must describe their protocols under the "Treatment Program Narrative" section of the "Proposal Submission Template":
3. Formal relationships with other level of care (written, approved MOUs for referrals);
4. Ability to provide appropriate laboratory and toxicology tests.

Required Level 3.2-WM services must be staffed by appropriately credentialed staff who are trained and competent in implementing physician-approved protocols for patient observation and supervision, determination of appropriate level of care, and support for the patient's transition to continuing care. Level 3.2-WM is social withdrawal management model that is clinically managed and designed to safely assist patients through withdrawal without the need for medical or nursing staff. However, medical evaluation and consultation must be available 24 hours a day.

Like Level 1-WM and Level 2-WM, all Level 3.2-WM clinicians who assess and treat patients must have knowledge about interpreting information on the needs of patients going through withdrawal services. Staff also must be knowledgeable about the signs and symptoms of alcohol and other drug intoxication and withdrawal, appropriate treatment and monitoring these conditions and supporting a patient's entry into ongoing care.

Residential facilities that supervise self-administered medications must have appropriately licensed or credentialed staff and Level 3.2-WM staff must be available to ensure that patients are taking medications according to physician prescriptions and legal requirements.

Required Level 3.2-WM therapies include daily clinical services to assess and address the needs of each patient. This may include appropriate medical services, individual and group therapies and withdrawal support. The following services are provided as clinically necessary depending on a patient's progress through withdrawal management and assessed needs on ASAM Dimensions 2-6:

1. A range of cognitive, behavioral, medical, mental health, and other therapies on an individual or group basis to enhance patient understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment;
2. Multi-disciplinary individualized assessment and treatment;

3. Health education services; and
4. Services to families and significant others.

Required Level 3.2-WM Assessment and Treatment Plan Review elements include:

1. An addiction-focused patient history, obtained as part of the initial assessment and conducted by or reviewed by a physician during the admission process;
2. A physical examination by a physician, physician assistant, or nurse practitioner performed as part of the initial assessment if self-administered medications are to be used;
3. Sufficient biopsychosocial screening assessments to determine the level of care placement and for the individualized treatment plan to address treatment priorities identified for ASAM Dimensions 2 through 6;
4. Individualized treatment plan that includes problem identification in ASAM Dimensions 2 through 6, development of treatment goals and measurable treatment objectives and activities to meet objectives;
5. Daily assessment of progress during withdrawal management and any treatment changes;
6. Discharge/transition planning beginning at the admission to WM services; and
7. Referrals as needed.

Like Level 1-WM and Level 2-WM, proposers for Level 3.2-WM services must describe their length of service and continued service and discharge criteria in their proposals. These criteria must be consistent Level 1-WM and Level 2-WM criteria which include:

- Withdrawal signs and symptoms are sufficiently resolved so that patients can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing WM monitoring; or
- Patient signs and symptoms of withdrawal have failed to respond to treatment and have intensified, requiring a transfer to a more intensive level of WM service; or
- A patient is unable to complete withdrawal management at Level 1-WM despite an adequate effort to participate.

E. Evidence Based Practices

The DMC-ODS Pilot project requires the use of evidence-based practices for SUD treatment to improve patient outcomes. Proposers must demonstrate capacity to provide at least two (2) of the approved DMC-ODS Pilot and DPH evidence-based practices (EBPs) through the following at a minimum in their proposals:

1. Motivational Interviewing
   A patient-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. The approach also has had success in supporting patient engagement and harm reduction for patients not yet motivated to abstain from substance use - www.motivationalinterviewing.org.

2. Cognitive Behavioral Therapy
   Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. This therapeutic approach has been effective in preventing relapse.
3. Relapse Prevention
   A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
4. Seeking Safety/Trauma-Informed Treatment
   Services must take into account an understanding of trauma and place priority on trauma survivors' safety, choice and control - www.seekingsafety.org.
5. Psycho-Education
   Psycho-educational groups are designed to educate patients about substance abuse and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to patients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

F. Medication Assisted Treatment

The DMC-ODS Pilot supports expanded access to Medication Assisted Services (MAT) and requires greater management of patient compliance with medication to support the goals of improved patient outcomes, a better patient experience, and reduced healthcare costs. Providers must demonstrate linkages to MAT services for patients through:

- Practices and processes to prescribe, monitor, adjust, and manage MAT for patients including methadone, buprenorphine, naloxone, disulfiram, injectable naltrexone and clinically necessary adjunctive services for patients with opioid and alcohol use disorders;
- Case management practices and processes to support regular communication, consultation, and coordination between SUD treatment staff and mental health professionals and physicians of patients that are prescribed medications.

As evidence of formal collaborative partnerships with primary care and mental health service providers, proposers must include copies of written, approved MOUs with providers for coordinated and integrated patient care.

G. Case Management Services

The DMC-ODS Pilot requires all counties to offer case management services to ensure that the "whole person" needs of SUD treatment patients are met. Case management services are considered effective and proactive when they directly link patients to needed services and supports through "warm handoffs" that ensure patients are connected and stay connected to mental health, primary care, and other needed services through closely coordinated referrals by SUD counselors. This includes proactive management of patient withdrawal and medication compliance working in partnership with a patient's primary care home while patients are in treatment, as well as regular check-ins after treatment discharge with primary care homes and mental health providers to support continued patient recovery and prevent relapse. It may also include interactions with the criminal and juvenile justice systems, school student success teams, or child welfare.

Proposers must integrate effective and proactive case management services into their treatment programs at all ASAM Levels of Care. Goals of case management services include:

- Addressing the comprehensive needs of SUD patients including medical, psychosocial, behavioral, and spiritual needs;
- Partnering with patients to problem-solve and explore treatment options;
- Improving coordination of care and communication among members of the care planning team;
- Promoting patient self-advocacy, self-care, and self-determination;
- Integrating peer support specialists within treatment planning to share their knowledge, advocate for and support patients;
- Proactively ensuring that transitions to other levels of care are effective, safe, timely and complete ("warm hand-offs");
- Improving patient safety and satisfaction;
- Helping patients reach their optimal level of health, well-being and recovery.

Case management includes services that assist a patient in accessing needed medical, educational, social, prevocational, rehabilitative, or other community services and focus on coordination of SUD care and integration around primary care and interaction with the criminal justice system if needed. Service components include all of the following:

1. Comprehensive assessment and periodic reassessment of individual needs for continuation of case management;
2. Transition to a higher or lower level of care;
3. Development and periodic revision of a patient plan that includes service activities;
4. Communication, coordination, referral and related activities;
5. Monitoring service delivery to ensure patient access to service and service delivery system;
6. Monitoring patient progress; and
7. Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

H. Recovery Services

Proposers must demonstrate capacity within their proposals to integrate recovery services into their treatment programs at all ASAM levels of care. Community-based recovery and wellness services may be provided face-to-face, by telephone or by telehealth, to patients that have been triggered, have relapsed, or as a preventative measure to prevent relapse. Recovery services must at a minimum include all of the following:

1. Individual and Group Outpatient Counseling to stabilize patients and reassess if further care is needed;
2. Recovery Monitoring: recovery coaching, monitoring via telephone and internet;
3. Substance Abuse Assistance: peer-to-peer services and relapse prevention;
4. Education and Job Skills: linkages to life skills, employment services, job training and education services;

5. Family Support: linkages to childcare, parent education, child development support services, and family/marriage education;
6. Support Groups: linkages to self-help and support, spiritual and faith-based support;
7. Ancillary Services: linkages to housing assistance, transportation, case management, and individual services coordination; and
8. Recovery Residences.

I. County of Responsibility (required information but no points awarded)

Under the DMC-ODS Pilot, counties are responsible for serving any patient that seeks SUD treatment services within their geographic boundaries. This includes providing Medication Assisted Treatment (MAT) services for patients. Proposers must demonstrate the capacity to meet the DMC-ODS Pilot requirement that patients seeking SUD treatment services in the City and County of San Francisco will be served regardless of their county of responsibility (residency) by:

1. Identifying the anticipated counties of responsibility for patients proposed to be served in San Francisco; and

2. Providing a written assurance that proposer will: 1) serve out-of-county patients in full compliance with the DMC-ODS Pilot County of responsibility requirement, including related requirements imposed on counties by the State at a future date; and 2) seek written agreements with counties of responsibility to serve out-of-county patients on or before June 1, 2017 if funded under this RFP. For more information, please see: www.dhcs.ca.gov/formsandpubs/.../MHSUDS_IN_16-023.pdf

J. Cultural and Linguistic Competency

All SUD outpatient treatment services must be offered consistent with the Culturally and Linguistically Appropriate Services (CLAS) Standards and related DPH Cultural and Linguistic Competency Policy. Availability of services in languages other than English is an Access Measure that will be reported under the DMC-ODS Pilot evaluation. The Department of Public Health will award a scoring preference to proposals where professionally certified/licensed provider staff are designated to meet patient primary language needs other than English.

K. Harm Reduction

All SUD treatment services are required to be offered consistent with the Harm Reduction Resolution of the Health Commission (September 2000) and new DPH Harm Reduction Policy requirements. Recently, the Department of Public Health enhanced the Health Commission's Policy with new requirements to demonstrate compliance with the intent of the policy. In addition to providing copies of a provider's harm reduction policy, all SUD treatment services are expected to integrate these new requirements within treatment services:

1. Post in common areas where they can be viewed by patients up-to-date referral information about Syringe Access & Disposal services and schedule;
2. Have an onsite overdose response policy;
3. Post in common areas where they can be viewed by patients up-to-date referral

information about naloxone access and DOPE Project schedule; and

4. Program staff participate in at least one training with the Harm Reduction Training Institute either at the program site or at a Training Institute site.

For more information about Harm Reduction, please visit www.sfdph.org.

L. Collaborative Partnerships/Integrated Services

A major goal of the DMC-ODS Pilot's goal is to improve SUD treatment coordination for patients, both within the SUD continuum of services and with primary care, mental health and recovery support services. The Department of Public Health strongly supports this goal through local integration initiatives such as the Behavioral Health Home (BHH) model. A preference will be given to proposals that support service integration for addiction, mental health and primary care services under a BHH or on-site multi-disciplinary team. For more information on BHHs and integrated care models, please visit: http://www.integration.samhsa.gov.

Another major focus of the DMC-ODS Pilot is strengthening partnerships with agency and community partners that can support patient recovery. This includes the criminal and juvenile justice systems, Drug Court, housing providers, vocational and rehabilitation providers, and others. Proposers must describe in their proposals community and agency partnerships in place to support patients proposed to be served in SUD treatment services.

M. Evaluation and Quality Management

The UCLA Integrated Substance Abuse Programs has been retained by the State to conduct an evaluation to measure and monitor outcomes from the DMC-ODS Pilot program. All DMC-ODS Pilot counties and their providers are required to participate in the UCLA evaluation. Consistent with the goals of the DMC-ODS pilot, the design of the evaluation will focus on four key areas: 1) increased access; 2) higher service quality; 3) more appropriate costs (e.g. reduced inpatient and ER use); and 4) improved integration and coordination of care with primary care, mental health and recovery support services. For more information about the scope of UCLA DMC-ODS Pilot evaluation, please see: http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf.

At a minimum, evaluation data will be collected on the following items:

1. Patient engagement and participation;
2. Patient access to treatment services within 72 hours;
3. Patient treatment progress and recovery;
4. Patient compliance with medications/MAT use;
5. Appropriate patient utilization of services/ASAM assessments (level of care placements);
6. Successful care transitions and discharges;
7. Collaborative treatment planning with managed care;
8. Case management/navigation support for patients;
9. Patient perceptions of service access/quality; and
10. Accuracy/quality of CalOMS Treatment, DATAR, and Avatar data.

At a minimum, data will be collected on the following QI benchmarks:

1. Timeliness of first initial patient contact to face-to-face appointment;

2. Timeliness of services for the first dose of Narcotic Treatment Program services;
3. Access to after-hours care;
4. Improved reliability and timeliness of data entry;
5. Reduction in avoidable patient hospitalizations;
6. Coordination with physical, mental health and recovery services;
7. Utilization management/appropriate level of care;
8. Patient experience; and
9. Services available in patient primary languages.

