RFP 11-2017

INTENSIVE CASE MANAGEMENT MODALITY SERVICES

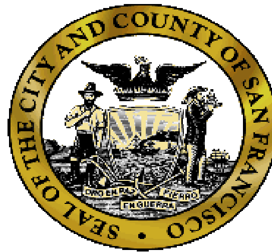
Full Services Partnerships (FSP) and Non-Full Service Partnerships (Non-FSP) Programs

REQUEST FOR PROPOSALS

DEPARTMENT OF PUBLIC HEALTH

Behavioral Health Services (BHS)

Adult/Older Adult System of Care



Request for Proposals (RFP) 11- 2017

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF CONTRACT MANAGEMENT AND COMPLIANCE
1380 HOWARD STREET, SUITE 421
SAN FRANCISCO, CA 94103

CONTACT
MAHLET GIRMA
CONTRACT ANALYST
(415) 255-3504
sfdphcontractsoffice@sfdph.org

Date Issued:	June 12, 2017
Email Questions Period:	June 12, 2017 – June26, 2017
Pre-Proposal Conference:	July 6, 2017
Letter of Intent Due:	12:00 p.m., July13, 2017
Proposals Due:	**12:00 p.m., July 26, 2017**

TABLE OF CONTENTS

		Page
I.	Introduction, Contract Term, Funding and Schedule	[1]
II.	Scope of Work	[7]
III.	Proposal Submission Requirements	[19]
IV.	Proposal Content	[21]
V.	Evaluation and Selection Criteria	[27]
VI.	Email Questions and Answers, Pre-Proposal Conference and Contract Award	[30]
VII.	Terms and Conditions for Receipt of Proposals	[31]
VIII.	Contract Requirements	[34]
IX.	Protest Procedures	[37]

APPENDICES

The following appendices (A-1, A-2, A-3) are available in three separate folders in the zip file attachment available for download at: the Department of Public Health RFP/Q Center located at http://www.sfdph.org/dph/comupg/aboutdph/insideDept/Contracts/default.asp.
Click on **RFP 11- 2017** and follow the instructions.

A-1. THESE FORMS MUST BE COMPLETED IN ORDER FOR PROPOSALS TO BE CONSIDERED.
Zip archive name: **A1.zip**

- Appendix A1-a – **Agency Cover Sheet** (please use this form only as your cover)
- Appendix A1-a – **RFP Form 1 Solicitation & Offer** & **RFP Form 2 Contractual Record Form** and **CMD Attachment** 2 this contains the required CMD forms (Form 3)
- Appendix A1-b – **Budget Forms** & **Instructions** (please use this form)
- Appendix A1-c – **Letter of Intent** (please use this form to submit your Letter of Intent)

A-2. Forms the qualified firm must submit within 5 working days after the notification of an award.
Zip archive name: **A2.zip**
If the qualified firm is a current vendor with the City you may not need to submit these forms.

- **MCO Dec.pdf -** Declaration for the Minimum Compensation Ordinance
- **HCAO Dec.pdf-** Declaration for the Health Care Accountability Ordinance
- **Vendor Profile.pdf** - Vendor Profile Application
- **Biztax.pdf** - Business Tax Application Form (P-25)
- **Fw9.pdf** - Federal W-9
- **Employer Projection of Entry Level Positions rev7-11.doc -** First Source Hiring Program
- **12b101.pdf** How to do business with the City http://sfgov.org/oca/qualify-do-business

---

A-3. For Information Only
Zip archive name: **A3.zip**

- **Standard Professional Services.pdf** – The City Standard Professional Services Agreement (P-600)
- **Insurance Requirements.pdf** - Department of Public Health Insurance Requirements
- **Insurance Sample.pdf -**Sample Insurance certificate and Endorsement
- **HIPAA for Business Associates Exhibit.pdf -** Standard DPH HIPAA Business Associates Exhibit
- **Quickref.pdf Also visit:** http://sfgsa.org/index.aspx?page=6125
  Quick Reference Guide to Chapter 12B

I. INTRODUCTION, CONTRACT TERM, FUNDING & SCHEDULE

A. General Overview

BHS funding is available to be contracted out for the provision of **Mental Health Intensive Case Management (ICM) Modality Services** described below, starting Fiscal Year 2017-18. The ICM Modality Services comprise of Full Service Partnership (FSP) and Non-Full Service Partnership (Non-FSP) programs.