Proposers must demonstrate capacity to collect and submit this required evaluation and quality improvement data in a timely manner for the UCLA evaluation, as well as data for DPH contractor performance objectives. A scoring preference will be given to proposals that identify dedicated evaluation and quality improvement staff to support these important program improvement and planning activities.

N. Peer Support

While the role of a peer support specialists will varies based on the level of care and patient needs, peer support specialists engage in the following activities:

1. Provide Support and Advocacy
   Peer support specialists work with patients to connect them to resources in the community including how to independently identify needs and access resources. As integrated members of the treatment team, peer support specialists also advocate for their peers in treatment settings and within the community.

2. Role Model Recovery
   Peer support specialists have a wealth of experience navigating their own recovery journeys. By sharing their stories and modeling healthy, effective decision-making in peer relationships, they can inspire patients to do the same.

3. Facilitate Positive Change
   The spirit of recovery and resilience is grounded in hope and optimism. Peer support specialists work to motivate patients through positive means, highlighting strengths and resources. Peer support specialists can facilitate change through goal setting, education, and skills building.

Since peer support specialists freely identify as being in recovery, they actively work to reduce stigma and inspire others in their process of recovery. They strongly uphold the values of recovery and resiliency, and they serve as role models for wellness, responsibility, and empowerment. Throughout all interactions, peer support specialists communicate warmth, empathy, and a non-judgmental stance. They provide support and guidance without telling their peers what they should do.

This unique relationship is considered "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement on what is helpful." While precise job descriptions vary across agencies, peer support specialists focus heavily on the identification of strengths, skill building, effective symptom management, and goal setting among those with whom they work. In addition, they often provide outreach, advocacy, social and logistical support, and education.

Proposers must describe how peer support specialists will be integration within treatment planning teams and recovery support services including identifying the specific roles and responsibilities of peer support specialists.

O. Therapeutic Alliances with Patients

All SUD treatment level of care providers are expected to proactively engage patients in all aspects of their care from intake and treatment planning, treatment plan review, discharge and transitions across levels of care or into the community. Proposers should describe in their proposals client engagement strategies they will use to support therapeutic alliances with patients for improve patient outcomes, wellness and recovery.

P. Electronic Health Records and Data Collection Capacity

Under the DMC-ODS Pilot, counties and their treatment providers will be required to enter timely and accurate data to support the DMC-ODS Pilot evaluation and other quality improvement activities. The UCLA Integrated Substance Abuse Programs Center has identified multiple data sources to evaluate outcomes of the DMC-ODS Pilot across multiple electronic record and data systems. Additionally, DPH requires SUD providers to enter timely and accurate patient record data in Avatar, and in the future, providers will be required to utilize EPIC, the DPH electronic health record (EHR) under current development (for more information, please visit www.sfdph.org).

Proposers must demonstrate they have the organizational capacity to collect and report data to DPH within five (5) business days of a request and in compliance with all other State and DPH data system reporting requirements. This includes employing trained staff who are able and knowledgeable about collecting, analyzing and reporting data for the following systems:

1. DPH Avatar data system;
2. State Drug and Alcohol Treatment Access Report data system (DATAR);
3. State CalOMS Treatment data system; and
4. DPH EPIC and/or future DPH EHR.

Proposers must demonstrate that they have program capacity to support data collection and evaluation activities, including the necessary hardware, software, and information technology (IT) resources to support these activities. This includes, at a minimum, demonstrated organizational capacity to:

1. Provide data for the DMC-ODS Pilot evaluation;
2. Use or provide for interface with DHCS and DPH data collection systems such as Avatar, CalOMS Treatment and DATAR;
3. Use electronic health records to review patient information and enter screening, prevention, admission and treatment and progress information directly into an electronic record, as well as complete required surveys and assessments to meet all billing documentation, outcomes, quality improvement, and performance measurement and reporting requirements;

4. Use federal, state, and DPH ePrescribing functions and systems;
5. Identify and train staff required to provide registration and eligibility verification functions within the electronic recordkeeping system in order to meet all scheduling, registration and eligibility related billing, reporting, quality management, and program evaluation and monitoring requirements; and
6. Provide for other required data collection including patient satisfaction surveys, ASAM level of care assessments, as well as other data collection requirements not yet identified.

All proposers must demonstrate that they have sufficient capacity and resources including:

1. Hardware including a computer on each workstation or desk with sufficient processing power to support real time use of highly complex scheduling, electronic healthcare record and eligibility verification applications;
2. Software including current internet browser software, Microsoft Office applications to support practice management functions, and VPN or Token share of cost;
3. Connectivity including high speed internet and local area networking within facilities; and
4. Information Technology (IT) support services sufficient to the level of IT resources within programs and facilities including desk top support, computer break fix, networking support, and basic computer training.

Q. Patient Confidentiality Requirements

All federal, state and local patient confidentiality requirements must be adhered to by SUD treatment providers. Proposers must have policies, practices, and workforce training in place that are consistent with and in full compliance with confidentiality requirements. This includes ensuring patients have signed a consent for a 42 CFR part 2 compliant release of information to allow for the sharing of patient information for the purpose of multi-disciplinary treatment planning, treatment, medication management, mental health monitoring and management, medical monitoring and management, and transitions to other levels of care or treatment program discharge. Providers also should describe in their proposals how compliance with patient confidentiality requirements is monitored and specific provider strategies for obtaining consent in cases where a patient has refused or unable to provide consent (e.g. severity of functioning limits ability to comprehend consent).

R. Workforce Development and Support

The DMC-ODS Pilot establishes the framework for a series of fundamental changes in the SUD treatment service delivery system in California. SUD treatment providers will transition to a new set of business and clinical practices, new regulatory requirements with DMC certification, and new relationships within integrated service delivery models. Recognizing the need to train the addiction treatment workforce to support the adoption of new addiction treatment systemic reform under the DMC-ODS Pilot, the State has provided funding to the UCLA ISAP and by the California Institute of Behavioral Health Solutions (CIBHS) to provide technical assistance and training services to SUD treatment agencies in California. In addition, DPH support workforce training and technical assistance.

For more information about available training and technical assistance, please visit:

- For UCLA ISAP, please visit: www.uclaisap.org.
- For CIBHS: http://www.cibhs.org/dmc-ods-waiver-trainings.
- For DPH: www.sfdph.org.

Proposes must demonstrate capacity for having qualified professional staff to meet ASAM Level of Care and DMC if applicable) staff requirements[1] and a robust workforce training, technical assistance and support program that includes:

1. An organizational chart that shows proposed SUD outpatient treatment full-time equivalents (FTEs) by profession and where those FTEs report within the provider's organization;
2. A staffing plan for proposed SUD treatment services including proposed staff to patient ratios (staff patient caseloads), clinical supervisor to staff ratios, and peer workers (consumers with lived experience) to provide peer support to patients;
3. The provider's staff supervision model including the role of supervisors in staff coaching, patient care, and QI and service utilization activities;
4. An SUD treatment staff training and technical assistance plan for Fiscal Year 2016-17 and beyond that supports staff in meeting DMC-ODS Pilot and DPH requirements including what and how state supported training will be accessed;
5. Provider policies, procedures, and processes for ensuring that professional staff[2]: 1) are licensed, registered, certified, or recognized under California State scope of practice statutes[3]; 2) will provide services within their individual scope of practice; and 3) receive supervision required under their scope of practice laws.
6. Appropriate on-site orientation, support, and training for non-professionally licensed, such as peer support specialists, prior to and during performance of assigned duties, and strategies for supervision by professional staff; and
7. Assurances that registered and certified alcohol and other drug counselors adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

S. State Required Elements of Provider Selection

The Department of Health Care Services and DPH require counties to ensure that all SUD treatment providers meet a set of provider selection elements. Proposers must demonstrate that they meet these requirements by completing the following certification checklist and submitting under the proposal appendix.

[1] For any proposed positions that are vacant upon submission of a proposal for this RFP, a job description for and an assurance that the vacant position(s) will be filled within 90 days of receiving a contract award from DPH should be included with the proposal submission.

2 Professional staff includes Licensed Practitioners of the Healing Arts such as Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), licensed-eligible practitioners working under the supervision of licensed clinicians, and non-professionally licensed and certified staff such as peer support specialists.

[3] Copies of proposed staff's professional licenses should be included in the proposal appendix.

California Department of Health Care Services (DHCS) & San Francisco Department of Public Health (DPH) SUD Treatment Provider Required Elements Certification Checklist

The DMC-ODS Waiver and 42 CFR Section 438 require that counties have policies and procedures for provider selection. Proposers must certify that the following elements are incorporated into their policies and procedures by checking all of the boxes below.

- ☐ Proposers have a documented process for credentialing and re-credentialing of providers (i.e., individual practitioners);
- ☐ Proposer has a license and/or certification issued by DHCS that is in good standing;
- ☐ Proposer, prior to the furnishing of services under this RFP, has enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, has been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services under this pilot, has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and has complied with the ownership and control disclosure requirements of 42 CFR 455.104;
- ☐ Proposer is not under investigation for Medi-Cal fraud;
- ☐ Proposer has a Medical Director who, prior to the delivery of services under this RFP, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107;
- ☐ Proposer accepts DPH right to revoke delegation of county responsibilities to a proposer or impose other sanctions if a contractor's performance is inadequate;
- ☐ Proposer meets state standards for timely access to care and services, taking into account the urgency of the need for services;
- ☐ Proposer offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-services, if the provider serves only Medicaid enrollees;
- ☐ Proposer agrees that any decision issued by DHCS with regard to a bidder's appeal to DHCS following the DPH contract protest procedure shall be final and not appealable.

The agency named below acknowledges it has read and understands all of the requirements above and certifies that the agency and its agents, employees and contractors will comply with each of the requirements.

_____ _____

Agency Name Date

_____

Printed Name of Agency Authorized Representative

_____

Signature of Agency Authorized Representative

T. Ancillary Treatment and Outreach Services

The Department of Public Health invites proposals to provide ancillary treatment and outreach services from qualified proposers. Examples of ancillary services include jail dosing at methadone clinics or stimulant user outreach. These services must be provided as part of an ASAM level of care treatment services proposal.

Proposers of ancillary treatment and outreach services must submit a completed Proposal Submission Template in addition to the "Ancillary Services Addendum.

U. Recovery Track Residence Program Services

The Department of Public Health invites proposals from qualified proposers to provide Recovery Track Residence Program services for patients, aged 18 and over, who have transitioned from Residential Services, but who are unable to return home or be served successfully in Level 1 Outpatient Services or Level 2.1 Intensive Outpatient Services settings. The goal of Recovery Track Residences is to prevent relapse and to eventually transition patients back home or to stable housing in the community as treatment progress allows.

Proposers for Recovery Track Residence Program services must otherwise meet all requirements under this RFP. In addition, proposers for this service must submit proposals using the "Recovery Track Resident Program Proposal Template" (see #13 below). This template serves as a substitute for the "Proposal Submission Template" found on page 59 of the RFP for this service only.

Proposers of Recovery Track Residence Program services are eligible for all applicable priority system needs preference points identified within the RFP upon completion of the required documentation to receive these points found under the "Proposal Content" subsection of Section IV. PROPOSAL SUBMISSION REQUIREMENTS.

IV. PROPOSAL SUBMISSION REQUIREMENTS

Failure to provide any of the following information or forms may result in a proposal being disqualified.

A. NON-BINDING LETTER OF INTENT

Prospective proposers are required to submit a Letter of Intent (LOI) on their agency's letterhead stationery to the DPH Office of Contracts Management and Compliance by **12:00 p.m.**, on **November 1, 2016**, to indicate their interest in submitting a proposal under this RFP. Such a letter of intent is non-binding and will not prevent acceptance of an agency's proposal and neither commits and agency to submitting a proposal. See Appendix A1-b.

B. TIME AND PLACE OF SUBMISSION

Proposals must be received by **12:00 p.m.** on **NOVEMBER 22, 2016**. Postmarks will not be considered in judging the timeliness of submissions. Proposals may be delivered in person and left with SFDPH Office of Contracts Management and Compliance ("Contracts Office"), or mailed to:

Mahlet Girma, Contract Analyst
San Francisco Department of Public Health
Office of Contracts Management and Compliance
1380 Howard St., 4th Floor, # 421
San Francisco, CA 94103

Proposers shall submit **one** (1) original and **seven** (7) copies of the proposal, and separately bound, of required Contracts Monitoring Division (CMD) Forms in a sealed envelope clearly marked "**RFP 26-2016 – SUBSTANCE USE DISORDER TREATMENT SERVICES**" to the above location. The original copy of the proposal must be clearly marked as "ORIGINAL" and also emailed to Mahlet.Girma@sfdph.org. Copies of the proposals must be submitted to the office. Applications that are submitted by facsimile, telephone or electronic mail (other than the original) will not be accepted. Late submissions will not be considered.

**** Proposals submitted by facsimile, telephone or electronic mail will not be accepted.**

C. LATE SUBMISSIONS

Submissions are due at Noon on the due date. Postmarks will not be considered in judging the timeliness of submissions. Submissions received after the noon deadline but before 12:01 P.M. the following day will be accepted due to extenuating circumstances at the sole discretion of the Director of Health. Organizations/agencies/firms/consultants that submit submissions within this grace period must provide a letter explaining the extenuating circumstances by 12:00 noon of the second day. Decisions of the Director of Health to accept or reject the submission during the grace period will not be appealable. Following the 24-hour grace period no late submissions will be accepted for any reason and there will be no appeal.

All submissions shall be firm offers and may not be withdrawn for a period of ninety (90) days following last day of acceptance.

D. FORMAT

All submission must be typewritten on standard recycled paper with an easy to read 12-point font such as Arial or Times New Roman and one-inch margins. Please print on double-sided pages to the maximum extent possible (note that one, double-sided page is the equivalent of two proposal pages when meeting program proposal page limits). Please bind your proposal with a binder clip or single staple. Please do not submit your proposal in a three-ring binder, do no bind your proposal with a spiral binding, glued binding, or anything similar that prevents easy duplication. You may use tabs or other separators within the proposal. Please number pages and include a Table of Contents. *(Applicants must follow the format and submission requirements with the required page limit – points will be subtracted if the submission guideline is not followed).*

For each level of care for which a proposal is being submitted for either the Adult/Older Adult Systems of Care or the Children, Youth and Family System of Care, please organize the Letter of Introduction and Proposal Content as follows: 1) Table of Contents; 2) Letter of Introduction; 3) Proposal Content (Proposal Submission Template/Priority System Needs Template); 4) Budget Forms, Budget Narrative and Fee Proposal; and 5) Appendices.

E. REQUIRED FORMS (Appendix A1-a)

1. RFP Form #1 - Solicitation and Offer
2. RFP Form # 2 - Contractual Record Form
3. Contract Monitoring Division - CMD Forms:
   All proposals submitted must include the following:

a) Form 2A, CMD Contract Participation Form;
b) Form 3, CMD Non Discrimination Affidavit;
c) Form 4, CMD Joint Venture Form (if applicable); and
d) Form 5, CMD Employment Form.

If these forms are not returned with the proposal, the proposal may be determined to be non-responsive and may be rejected. The CMD forms should be placed in a separate, sealed envelope labeled CMD Forms. If you have any questions concerning the CMD Forms, you may call Contract Monitoring Division (415) 581-2310.

F. MINIMUM QUALIFICATIONS NARRATIVE

The Minimum Qualifications Narrative may be no more than five (5) pages total, excluding forms and other required attachments. The Minimum Qualifications Requirements should be clearly labeled and bound separately from program proposals. See Section II, page 13.

Using a half page or less for each item, please describe how your agency meets the following requirements as detailed in Section II, Minimum Agency Requirements:

1. Drug Medi-Cal Certification
2. Harm Reduction Requirements
3. Cultural & Linguistic Competency Requirements
4. Financial Management Capacity & Fiscal Integrity Requirements
5. Prior Performance Requirements
6. Priority Service Populations Requirements
7. Priority Geographic Service Areas Requirements
8. Americans with Disabilities Act and Access Requirements
9. Approved City Vendor

10. Compliance with City and County Policies, Laws, Rules and Regulations

Only one copy of the above is required for each agency regardless of the number of proposals submitted. Any proposal that does not demonstrate that the proposer meets these minimum requirements by the deadline for submittal of proposals will be considered non-responsive and will not be eligible for project proposal review or for award of a contract.

G. LETTER OF INTRODUCTION (no more than one (1) page)
A one-page letter signed by the person authorized to obligate the proposing agency stating that the proposing agency is willing and able to perform the commitments contained in the proposal.

H. PROPOSAL CONTENT
Proposers must use the "Proposal Submission Template" in preparing and submitting their proposals (page 60) for all proposals except for Recovery Track Residence Program services proposals which must use the "Recovery Track Resident Program Proposal Template". Information submitted for template sections that exceed the maximum page limits noted for each section of the template will not be considered by the review panels. Any proposal that does not include all of the information requested in the "Proposal Submission Template", or the "Recovery Track Residence Program Submission Template" if a proposal is being submitted for recovery residence services, will be considered non-responsive and will not be eligible for proposal project review or for award of a contract.

Please note that for Level 1/Outpatient Services and Level 2.1/Intensive Outpatient Services, additional information has been requested under the "Treatment Program Narrative" section of the "Proposal Submission Template" for providers proposing to serve adolescents, aged 10-18. In addition, for Level 3.1, 3.3, and 3.5/Residential Services, additional information has been requested under the "Treatment Program Narrative" section of the "Proposal Submission Template" for providers proposing to serve pregnant and parenting women with children. Any proposal that does not include all of the information requested for the adolescent and pregnant/parenting women with children populations in the "Proposal Submission Template", or for serving pregnant/parenting women with children under the "Recovery Track Residence Program Submission Template, will be considered non-responsive and will not be eligible for project proposal review or for award of a contract. The "Recovery Track Resident Program Submission Template" is included in the following pages.

For each SUD treatment level of care proposed to be provided, a complete "Proposal Submission Template" must be completed and submitted with the proposal.

For each System of Care for which SUD levels of care are proposed to be served (CYFOSC and A/OA SOC), a complete "Proposal Submission Template" must be completed and submitted with the proposal.

The "Proposal Submission Template for all services" and "Proposal Submission Template for Recovery Track Residence" follows on the next page.

Proposal Submission Template for All Services (except Recovery Track Residence)

1. Priority Service Populations Description (Up to 20 Points) – **3** Pages Maximum			
A. Please check at least two (2) Priority Service Populations that are proposed to be served from the list to the right. (10 points)	☐ Persons Who Are Black/African American ☐ Persons Who Are Homeless ☐ Persons Who Are Incarcerated or Involved with the Criminal/Juvenile Justice Systems/ Drug Court ☐ Adolescents, Aged 10-18	☐ Persons Whose Primary Substance Is Alcohol ☐ Transition Age Youth, 18-24 ☐ Persons Who Are Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Ally or Two-Spirit ☐ Pregnant or Parenting Women w/Children	
B. Please describe at least five (5) years of specific organizational and staff knowledge, experience, and professional qualifications successfully engaging, treating, and transitioning Priority Service Populations proposed to be served. If adolescents are the service population, please describe staff knowledge of adolescent developmental stages and experience engaging adolescents in treatment. If pregnant women and/or parenting women with dependent children are the service population, please describe organizational capacity and staff knowledge, experience and professional qualifications to meet DHCS FY 2016-17 Perinatal Service Network Guidelines and meet the child development needs of dependent children. (10 points)			
2. Priority Geographic Service Areas Description (Up to 20 Points) – **2** Pages Maximum			
A. Please check at least one (1) of the Priority Geographic Services Areas proposed to be served from the list to the right. (10 points)	☐ Hayes Valley/Tenderloin/North of Market/94102 ☐ South of Market/94103 ☐ Bernal Heights/Inner Mission/94110	☐ Bayview-Hunter's Point/94124 ☐ Southeast/Visitacion Valley/Sunnydale/94134 ☐ Other: _____	
B. Please describe at least five (5) years of specific organizational and staff knowledge, experience, and professional qualifications successfully engaging, treating and transitioning Priority Service Populations in Proposed Geographic Services Areas. (6 points)			
C. Please list formal partnerships with other systems and service providers including housing, primary care, mental health, and the criminal and juvenile justice systems/Drug Court in each proposed Priority Geographic Service Area that will support patient recovery and include copies of written, signed MOUs that identifies specific roles and responsibilities of each partner in the Appendix. (4 points)			

3. Treatment Program Narrative (Up to 70 Base Score Points Total) – **14** Pages Maximum

A. Please check the ASAM Level of Care proposed to be provided and whether the program is Drug Medi-Cal certified.

- ☐ ASAM 1/Outpatient Services
  - ☐ Adult/Older Adult or ☐ Adolescent
- ☐ ASAM 1/Opioid Treatment Program
- ☐ ASAM 2.1/Intensive Outpatient Services:
  - ☐ Adult/Older Adult or ☐ Adolescent
- ☐ ASAM 3.1/Residential
- ☐ ASAM 3.1/Residential: Perinatal
- ☐ ASAM 3.3/Residential
- ☐ ASAM 3.3/Residential: Perinatal
- ☐ ASAM 3.5/Residential
- ☐ ASAM 3.5/Residential: Perinatal

Drug Medi-Cal Certified Program? ☐Yes ☐ No

B. Treatment Program (20 points)

Describe the proposed treatment program approach and strategies and resources to meet The ASAM Criteria and requirements for the Level of Care identified above. Be sure to discuss each of the following level of care specific program components: a) required services (4 points); b) available supports (4 points); c) available therapies (4 points); d) admission/treatment plan review process (4 points); and e) co-occurring mental disorder enhancements (4 points). For Residential Services, include a description of onsite Incidental Medical Services programs.

C. Patient Engagement & Peer Support (Up to 10 points)

1. Describe patient treatment engagement strategies and the rationale why these strategies will be successful for the proposed service population. (5 points)
2. Describe how peer support specialists will be integrated into patient engagement, treatment planning, treatment, and recovery. (5 points)

D. Medication Assisted Treatment (Up to 10 points)

Address all of the following:

1. Describe Medication Assisted Treatment services that are available for patients including, but not limited to, staffing and program capacity to prescribe, monitor, adjust, and manage MAT including methadone, buprenorphine, naloxone, disulfiram, injectable naltrexone and provide clinically necessary adjunctive services for patients with opioid and alcohol use disorders (4 points);
2. Describe strategies and the process for regular communication, consultation, and coordination between SUD treatment staff and patient physicians and mental health providers for patients that are prescribed medications (2 points);
3. Provide evidence of the provider's success in achieving high levels of patient compliance with medication while in treatment including identifying patient medication management and support engagement strategies (4 points); and
4. List and provide copies in the proposal appendix of authorization agreements with other counties for MAT services to out-of-county patients (required information but no points awarded).

3. Treatment Program Narrative *Continued* (Up to 70 Points) – **14** Pages Maximum	
E. Withdrawal Management (Up to 10 points) 1) Please check the ASAM Level of Withdrawal Management (WM) that is proposed to be provided.	___ Level 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring ___ Level 2-WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring ___ Level 3.2-WM: Clinically Managed Residential Withdrawal Management
2) Describe how the following ASAM WM required staffing resources and services will be provided to patients in need of withdrawal/ detoxification services: a. WM Supports (2 points); b. WM Staffing (2 points); c. WM Therapies (2 points); and d. WM Assessment/treatment plan review (2 points) e. WM Length of Service and Continued Service and Discharge Criteria (2 points)	
F. Case Management (Up to 10 points) Describe how the following case management services will be integrated into the treatment planning, treatment, transitions among levels of care, and discharge practices and processes: 1) Transitions to a higher or lower levels of care (2 points); 2) Communication, coordination, referral and related activities (2 points); 3) Monitoring service delivery to ensure patients access needed services and service delivery systems (2 points); 4) Monitoring patient progress including medication compliance in partnership with a patient's medical home) (2 points); and 5) Patient advocacy, linkages to physical and mental health care, transportation, retention in primary care services, and other supports (2 points).	

3. Treatment Program Narrative *Continued* (Up to 70 Points) – **14** Pages Maximum

G. Recovery Services & Supports (Up to 10 Points)

Describe how the following recovery services and support will be integrated into the treatment planning, treatment, transitions among levels of care and discharge practices and processes:

1) Individual and Group Outpatient Counseling to stabilize clients and reassess if further care is needed;
2) Recovery Monitoring: recovery coaching, monitoring via telephone or internet;
3) Substance Abuse Assistance: peer-to-peer services and relapse prevention;
4) Education and Job Skills: linkages to life skills, employment services, job training and education services;
5) Family Support: linkages to childcare, parent education, child development support services, family/marriage education;
6) Support Groups: linkages to self-help and support, spiritual and faith-based support;
7) Ancillary Services: linkages to housing assistance, transportation, case management, individual services coordination;
8) Recovery Residence: access to recovery services and supports necessary to prevent relapse delivered in transitional community housing.

Treatment Program Narrative Additional Information for Proposals Serving Adolescents, Aged 10-18 – 2 Pages Maximum

Adolescent-Specific Considerations

For Outpatient Services or Intensive Outpatient Services proposals that serve adolescent describe adolescent-specific considerations that have been integrated into the treatment program using The ASAM Criteria. Please see below for Level of Care considerations.

Check one:

□ For Outpatient Services, describe: a) staff knowledgeable about adolescent development and experience in working with and engaging adolescents; and b) ongoing services to support therapeutic gains made by adolescents including strategies to prevent relapse and strengthen protective factors such as parental supervision, school performance, and positive peer relationships.

□ For Intensive Outpatient Services, describe: a) staff knowledge about adolescent development and experience in working with and engaging adolescents; b) assessment and treatment staff's experience in recognizing adolescent needs for specialty evaluation and treatment for intoxication or withdrawal and ability to arrange for these evaluation and treatment services in a timely manner; and c) strategies for engaging parents, caregivers or other significant other important resources to obtain information for patient assessment and treatment planning.

Treatment Program Narrative Additional Information for Proposals Serving Pregnant and Women with Dependent Children – **4** Pages Maximum

Pregnant Women and Women with Dependent Children Residential Treatment Requirements

For all levels of care, including Level 3/Residential Services, proposing to serve pregnant women and women with dependent children, special components must be integrated in treatment programs. Please describe how all of the following have been integrated into the treatment program:

1. Compliance with the state Fiscal Year 2016-17 Perinatal Services Network Guidelines
2. Primary medical care for women, including referral for prenatal care and child care while women are receiving such services;
3. Primary pediatric care, including immunization for children;
4. Gender specific substance use treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care for women receiving these services;
5. Therapeutic interventions for children in custody of women in treatment which address at a minimum their developmental needs, their issues of sexual and physical abuse, and neglect;
6. Sufficient case management and transportation to ensure that women and their children have access to services;
7. Assessments of child-parent relationship and needs of the child including facilitating access to age-appropriate treatment for the child;
8. Trained staff in child development and positive parenting, trauma-informed care, and gender-specific treatment and staff skills required to establish and maintain recovery while parenting;
9. Trained staff in couples and family therapy to support patients in their interaction with the other parent of the child and/or with their current partner including caregivers and any supportive family members;
10. Connections with supportive resources early in treatment to support patient recovery and transitions to other levels of care;
11. Engagement of patient family members including significant others; and
12. Collaborative partnerships with family and child serving agencies to put into place supports and services that support patient transitions and recovery, including Medi-Cal, TANF, vocational rehabilitation, and housing.

4. Evidence-Based Practices (up to 10 points) – **3** Pages Maximum	
A. Please identify at least two (2) evidenced-based practices (EBPs) that will be offered in the proposed treatment program.	☐ Cognitive Behavioral Therapy ☐ Motivational Interviewing ☐ Psycho-Education ☐ Relapse Prevention ☐ Seeking Safety/Trauma Informed Treatment

B. Describe how EBPs will be integrated within the proposed treatment program including all of the following:

1) Describe the rationale for how the selected EBPs will support client recovery for the proposed service populations (2 points);
2) Identify staff that have been certified and trained to provide each of the EBPs (2 points);
3) Identify the process that the provider will use to ensure that each EBP is being offered to fidelity including available staff booster training, available coaching, support during staff supervision, and EBP developer support including any cultural adaptations made to EBPs (2 points);
4) Describe how the use of EBPs will be documented (e.g. progress notes) in a manner that is compliant for the purpose of external program reviews and audits (2 points); and
5) Describe provider evaluation capacity to collect and report outcome data for patients receiving EBPs including client satisfaction with proposed EBPs (2 points).

If EBPs will be offered that are not listed under 4 A, please list those here: _____
_____

5. Policies & Regulations (up to 10 points) – Up to **3** Pages Maximum

All SUD treatment providers must comply with all federal, state, and City and County of San Francisco policies, rules and regulations that govern SUD treatment services, funding, and City and County of San Francisco contractors. An assurance must be included in the proposal that providers will comply. In addition, proposals must address the following policies, rules, and funding reimbursement areas:

A. Americans with Disabilities Act (2 points)
Describe provider policies, practices, procedures, and staff training to fully comply with the American with Disabilities Act requirements, including a description of polices, practices and procedures that both protect the patient ADA right to have companion animals within treatment settings and ensure the safety of all SUD treatment patients.

B. Cultural and Linguistic Competency (2 points)
Describe how provider cultural and linguistic competency policies, practices, procedures, and staff training fully comply with the DPH Cultural and Linguistically Appropriate Services Policy including a discussion about resources available to meet patient primary language needs.

5. Policies & Regulations *continued* (Up to 10 points) – Up to **3** Pages Maximum

C. Harm Reduction (4 points)
Describe how provider policies, practices, procedures, and staff training fully comply with the Health Commission Harm Reduction Policy and recent DPH policy enhancements described in this RFP.

D. Patient Confidentiality (2 points)
Describe how provider policies, practices, procedures, and staff training comply with all patient confidentiality requirements including HIPAA requirements for mental health and medical/physical health treatment. Include a description of strategies to obtain patient consent for information sharing for multi-disciplinary treatment planning, case management, transfer among levels of care and discharge planning.

E. County of Responsibility (required information but no points awarded)
List anticipated counties of responsibility for the proposed service populations and provide a written assurance that proposer will: 1) serve out-of-county patients in full compliance with the DMC-ODS Pilot county of responsibility requirement, including related requirements imposed on counties by the State at a future date; and 2) seek written agreements with counties of responsibility to serve out-of-county patients on or before June 1, 2017.

6. Electronic Health Records & Data Systems (Up to 10 points) – **3** Pages Maximum

A. Describe all of the following:

1) How the provider's protocols and strategies will support the timely and accurate entry and transmission of data for the State CalOMS Treatment data system, the State Drug and Alcohol Treatment Access Report data system, and the DPH Avatar data system (4 points);
2) How adequate staffing and resources will be available to support EHR, evaluation, and data system reporting requirements described in this RFP, including the process for monitoring and managing data entry and available training for staff on timely, accurate and compliant data entry and reporting (4 points);
3) How provider data collection systems or software will allow for timely submission/transmission (within 24 hours) of required DMC-ODS Pilot and DPH data and describe their compatibility with DPH data collection systems (2 points); and
4) How data entry and transmission policies, protocols and procedures fully comply with patient confidentiality requirements (required information, but no points awarded); and

B. Provide an assurance that the provider will meet future DPH electronic health record requirements (e.g. EPIC) and QI data collection and transmission requirements and will submit all data requested by DPH within 24 hours (assurance required but no points awarded).

7. Evaluation & Quality Improvement (Up to 10 points) – **3** Pages Maximum

Provide the following information:

A. Evaluation & Quality Improvement

1) Describe and provide a flow chart (the flow chart does not count toward the maximum page limit) showing the provider's process for collecting, analyzing and integrating outcomes/evaluation and quality improvement data into treatment program planning, development, and implementation activities with the goal of improving patient experience (4 points);

2) Describe how the provider's evaluation and quality improvement protocol and policies are consistent with the DMC-ODS Pilot evaluation and quality improvement requirements and include a copy of the evaluation and quality improvement policy in the proposal appendix (4 points); and

3) Provide a Logic Model (the Logic Model does not count toward the maximum page limit) showing provider capacity, resources and key strategies to meet at a minimum the following DMC-ODS Pilot program and patient outcomes (2 points):

   a) High patient engagement and participation;
   b) Patient access to treatment services within 72 hours;
   c) Patient treatment progress and recovery;
   d) High patient compliance with medications/MAT use;
   e) Appropriate patient utilization of services/ASAM assessments (level of care placements);
   f) Successful care transitions and discharges;
   g) Collaborative treatment planning with mental health and primary care;
   h) Case management/navigation support for patients;
   i) High patient perceptions of service access/quality; and
   j) High accuracy/quality of client and program data (less than 5% error rate).

B. Staffing and Resources

1) Identify an evaluation and QI point of staff contact OR identify a dedicated evaluation and QI staff person/subcontractor (see scoring preference) that will be responsible for meeting all evaluation requirements (required information but no points awarded); and

2) Provide a certification that all staff will be trained on DMC-ODS Plot and DPH evaluation requirements and the provider will submit all required evaluation and QI data to DPH in a timely manner (required certification but no points awarded).

8. Workforce Development & Staffing (Up to 20 points) – **4** Pages Maximum

A. In addition to providing a one (1) page organizational chart that shows proposed SUD outpatient treatment full-time equivalents (FTEs) by profession and where those FTEs report within the provider's organization (the organizational chart does not count toward maximum page limit), address the following

1) Adequate number of qualified and experienced staff to serve proposed service populations included a staffing plan that includes proposed staff to patient ratios (staff patient caseloads), proposed clinical supervisor to staff ratios, and proposed number of peer support specialists (consumers with lived experience) to provide support to patients (10 points);
2) A staff supervision model that support the role of supervisors in staff coaching, patient care, and QI and service utilization activities (2 points);
3) An SUD treatment staff training plan for Fiscal Year 2016-17 that supports staff in meeting DMC-ODS Pilot and DPH requirements including how and which state supported training will be accessed (2 points); and
4) A description of the provider's process, policies and procedures for meeting all of the following professional licensure and workforce requirements (6 points):

    a. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians;
    b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff;
    c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring; and
    d. Registered and certified alcohol and other drug counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

B. An assurance that any vacant positions will be filled within 90 days of receiving a contract award to provide SUD treatment services (required information but no points awarded); and

C. List of professional licensed and credentialed staff and include in the proposal appendix copies of all professional licenses for staff (required information but no points awarded).

9. Ancillary Treatment & Outreach Services Addendum - (Up to 5 Points) - **5** Pages Maximum

A. For SUD treatment proposals that propose to provide ancillary SUD treatment and outreach services not described in this RFP as part of the proposed ASAM level of care treatment program, please identify and describe all of the following:

1. Proposed ancillary service(s) to be provided;
2. At least two priority service populations that will receive the ancillary service(s) and the proposed annual unduplicated service count;
3. The proposed service location(s) where the proposed ancillary service(s) will be provided;
4. Organizational experience and capacity to offer the proposed ancillary services including staff capacity, knowledge, and experience providing the proposed ancillary service(s) to the proposed service populations;
5. How the ASAM Criteria will be integrated within the assessment/treatment plan review process for patient need for the proposed ancillary service(s);
6. Coordination of the proposed ancillary service(s) with the proposed ASAM level of care treatment services and other levels of care as patient needs require;
7. Patient engagement strategies;
8. Linkages to medical homes, mental health, recovery and support services through closely coordinated case management as the patient needs require;
9. Formal partnerships with other systems and service providers in offering the proposed ancillary service(s);
10. Patient outcomes for proposed ancillary service(s).

B. Submit total annual cost and budget justification of the proposed ancillary service(s) including identification of leveraged funding or resources to support and sustain the proposed ancillary service(s). (Required information but no points awarded).

Priority System Needs Preference Points Proposal

Proposers must complete the following "Priority System Needs Template" to be considered for up to seventy (70) preference points. In completing the "Past Performance Chart" portion of the "Priority System Needs Template" on the next page, proposers must include the following along with their completed template:

- DPH contracted providers should include in the proposal appendix copies of FY 2014-15 and FY 2015-16 contractor monitoring reports from the DPH Business Office of Compliance and Contracts; note: if FY 2015-16 reports are not available as of the submission deadline, submit the FY 2013-14 report with the FY 2014-15 report and indicate that the FY 2015-16 is not yet available;
- Providers that did not contract with DPH in FY 2014-15 and/or FY 2015-16 to provide an SUD treatment service for which a proposal is being submitted, please include in the proposal appendix a copy of contractor/vendor monitoring reports from a California county in which the treatment service was provided in FY 2014-15 and FY 2015-16, including contact information for contract monitor(s) including name, title, email address and phone number to allow DPH to verify performance.

Priority System Needs Template

Treatment Component (Up to 50 Preference Points)	**Provider Assurances and Response** (complete only for Treatment Components for which a scoring preference is being requested)
Cultural and Linguistic Competency (10 points) For each primary language other than English, please identify the number of patients expected to be served annually by their primary language and the number of full-time equivalent (FTE) and names of addiction counselors who are fluent in the primary language and that will serve patients.	___ (#) patients in _____ (e.g. Spanish, Cantonese) ___ FTEs fluent in primary language noted: ____ FTEs as follows: _____ (addiction counselor name) _____ (addiction counselor name)
Evaluation & QI Support (10 points) Please indicate the number of FTEs and staff names dedicated to evaluation and quality improvement activities and/or the name of and # of committed hours by the subcontractor that will manage these activities. Please include a copy of executed contracts in the proposal appendix for the subcontractor.	___ FTEs (must be 0.5 FTE or greater annually to receive preference) Evaluation & QI Staff Name: _____ Support to be provided by: _____ (subcontractor name) ___ hours committed (must be 960 hours/annually or greater to receive preference) Contract included in proposal appendix?: ___Yes ___ No
Integrated Treatment (10 points) Please indicate the integrated treatment model or approach that will be used to deliver integrated treatment services to SUD patients and which patient services will be available on-site.	Check one (3 points): ___ Behavioral Health Home Model **OR** ___ On-Site Multi-Disciplinary Team (Addiction, Mental Health and Medical Services) Patient services to be integrated on-site (check all that apply): ___ Mental Health Treatment (1 point) ___ Medical Care (1 point)

Treatment Component *Continued*	**Provider Assurances and Response** (complete only for Treatment Components for which a scoring preference is being requested)
Level 3.3/Residential Services On-Site Medical Monitoring (10 points) Please indicate the number of qualified FTEs available to provide medical monitoring for patients to assess and treat co-occurring biomedical disorders and to monitor the administration of medications in accordance with a physician's prescription including nursing care and sufficient observation to meet patient needs.	___ FTEs to provide on-site medical monitoring services as follows: _____ (qualified medical staff name) _____ (qualified medical staff name) _____ (qualified medical staff name)
Level 3.1, 3.3, 3.5/Residential Services Continuity of Care (10 Points) Please indicate capacity to provide recovery living environments with ongoing Outpatient or Intensive Outpatient Services beyond the state imposed reimbursement limits for Residential Services.	___ Number of unreimbursed days per patient to be provided ___ Estimated number of patients to be provided recovery living environment after 90 days

Past Performance Chart

Past Performance Data (Up to 10 Preference Points – 2 point per data point met or exceeded)	**FY 2014-15**	**FY 2015-16**
1) Percentage of all SUD Services patients who were readmitted to psychiatric inpatient hospital services within 30 days or less after discharge from the hospital. Benchmark: No more than 15%.	___%	___%
2) Percentage of all SUD patients discharged who successfully completed treatment or left treatment before completion with satisfactory progress. Benchmark: 60% or more.	___%	___%
3) Percentage of all SUD patients in treatment for 60 or more days who maintained abstinence or showed a reduction in alcohol and other drug use. Benchmark: 60% or more.	___%	___%
4) Percentage of SUD patients in treatment who expressed satisfaction with their patient experience. Benchmark: 80% or higher.	___%	___%
5) Percentage of patients admitted to methadone maintenance treatment program who stayed in treatment 12 months or more. Benchmark: 70% or more.	___%	___%

Proposal Submission Template for Recovery Track Housing Program Submission Template

1. Recovery Track Residence Program Priority Service Populations Description (Up to 20 Points) 3 Pages Maximum		
A. Please check at least two (2) Priority Service Populations that are proposed to be served from the list to the right. (10 points)	☐ Persons Who Are Black/African American ☐ Persons Who Are Homeless ☐ Persons Who Are Incarcerated or Involved with the Criminal/ Juvenile Justice Systems/ Drug Court	☐ Persons Whose Primary Substance Is Alcohol ☐ Transition Age Youth, 18-24 ☐ Persons Who Are Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Ally or Two-Spirit ☐ Pregnant or Parenting Women w/Children
B. Please describe at least five (5) years of specific organizational and staff knowledge, experience, and professional qualifications successfully engaging, treating, and transitioning Priority Service Populations proposed to be served. If pregnant women and/or parenting women with dependent children are the service population, please describe organizational capacity and staff knowledge, experience and professional qualifications to meet DHCS FY 2016-17 Perinatal Service Network Guidelines and meet the child development needs of dependent children. (10 points)		

2. Recovery Track Residence Program Priority Geographic Service Areas Description (Up to 20 Points) 2 Pages Maximum		
A. Please check at least one (1) of the Priority Geographic Services Areas proposed to be served from the list to the right. (10 points)	☐ Hayes Valley/Tenderloin/ North of Market/94102 ☐ South of Market/94103 ☐ Bernal Heights/Inner Mission/94110	☐ Bayview-Hunter's Point/94124 ☐ Southeast/Visitacion Valley/ Sunnydale/94134 ☐ Other: _____
B. Please describe at least five (5) years of specific organizational and staff knowledge, experience, and professional qualifications successfully engaging, treating and transitioning Priority Service Populations in Proposed Geographic Services Areas. (6 points)		
C. Please list formal partnerships with other systems and service providers including housing, primary care, mental health, and the criminal and juvenile justice systems/Drug Court in each proposed Priority Geographic Service Area that will support patient recovery and include copies of written, signed MOUs that identify specific roles and responsibilities of each partner in the Appendix. (4 points)		

3. Recovery Track Residence Program Narrative (Up to 70 Points)
14 Pages Maximum

A. Recovery and Support Services (25 points)

Describe how each of the following recovery services and supports will be integrated within the Recovery Track Residence Program:

1. Recovery Monitoring that includes recovery coaching (5 points);
2. Education and Job Skills that includes life skills, employment services, job training and education services (5 points);
3. Family Support which includes linkages to childcare, parent education, child development support services, family/marriage education (5 points);
4. Support Groups with linkages to self-help and support, spiritual and faith-based support (5 points); and
5. Ancillary Services such as linkages to housing assistance, transportation, case management, individual services coordination (5 points).

B. Patient Engagement and Peer Support (Up to 10 points)

1. Describe patient engagement strategies and the rationale why these strategies will be successful for the proposed service population(s). (5 points)
2. Describe how peer support specialists will be integrated into proposed recovery program including peer-to-peer services and relapse prevention (5 points)

C. Treatment Service Access (Up to 25 points)

escribe how the each of the following treatment service components will be provided either on-site or through closely coordinated community referrals:

1. Assessment and treatment planning consistent with The ASAM Criteria (5 points);
2. ASAM Level 1 Outpatient Services and ASAM Level 2.1 Intensive Outpatient Services Individual and Group Outpatient Counseling to stabilize patients and reassess patient if further care is needed (5 points);
3. Linkage to other ASAM level of care treatment services such as Residential Services as needed (5 points);
4. Linkage to Medication Assisted Treatment as needed (5 points);
5. Linkage to Withdrawal Management services as needed (5 points).

D. Case Management (Up to 10 points)

Describe how the following case management services will be integrated into the proposed recovery resident program:

1. Transitions to a higher or lower levels of care (2 points);
2. Communication, coordination, referral and related activities (2 points);
3. Monitoring service delivery to ensure patients access needed services and service delivery systems (2 points);
4. Monitoring patient progress including medication compliance in partnership with a patient's medical home) (2 points); and
5. Patient advocacy, linkages to physical and mental health care, transportation, retention in primary care services, and other supports (2 points).

Treatment Program Narrative Additional Information for Recovery Track Residence Proposals Serving Pregnant and Women with Dependent Children
3 Pages Maximum (information required but no points awarded)

For all levels of care proposing to serve pregnant women and women with dependent children, special components must be integrated in treatment programs. Please describe how all of the following have been integrated into the proposed recovery residence program:

1. Compliance with the state Fiscal Year 2016-17 Perinatal Services Network Guidelines
2. Primary medical care for women, including referral for prenatal care and child care while women are receiving such services;
3. Primary pediatric care, including immunization for children;
4. Gender specific substance use treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care for women receiving these services;
5. Therapeutic interventions for children in custody of women in treatment which address at a minimum their developmental needs, their issues of sexual and physical abuse, and neglect;
6. Sufficient case management and transportation to ensure that women and their children have access to services;
7. Assessments of child-parent relationship and needs of the child including facilitating access to age-appropriate treatment for the child;
8. Trained staff in child development and positive parenting, trauma-informed care, and gender-specific treatment and staff skills required to establish and maintain recovery while parenting;
9. Trained staff in couples and family therapy to support patients in their interaction with the other parent of the child and/or with their current partner including caregivers and any supportive family members;
10. Connections with supportive resources early in treatment to support patient recovery and transitions to other levels of care;
11. Engagement of patient family members including significant others; and
12. Collaborative partnerships with family and child serving agencies to put into place supports and services that support patient transitions and recovery, including Medi-Cal, TANF, vocational rehabilitation, and housing.

4. Recovery Track Residence Program Evidence-Based Practices (Up to 10 points) 3 Pages Maximum	
A. Please identify at least two (2) evidenced-based practices (EBPs) that will be offered in the proposed treatment program.	□ Cognitive Behavioral Therapy □ Motivational Interviewing □ Psycho-Education □ Relapse Prevention □ Seeking Safety/Trauma Informed Treatment
B. Describe how EBPs will be integrated within the proposed treatment program including all of the following: 1. Describe the rationale for how the selected EBPs will support client recovery for the proposed service populations (2 points); 2. Identify staff that have been certified and trained to provide each of the EBPs (2 points); 3. Identify the process that the provider will use to ensure that each EBP is being offered to fidelity including available staff booster training, available coaching, support during staff supervision, and EBP developer support including any cultural adaptations made to EBPs (2 points); 4. Describe how the use of EBPs will be documented (e.g. progress notes) in a manner that is compliant for the purpose of external program reviews and audits (2 points); and 5. Describe provider evaluation capacity to collect and report outcome data for patients receiving EBPs including client satisfaction with proposed EBPs (2 points). If EBPs will be offered that are not listed under 4 A, please list those here: _____ _____	

5. Recovery Track Residence Program Policies & Regulations (up to 10 points) 3 Pages Maximum
All SUD treatment providers must comply with all federal, state, and City and County of San Francisco policies, rules and regulations that govern SUD treatment services, funding, and City and County of San Francisco contractors. An assurance must be included in the proposal that providers will comply. In addition, proposals must address the following policies, rules, and funding reimbursement areas: A. Americans with Disabilities Act (2 points) Describe provider policies, practices, procedures, and staff training to fully comply with the American with Disabilities Act requirements, including a description of polices, practices and procedures that both protect the patient ADA right to have companion animals within treatment settings and ensure the safety of all SUD treatment patients.
B. Cultural and Linguistic Competency (2 points) Describe how provider cultural and linguistic competency policies, practices, procedures, and staff training fully comply with the DPH Cultural and Linguistically Appropriate Services Policy including a discussion about resources available to meet patient primary language needs.
C. Harm Reduction (4 points) Describe how provider policies, practices, procedures, and staff training fully comply with the Health Commission Harm Reduction Policy and recent DPH policy enhancements described in this RFP.
D. Patient Confidentiality (2 points) Describe how provider policies, practices, procedures, and staff training comply with all patient confidentiality requirements including HIPAA requirements for mental health and medical/physical health treatment. Include a description of strategies to obtain patient consent for information sharing for multi-disciplinary treatment planning, case management, transfer among levels of care and discharge planning.
E. County of Responsibility (required information but no points awarded) List anticipated counties of responsibility for the proposed service populations and provide a written assurance that proposer will: 1) serve out-of-county patients in full compliance with the DMC-ODS Pilot county of responsibility requirement, including related requirements imposed on counties by the State at a future date; and 2) seek written agreements with counties of responsibility to serve out-of-county patients on or before June 1, 2017.

6. Recovery Track Residence Program Electronic Health Records & Data Systems (Up to 10 points) 3 Pages Maximum
A. Describe all of the following: 1) How the provider's protocols and strategies will support the timely and accurate entry and transmission of data for the State CalOMS Treatment data system, the State Drug and Alcohol Treatment Access Report data system, and the DPH Avatar data system (4 points); 2) How adequate staffing and resources will be available to support EHR, evaluation, and data system reporting requirements described in this RFP, including the process for monitoring and managing data entry and available training for staff on timely, accurate and compliant data entry and reporting (4 points); 3) How provider data collection systems or software will allow for timely submission/transmission (within 24 hours) of required DMC-ODS Pilot and DPH data and describe their compatibility with DPH data collection systems (2 points); and 4) How data entry and transmission policies, protocols and procedures fully comply with patient confidentiality requirements (required information, but no points awarded); and B. Provide an assurance that the provider will meet future DPH electronic health record requirements (e.g. EPIC) and QI data collection and transmission requirements and will submit all data requested by DPH within 24 hours (assurance required but no points awarded).

7. Recovery Track Residence Program Evaluation & Quality Improvement (Up to 10 points)
3 Pages Maximum

Provide the following information:

A. Evaluation & Quality Improvement

1) Describe and provide a flow chart (the flow chart does not count toward the maximum page limit) showing the provider's process for collecting, analyzing and integrating outcomes/evaluation and quality improvement data into treatment program planning, development, and implementation activities with the goal of improving patient experience (4 points);
2) Describe how the provider's evaluation and quality improvement protocol and policies are consistent with the DMC-ODS Pilot evaluation and quality improvement requirements and include a copy of the evaluation and quality improvement policy in the proposal appendix (4 points); and
3) Provide a Logic Model (the Logic Model does not count toward the maximum page limit) showing provider capacity, resources and key strategies to meet at a minimum the following DMC-ODS Pilot program and patient outcomes (2 points):
    a. High patient engagement and participation;
    b. Patient access to treatment services within 72 hours;
    c. Patient treatment progress and recovery;
    d. High patient compliance with medications/MAT use;
    e. Appropriate patient utilization of services/ASAM assessments (level of care placements);
    f. Successful care transitions and discharges;
    g. Collaborative treatment planning with mental health and primary care;
    h. Case management/navigation support for patients;
    i. High patient perceptions of service access/quality; and
    j. High accuracy/quality of client and program data (less than 5% error rate).

B. Staffing and Resources

1. Identify an evaluation and QI point of staff contact OR identify a dedicated evaluation and QI staff person/subcontractor (see scoring preference) that will be responsible for meeting all evaluation requirements (required information but no points awarded); and
2. Provide a certification that all staff will be trained on DMC-ODS Plot and DPH evaluation requirements and the provider will submit all required evaluation and QI data to DPH in a timely manner (required certification but no points awarded).

8. Recovery Track Residence Program Recovery Track Residence Program Workforce Development & Staffing (Up to 20 points)
4 Pages Maximum

A. In addition to providing a one (1) page organizational chart that shows proposed SUD outpatient treatment full-time equivalents (FTEs) by profession and where those FTEs report within the provider's organization (the organizational chart does not count toward maximum page limit), address the following

1. Adequate number of qualified and experienced staff to serve proposed service populations included a staffing plan that includes proposed staff to patient ratios (staff patient caseloads), proposed clinical supervisor to staff ratios, and proposed number of peer support specialists (consumers with lived experience) to provide support to patients (10 points);
2. A staff supervision model that support the role of supervisors in staff coaching, patient care, and QI and service utilization activities (2 points);
3. An SUD treatment staff training plan for Fiscal Year 2016-17 that supports staff in meeting DMC-ODS Pilot and DPH requirements including how and which state supported training will be accessed (2 points); and
4. A description of the provider's process, policies and procedures for meeting all of the following professional licensure and workforce requirements (6 points):

    a. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians;
    b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff;
    c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring; and
    d. Registered and certified alcohol and other drug counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

B. An assurance that any vacant positions will be filled within 90 days of receiving a contract award to provide SUD treatment services (required information but no points awarded); and

C. List of professional licensed and credentialed staff and include in the proposal appendix copies of all professional licenses for staff (required information but no points awarded).

Ancillary Treatment & Outreach Services Addendum (Up to 10 Points)
5 Pages Maximum

A. For SUD treatment proposals that propose to provide ancillary SUD treatment and outreach services not described in this RFP as part of the proposed ASAM level of care treatment program, please identify and describe all of the following (1 point each):
   1. Proposed ancillary service(s) to be provided;
   2. At least two priority service populations that will receive the ancillary service(s) and the proposed annual unduplicated service count;
   3. The proposed service location(s) where the proposed ancillary service(s) will be provided;
   4. Organizational experience and capacity to offer the proposed ancillary services including staff capacity, knowledge, and experience providing the proposed ancillary service(s) to the proposed service populations;
   5. How the ASAM Criteria will be integrated within the assessment/treatment plan review process for patient need for the proposed ancillary service(s);
   6. Coordination of the proposed ancillary service(s) with the proposed ASAM level of care treatment services and other levels of care as patient needs require;
   7. Patient engagement strategies;
   8. Linkages to medical homes, mental health, recovery and support services through closely coordinated case management as the patient needs require;
   9. Formal partnerships with other systems and service providers in offering the proposed ancillary service(s);
   10. Patient outcomes for proposed ancillary service(s).

B. Submit total annual cost and budget justification of the proposed ancillary service(s) including identification of leveraged funding or resources to support and sustain the proposed ancillary service(s) (information required but no points awarded)

Priority System Needs Preference Points Proposal

Proposers must complete the following "Priority System Needs Template" to be considered for up to seventy (70) preference points. In completing the "Past Performance Chart" portion of the "Priority System Needs Template" on the next page, proposers must include the following along with their completed template:

- DPH contracted providers should include in the proposal appendix copies of FY 2014-15 and FY 2015-16 contractor monitoring reports from the DPH Business Office of Compliance and Contracts; note: if FY 2015-16 reports are not available as of the submission deadline, submit the FY 2013-14 report with the FY 2014-15 report and indicate that the FY 2015-16 is not yet available;
- Providers that did not contract with DPH in FY 2014-15 and/or FY 2015-16 to provide an SUD treatment service for which a proposal is being submitted, please include in the proposal appendix a copy of contractor/vendor monitoring reports from a California county in which the treatment service was provided in FY 2014-15 and FY 2015-16, including contact information for contract monitor(s) including name, title, email address and phone number to allow DPH to verify performance.

Priority System Needs Template

Treatment Component (Up to 50 Preference Points)	**Provider Assurances and Response** (complete only for Treatment Components for which a scoring preference is being requested)
Cultural and Linguistic Competency (10 points) For each primary language other than English, please identify the number of patients expected to be served annually by their primary language and the number of full-time equivalent (FTE) and names of addiction counselors who are fluent in the primary language and that will serve patients.	___ (#) patients in _____ (e.g. Spanish, Cantonese) ___ FTEs fluent in primary language noted: ____ FTEs as follows: _____ (addiction counselor name) _____ (addiction counselor name)
Evaluation & QI Support (10 points) Please indicate the number of FTEs and staff names dedicated to evaluation and quality improvement activities and/or the name of and # of committed hours by the subcontractor that will manage these activities. Please include a copy of executed contracts in the proposal appendix for the subcontractor.	___ FTEs (must be 0.5 FTE or greater annually to receive preference) Evaluation & QI Staff Name: _____ Support to be provided by: _____ (subcontractor name) ___ hours committed (must be 960 hours/annually or greater to receive preference) Contract included in proposal appendix?: ___Yes ___ No
Integrated Treatment (10 points) Please indicate the integrated treatment model or approach that will be used to deliver integrated treatment services to SUD patients and which patient services will be available on-site.	Check one (3 points): ___ Behavioral Health Home Model **OR** ___ On-Site Multi-Disciplinary Team (Addiction, Mental Health and Medical Services) Patient services to be integrated on-site (check all that apply): ___ Mental Health Treatment (1 point) ___ Medical Care (1 point)

Treatment Component *Continued*	**Provider Assurances and Response** (complete only for Treatment Components for which a scoring preference is being requested)
Level 3.3/Residential Services On-Site Medical Monitoring (10 points) Please indicate the number of qualified FTEs available to provide medical monitoring for patients to assess and treat co-occurring biomedical disorders and to monitor the administration of medications in accordance with a physician's prescription including nursing care and sufficient observation to meet patient needs.	___ FTEs to provide on-site medical monitoring services as follows: _____ (qualified medical staff name) _____ (qualified medical staff name) _____ (qualified medical staff name)
Level 3.1, 3.3, 3.5/Residential Services Continuity of Care (10 Points) Please indicate capacity to provide recovery living environments with ongoing Outpatient or Intensive Outpatient Services beyond the state imposed reimbursement limits for Residential Services.	___ Number of unreimbursed days per patient to be provided ___ Estimated number of patients to be provided recovery living environment after 90 days

Past Performance Chart

Past Performance Data (Up to 10 Preference Points – 2 point per data point met or exceeded)	**FY 2014-15**	**FY 2015-16**
6) Percentage of all SUD Services patients who were readmitted to psychiatric inpatient hospital services within 30 days or less after discharge from the hospital. Benchmark: No more than 15%.	___%	___%
7) Percentage of all SUD patients discharged who successfully completed treatment or left treatment before completion with satisfactory progress. Benchmark: 60% or more.	___%	___%
8) Percentage of all SUD patients in treatment for 60 or more days who maintained abstinence or showed a reduction in alcohol and other drug use. Benchmark: 60% or more.	___%	___%
9) Percentage of SUD patients in treatment who expressed satisfaction with their patient experience. Benchmark: 80% or higher.	___%	___%
10) Percentage of patients admitted to methadone maintenance treatment program who stayed in treatment 12 months or more. Benchmark: 70% or more.	___%	___%

I. BUDGET

1. **Budget Forms**
   Proposers must complete DPH Budget Forms (**see Appendix B**) OR using their own agency generated budget forms must demonstrate the detail costs associated with this RFP (if using your own forms, use DPH form as example and make sure your budget includes unit of service and unit rates, salaries and benefits, operating expense details, direct and indirect costs).

2. **Budget Narrative** (no more than two (2) pages)
   a. Demonstrate that the proposed budget is cost effective and reasonable for providing treatment services proposed under this RFP and consistent with the goals of the DMC-ODS Pilot AND that indirect costs specified are within the 12% City and County of San Francisco's guidelines for allowable indirect costs from DPH and federal or state grantors and provide sufficient overhead to manage the proposed program of which 12% may be billed to DPH;
   b. Justify the proposed budget using actual proposer cost data of providing similar or the same services for which a proposal is submitted under this RFP within the past 12 months; and
   c. Demonstrate that the proposed budget leverages Drug Medi-Cal, Medi-Cal, Medi-Cal/EPSDT and/or other funding and/or services.

3. **Fee Proposal**
   The City and County intends to award contracts to agencies that it considers will provide the highest quality, accessible and cost effective services. The City and County reserves the right to accept other than the lowest price offer and to reject any proposals that are not responsive to this request.

J. EVALUATION AND SELECTION CRITERIA

For all proposals, the Minimum Qualification Requirements will be reviewed first; applications that do not submit complete documentation meeting the minimum requirements will not have the project proposal reviewed.

Project proposals meeting minimum agency qualification requirements will be evaluated and scored using the "Proposal Scoring Criteria" (see below) by a selection committee made up of individuals with expertise in the SUD level of care for which the proposal is submitted, quality improvement and evaluation staff, consumers of service and family members, and financial management staff.

The City and County intends to evaluate the proposals generally in accordance with the criteria itemized below.

The City and County intends to award contracts to agencies that it considers will provide the most cost effective program services. The City and County reserves the right to accept other than the lowest price offer and to reject any proposals that are not responsive to this request.

K. PROPOSAL SCORING CRITERIA

1. **Submission Guidelines 20 Points**
   Does the applicant follow the submission requirement guidelines and format listed in section IV page 56? Are all submissions complete using the submission templates, are they within the page limits, using 12 point Times New Roman font, one inch margins, double spaced and on double sided, recycled pages? ……..10 points
   Does the applicant submit Appendix A-1a RFP Forms, CMD Attachment, Minimum Requirements, and follow the guidelines?..... 10 points

2. **2.1 SUD Treatment Program/Case Management Service 180 Points**
   Priority Service Populations…….……...20 points

   Priority Geographic Services Areas……....20 points

   Treatment Program/Services Narrative…….……...Up to 70 points

   Evidence-Based Practices……10 points

   Policies & Regulations……10 points

   Electronic Health Records & Data System Capacity……..10 points

   Evaluation & Quality Improvement Capacity……10 points

   Workforce & Staffing…….20 points

   Ancillary Services ……10 points

2. **2.2 Recovery Track Housing Program 180 Points**
   Recovery Track Residence Program Priority Service Populations……...20 points

   Recovery Track Residence Program Priority Geographic Services Areas…...20 points

   Recovery Track Residence Program Narrative…….……...Up to 70 points

   Recovery Track Residence Program Evidence-Based Practices……10 points

   Recovery Track Residence Program Policies & Regulations……10 points

   Recovery Track Residence Program EHR & Data System Capacity……..10 points

   Recovery Track Residence Program Evaluation & QI Capacity…….10 points

   Recovery Track Residence Program Workforce & Staffing…….20 points

   Ancillary Services ……10 points

3. **Budget 30 Points**
   Proposer's budget is reasonable, cost effective and justified using actual costs of providing services……...20 points
   Proposer's budget leverages Medi-Cal or Medi-Cal EPSDT or other services and funding…….……..10 points

4. **Financial Management Capacity and Fiscal Integrity 30 Points**
   Proposer's financial management and fiscal integrity as evidenced by citywide or DPH monitoring report, lack of corrective action plans, unqualified audit opinions, a reasonable level of cash reserves, cash flow statements and a list of financial management staff who will be supporting the services applied for.…….30 points

TOTAL EVALUATION/SCORING CRITERIA POINTS POSSIBLE: 260Points

Additional Points Available for Priority System Needs: 70 Points

Up to seventy (70) additional points may be awarded as follows for:

Priority System Needs	**Maximum Number of Points Available**
1) Cultural & Linguistic Competency: Dedicated Multi-Lingual Staff for Service Populations	10 Points
2) Evaluation & Quality Improvement: Dedicated Evaluation and Quality Improvement Staff	10 Points
3) Integrated Treatment Model: Behavioral Health Home or Integrated Substance Use Disorder Treatment, Mental Health Treatment & Primary Care Services On-Site	10 Points
4) Level 3.3/Residential Services On-Site Medical Monitoring	10 Points
5) Level 3.1, 3.3, 3.5/Residential Services Continuity of Services	10 Points
6) Past Performance	Up to 20 Points

The Contract Analyst will calculate any Priority System Needs points.

TOTAL POINTS POSSIBLE: up to 330 Points

V. EMAIL QUESTION PERIOD; BIDDER'S CONFERENCE AND CONTRACT AWARD

A. Email Question Period

All questions and requests for information must be received by electronic mail and will be answered few days after the end of the E-Question period, by electronic mail, to all parties who have requested and received a copy of the RFP. The questions will be answered by program staff. This is the only opportunity applicants can ask direct questions regarding the services mentioned in this RFP. All questions are to be directed to the following e-mail address: Mahlet.Girma@sfdph.org, OR by electronic mail, fax and or US Mail to:

Mahlet Girma, Contract Analyst
San Francisco Department of Public Health
Office of Contracts Management & Compliance
1380 Howard St., 4th floor, #421
San Francisco, CA 94103
Phone (415) 255-3504 / Fax (415) 252-3088

E-questions may only be submitted from September 27, 2016 until 12:00 Noon October 14, 2016.

No questions or requests for interpretation will be accepted after 12:00 PM on **October 14, 2016**. If you have further questions regarding the RFP, please contact Mahlet Girma at Mahlet.Girma@sfdph.org.

B. Pre-Proposal Conference (Bidder's Conference)

Proposers are encouraged to attend a Pre-Proposal conference **on October 24, 2016** from **1:00 PM to 3:00 PM,** to be held at **25 Van Ness, Room # 610, San Francisco, CA.** Additional questions will be addressed at this conference and any available new information will be provided at that time. **Please read the email questions and answers before coming to the Bidder's Conference.**

The City will keep a record of all parties who request and receive copies of the RFP.
Any requests for information concerning the RFP whether submitted before or after the pre-proposal conference, must be in writing, and any substantive replies will be issued as written addenda to all parties who have requested and received a copy of the RFP from the Department of Public Health**.** Questions raised at the pre-proposal conference may be answered orally. If any substantive new information is provided in response to questions raised at the pre-proposal conference, it will also be memorialized in a written addendum to this RFP and will be distributed to all parties that received a copy of the RFP. No questions or requests for interpretation will be accepted after **3:00 PM** on **October 24, 2016.**

C. Contract Award

The Department of Public Health, will issue Notices of Intent to Award to the selected Proposer with whom DPH staff shall commence contract negotiations. The selection of any proposal shall not imply acceptance by the City of all terms of the Proposal, which may be subject to further

negotiation and approvals before the City may be legally bound thereby. If a satisfactory contract cannot be negotiated in a reasonable time the Department in its sole discretion may terminate negotiations with the recommended Proposer and begin contract negotiations with the next recommended Proposer.

VI. TERMS AND CONDITIONS FOR RECEIPT OF PROPOSALS

A. Errors and Omissions in RFP

Proposers are responsible for reviewing all portions of this RFP. Proposers are to promptly notify the Department, in writing, if the proposer discovers any ambiguity, discrepancy, omission, or other error in the RFP. Any such notification should be directed to the Department promptly after discovery, but in no event later than five working days prior to the date for receipt of proposals. Modifications and clarifications will be made by addenda as provided below.

B. Inquiries Regarding RFP

Inquiries regarding the RFP and all oral notifications of an intent to request written modification or clarification of the RFP must be directed to:

Mahlet Girma, Contract Analyst
San Francisco Department of Public Health
Office of Contracts Management & Compliance
1380 Howard St., 4th Floor, #421
San Francisco, CA 94103
Phone (415) 255-3504/ Fax (415) 252-3088
E-mail: Mahlet.Girma@sfdph.org

C. Objections to RFP Terms

Should a proposer object on any ground to any provision or legal requirement set forth in this RFP, the proposer must, not more than ten calendar days after the RFP is issued, provide written notice to the Department setting forth with specificity the grounds for the objection. The failure of a proposer to object in the manner set forth in this paragraph shall constitute a complete and irrevocable waiver of any such objection.

D. Change Notices (Addenda)

The Department may modify the RFP, prior to the proposal due date, by issuing Change Notices, which will be posted on the website. The proposer shall be responsible for ensuring that its proposal reflects any and all Change Notices issued by the Department prior to the proposal due date regardless of when the proposal is submitted. Therefore, the City recommends that the proposer consult the website frequently, including shortly before the proposal due date, to determine if the proposer has downloaded all Change Notices.

E. Term of Proposal

Submission of a proposal signifies that the proposed services and prices are valid for 120 calendar days from the proposal due date and that the quoted prices are genuine and not the result of collusion or any other anti-competitive activity.

F. Revision of Proposal

A proposer may revise a proposal on the proposer's own initiative at any time before the deadline for submission of proposals. The proposer must submit the revised proposal in the same manner as the original. A revised proposal must be received on or before the proposal due date.

In no case will a statement of intent to submit a revised proposal, or commencement of a revision process, extend the proposal due date for any proposer.

At any time during the proposal evaluation process, the Department may require a proposer to provide oral or written clarification of its proposal. The Department reserves the right to make an award without further clarifications of proposals received.

G. Errors and Omissions in Proposal

Failure by the Department to object to an error, omission, or deviation in the proposal will in no way modify the RFP or excuse the vendor from full compliance with the specifications of the RFP or any contract awarded pursuant to the RFP.

H. Financial Responsibility

The City accepts no financial responsibility for any costs incurred by a firm in responding to this RFP. Submissions of the RFP will become the property of the City and may be used by the City in any way deemed appropriate.

I. Proposer's Obligations under the Campaign Reform Ordinance

Proposers must comply with Section 1.126 of the S.F. Campaign and Governmental Conduct Code, which states:

No person who contracts with the City and County of San Francisco for the rendition of personal services, for the furnishing of any material, supplies or equipment to the City, or for selling any land or building to the City, whenever such transaction would require approval by a City elective officer, or the board on which that City elective officer serves, shall make any contribution to such an officer, or candidates for such an office, or committee controlled by such officer or candidate at any time between commencement of negotiations and the later of either (1) the termination of negotiations for such contract, or (2) three months have elapsed from the date the contract is approved by the City elective officer or the board on which that City elective officer serves.

If a proposer is negotiating for a contract that must be approved by an elected local officer or the board on which that officer serves, during the negotiation period the proposer is prohibited from making contributions to:

- The officer's re-election campaign;
- A candidate for that officer's office;
- A committee controlled by the officer or candidate.

The negotiation period begins with the first point of contact, either by telephone, in person, or in writing, when a contractor approaches any city officer or employee about a particular contract, or a city officer or employee initiates communication with a potential contractor about a contract. The negotiation period ends when a contract is awarded or not awarded to the contractor. Examples of

initial contacts include:

1. A vendor contacts a city officer or employee to promote himself or herself as a candidate for a contract; and
2. A city officer or employee contacts a contractor to propose that the contractor apply for a contract. Inquiries for information about a particular contract, requests for documents relating to a Request for Proposal, and requests to be placed on a mailing list do not constitute negotiations.

Violation of Section 1.126 may result in the following criminal, civil, or administrative penalties:

1. Criminal. Any person who knowingly or willfully violates section 1.126 is subject to a fine of up to $5,000 and a jail term of not more than six months, or both.
2. Civil. Any person who intentionally or negligently violates section 1.126 may be held liable in a civil action brought by the civil prosecutor for an amount up to $5,000.
3. Administrative. Any person who intentionally or negligently violates section 1.126 may be held liable in an administrative proceeding before the Ethics Commission held pursuant to the Charter for an amount up to $5,000 for each violation.

For further information, proposers should contact the San Francisco Ethics Commission at (415) 581- 2300.

J. Sunshine Ordinance

In accordance with S.F. Administrative Code Section 67.24(e), contractors' bids, responses to RFPs and all other records of communications between the City and persons or firms seeking contracts shall be open to inspection immediately after a contract has been awarded. Nothing in this provision requires the disclosure of a private person's or organization's net worth or other proprietary financial data submitted for qualification for a contract or other benefits until and unless that person or organization is awarded the contract or benefit. Information provided which is covered by this paragraph will be made available to the public upon request.

K. Public Access to Meetings and Records

If a proposer is a non-profit entity that receives a cumulative total per year of at least $250,000 in City funds or City-administered funds and is a non-profit organization as defined in Chapter 12L of the S.F. Administrative Code, the proposer must comply with Chapter 12L. The proposer must include in its proposal (1) a statement describing its efforts to comply with the Chapter 12L provisions regarding public access to proposer's meetings and records, and (2) a summary of all complaints concerning the proposer's compliance with Chapter 12L that were filed with the City in the last two years and deemed by the City to be substantiated. The summary shall also describe the disposition of each complaint. If no such complaints were filed, the proposer shall include a statement to that effect. Failure to comply with the reporting requirements of Chapter 12L or material misrepresentation in proposer's Chapter 12L submissions shall be grounds for rejection of the proposal and/or termination of any subsequent Agreement reached on the basis of the proposal.

L. Reservations of Rights by the City

The issuance of this RFP does not constitute an agreement by the City that any contract will actually be entered into by the City. The City expressly reserves the right at any time to:

1. Waive or correct any defect or informality in any response, proposal, or proposal procedure;
2. Reject any or all proposals;
3. Reissue a Request for Proposals;
4. Prior to submission deadline for proposals, modify all or any portion of the selection procedures, including deadlines for accepting responses, the specifications or requirements for any materials, equipment or services to be provided under this RFP, or the requirements for contents or format of the proposals;
5. Procure any materials, equipment or services specified in this RFP by any other means; or
6. Determine that no project will be pursued.

M. No Waiver

No waiver by the City of any provision of this RFP shall be implied from any failure by the City to recognize or take action on account of any failure by a proposer to observe any provision of this RFP.

N. Local Business Enterprise (LBE) Goals and Outreach

The LBE Goal is deleted due to Federal Funds/State Funds being used in the funding mix for this RFP. **Department note on certified LBE's.** The City strongly encourages proposals from qualified and certified LBE's or the inclusion of certified LBE's in your project team. A list of certified LBE's can be found at: www.sfgsa.org. For information on becoming a certified LBE, visit www.sfgsa.org.

VII. CONTRACTS REQUIREMENTS

A. Standard Contract Provisions

The successful proposer will be required to enter into a contract substantially in the form of the Agreement for Professional Services or other applicable standard City agreement, contained in Appendix A-3. Failure to timely execute the contract, or to furnish any and all insurance certificates and policy endorsement, surety bonds or other materials required in the contract, shall be deemed an abandonment of a contract offer. The City, in its sole discretion, may select another firm and may proceed against the original selectee for damages.

Proposers are urged to pay special attention to the requirements of Administrative Code Chapters 12B and 12C, Nondiscrimination in Contracts and Benefits, (§Article 10.5 "Nondiscrimination; Penalties" in the Agreement); the Minimum Compensation Ordinance (§Article 10.7 "Requiring Minimum Compensation for Covered Employee" in the Agreement); the Health Care Accountability Ordinance (§Article 10.8 "Requiring Health Benefits for Covered Employees" in the Agreement); the First Source Hiring Program (§Article 10.9 "First Source Hiring Program" in the Agreement); and applicable conflict of interest laws (§Article 10.2 "Conflict of Interest" in the Agreement), as set forth in paragraphs B, C, D, E and F below.

B. Nondiscrimination in Contracts and Benefits

The successful proposer will be required to agree to comply fully with and be bound by the

provisions of Chapters 12B and 12C of the San Francisco Administrative Code. Generally, Chapter 12B prohibits the City and County of San Francisco from entering into contracts or leases with any entity that discriminates in the provision of benefits between employees with domestic partners and employees with spouses, and/or between the domestic partners and spouses of employees. The Chapter 12C requires nondiscrimination in contracts in public accommodation. Additional information on Chapters 12B and 12C is available on the CMD's website at www.sfgsa.org.

C. Minimum Compensation Ordinance (MCO)

The successful proposer will be required to agree to comply fully with and be bound by the provisions of the Minimum Compensation Ordinance (MCO), as set forth in S.F. Administrative Code Chapter 12P. Generally, this Ordinance requires contractors to provide employees covered by the Ordinance who do work funded under the contract with hourly gross compensation and paid and unpaid time off that meet certain minimum requirements. For the contractual requirements of the MCO, see §43 in the Agreement. For the amount of hourly gross compensation currently required under the MCO, see www.sfgov.org/olse/mco. Note that this hourly rate may increase on January 1 of each year and that contractors will be required to pay any such increases to covered employees during the term of the contract.

Additional information regarding the MCO is available on the web at www.sfgov.org/olse/mco

D. Health Care Accountability Ordinance (HCAO)

The successful proposer will be required to agree to comply fully with and be bound by the provisions of the Health Care Accountability Ordinance (HCAO), as set forth in S.F. Administrative Code Chapter 12Q. Contractors should consult the San Francisco Administrative Code to determine their compliance obligations under this chapter. Additional information regarding the HCAO is available on the web at www.sfgov.org/olse/hcao

E. First Source Hiring Program (FSHP)

If the contract is for more than $50,000, then the First Source Hiring Program (Admin. Code Chapter 83) may apply. Generally, this ordinance requires contractors to notify the First Source Hiring Program of available entry-level jobs and provide the Workforce Development System with the first opportunity to refer qualified individuals for employment.
Contractors should consult the San Francisco Administrative Code to determine their compliance obligations under this chapter. Additional information regarding the FSHP is available on the web at http://www.workforcedevelopmentsf.org/ and from the First Source Hiring Administrator, (415) 701-4857.

F. Conflicts of Interest

The successful proposer will be required to agree to comply fully with and be bound by the applicable provisions of state and local laws related to conflicts of interest, including Section 15.103 of the City's Charter, Article III, Chapter 2 of City's Campaign and Governmental Conduct Code, and Section 87100 et seq. and Section 1090 et seq. of the Government Code of the State of California. The successful proposer will be required to acknowledge that it is familiar with these laws; certify that it does not know of any facts that constitute a violation of said provisions; and agree to immediately notify the City if it becomes aware of any such fact during the term of the Agreement.

Individuals who will perform work for the City on behalf of the successful proposer might be

deemed consultants under state and local conflict of interest laws. If so, such individuals will be required to submit a Statement of Economic Interests, California Fair Political Practices Commission Form 700, to the City within ten calendar days of the City notifying the successful proposer that the City has selected the proposer.

G. Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA)

The parties acknowledge that City is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is therefore required to abide by the Privacy Rule contained therein. The parties further agree that Contractor may be defined as one of the following definitions under the HIPAA regulations:

- A Covered Entity subject to HIPAA and the Privacy Rule contained therein; [1]
- A Business Associate subject to the terms set forth in Appendix A-3 "HIPAA for Business Associates Exhibit";[2]
- Not Applicable, Contractor will not have access to Protected Health Information.

H. Insurance Requirements

Upon award of contract, Contractor shall furnish to the City a Certificate of Insurance and Additional Insured Endorsements stating that there is insurance presently in effect for Contractor with limits of not less than those established by the City. (Requirements are listed in Appendix A-3 and are available for download at the Departments RFP/Q center http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts/default.asp

I. Notes on Chapter 12B: Nondiscrimination in Contracts (Equal Benefits or Domestic Partners Ordinance)

Effective June 1, 1997, the City and County of San Francisco added to its Nondiscrimination in Contracts ordinance the requirement that all Contractors that enter into an agreement with the City must extend the same benefits to domestic partners of employees that are extended to spouses of employees. It is recommended that you thoroughly understand this requirement. Questions regarding this requirement can be directed to the person indicated in Section VI, item B, or visit the Contract Monitoring Divisions website at www.sfgsa.org.

J. Vendor Credentialing at Zuckerberg San Francisco General Hospital.

It is the policy of Zuckerberg San Francisco General Hospital to provide quality patient care and trauma services with compassion and respect, while maintaining patient privacy and safety. SFGH is committed to providing reasonable opportunities for Health Care Industry Representatives (HCIRs), external representatives/vendors, to present and demonstrate their products and/or services to the appropriate SFGH personnel. However, the primary objective of SFGH is patient care and it is therefore necessary for all HCIRs to follow guidelines that protect patient rights and the vendor relationship. Therefore, all HCIR's that will come onto the campus of San Francisco General Hospital must comply with Hospital Policy 16.27 "PRODUCT EVALUATION AND

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1 "Covered Entity" shall mean an entity that receives reimbursement for direct services from insurance companies or authorities and thus must comply with HIPAA.

2 "Business Associate" shall mean an entity that has an agreement with CITY and may have access to private information, and does not receive reimbursement for direct health services from insurance companies or authorities and thus is not a Covered Entity as defined by HIPAA.

PHARMACEUTICAL SERVICES: GUIDELINES FOR SALES PERSONNEL, HEALTHCARE INDUSTRY REPRESENTATIVES, AND PHARMACEUTICAL COMPANY REPRESENTATIVES".

Before visiting any SFGH facilities, it is required that a HCIR create a profile with "VendorMate." VendorMate is the company that manages the credentialing process of policy 16.27 for SFGH. For questions, or to register as a HCIR please contact the Director of Materials Management, or designee (during normal business hours) at (415) 206-5315 or sign on to https://sfdph.vendormate.com for details.

VIII. PROTEST PROCEDURES

A. Protest of Non-Responsiveness Determination

Within five working days of the City's issuance of a notice of non-responsiveness, any firm that has submitted a proposal and believes that the City has incorrectly determined that its proposal is non-responsive may submit a written notice of protest. Such notice of protest must be received by the City on or before the fifth working day following the City's issuance of the notice of non-responsiveness. The notice of protest must include a written statement specifying in detail each and every one of the grounds asserted for the protest. The protest must be signed by an individual authorized to represent the proposer, and must cite the law, rule, local ordinance, procedure or RFP provision on which the protest is based. In addition, the protestor must specify facts and evidence sufficient for the City to determine the validity of the protest.

B. Protest of Contract Award

Within five working days of the City's issuance of a notice of intent to award the contract, any firm that has submitted a responsive proposal and believes that the City has incorrectly selected another proposer for award may submit a written notice of protest. Such notice of protest must be received by the City on or before the fifth working day after the City's issuance of the notice of intent to award.

The notice of protest must include a written statement specifying in detail each and every one of the grounds asserted for the protest. The protest must be signed by an individual authorized to represent the proposer, and must cite the law, rule, local ordinance, procedure or RFP provision on which the protest is based. In addition, the protestor must specify facts and evidence sufficient for the City to determine the validity of the protest.

C. Delivery of Protests

All protests must be received by the due date. If a protest is mailed, the protestor bears the risk of non- delivery within the deadlines specified herein. Protests should be transmitted by a means that will objectively establish the date the City received the protest. Protests or notice of protests made orally (e.g., by telephone) will not be considered. Protests must be delivered to:

Director of Contract Management and Compliance
101 Grove Street, Room 307
San Francisco, CA 94102
Fax number: (415) 554-2555

ATTACHMENT 1

The following forms must be completed in order for proposals to be considered:

- ☐ **Appendix A1-a: DPH Forms:**
  1. RFP Form 1 Solicitation & Offer
  2. RFP Form 2 Contractual Record Form
  3. CMD Attachment 2 Contract Monitoring Division Forms

- ☐ **Appendix A1-b: Letter of Intent Form** (Due October 25, 2016, at or before 12:00 p.m.)

- ☐ **Appendix B: DPH Budget Forms and Instructions**
  (optional to use DPH Budget Forms or your own agency generated budget forms)