This is a Request for Proposals (RFP) to provide ICM modality services. These services are described in the Scope of Work section of this document. This RFP is seeking qualified providers of *ICM* mental health outpatient services. *ICM* mental health services are differentiated from *regular outpatient mental health* services which are being solicited in a separate RFP.

The Mental Health (MH) Adult/Older Adult (A/OA) System Of Care (SOC) funds mental health ICM, regular outpatient, crisis stabilization, residential treatment services, supportive housing and other adjunct services (such as representative payee, vocational rehabilitation, drop-in wellness-recovery centers and income assistance advocacy) to residents of the city and county of San Francisco who have serious mental illness and resulting significant functional impairments. About 21,000 unduplicated individuals are served annually by the Behavioral Health Services (BHS) MHA/OA SOC, ages 18 and over, for serious mood, schizophrenic/psychotic, anxiety, adjustment and other mental disorders, including with co-occurring substance use disorders, and significant primary care, functional impairment and quality of life issues. Separate RFPs are being issued to solicit providers for the other service modalities (crisis, intensive case management, residential treatment, supportive housing and other adjunct services) within the BHS Adult/Older-Adult Systems-of-Care.

(*Note:* BHS funding for behavioral health programs that are *dedicated to specifically serving only transitional-youth-aged clients* are being solicited in a *separate RFP* solicitation. *However,* all BHS services being solicited *in this RFP* are *also* meant to be able to serve transition-age youth clients ages 18-24, as part of serving all adult clients over 18.)

Services provided under the BHS A/OA SOC are funded via a combination of Medi-Cal, county general fund, state realignment, Mental Health Services Act (MHSA), Medicare, grants and other revenues dedicated to mental health. Clients eligible to be served are those who meet Medi-Cal medical necessity criteria for specialty mental health services, which requires the client to have an *included* mental health disorder diagnosis and significant functional impairment resulting from that diagnosis. BHS has a single standard of care, providing equivalent care to individuals without private health insurance coverage, including indigent or undocumented individuals.

The specific ICM modality services, for which this RFP is seeking providers, are described further below in the *Scope of Work* section of this document (*Section II).*

ICM FSP programs carry some unique program attributes, such as in data collection and a richer array of wrap around services (including housing and flexible funds for various community services), that are not present in the non-FSP ICMs. *Please refer to Section II. Subsection D. of this document for descriptions of these attributes.*

ICM Overarching Principles

All services funded and provided by BHS A/OA SOC, including the ICM services being solicited under this RFP, are guided by the following overarching principles:

- **Wellness & Recovery**
  BHS subscribes to a Wellness & Recovery approach to providing mental health services, and to working in partnership with clients to attain treatment plan objectives. Services assist clients in overcoming impairments resulting from their mental health diagnosis, and in order for them to achieve life goals. Belief is cultivated in clients' ability to recover from their mental illness and succeed in their endeavors. Providers become involved in a partnership with clients to identify and harness clients' strengths toward desired outcomes.

  Clients are not identified by their diagnosis and resulting impairments, but by their individual strengths and aspirations. Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives. BHS encourages confidence in clients' success.

  Clients are also valued by BHS in their ability to help fellow clients. Roles for peers to provide assistance to other peers are incorporated into program design and service delivery, including employing clients in the paraprofessional role of peer counselor.

- **Client Satisfaction**
  BHS A/OA SOC is committed to improving clients' experience-of-care, including quality and satisfaction. Services are client-centered, proceed from client choice and informed consent, and involve a partnership between the BHS provider and the client in the provision and receipt of mental health services to help the client achieve personal goals.

  In compliance with federal managed care regulations that protect clients' rights – given the Medicaid Section 1915(b) Waiver which carved-out Medi-Cal specialty mental health benefits (and given BHS's single standard of care for all clients) – all BHS clients have the right to timely access to care, grievance and appeals process, choice of provider within the BHS provider network, second medical opinion, privacy of health information and access to their medical records, among other rights, as detailed by regulations. All BHS programs have to comply with these managed care regulations.

  Services should engage clients, significant others and families in the provision of their care, as well as in all aspects of the mental health system, including planning, policy development, service delivery, and evaluation.

  BHS providers must adhere to the BHS client satisfaction survey protocols, including conducting an annual or biannual client satisfaction survey. All client satisfaction survey methods and findings must be reported to program leadership on an annual basis, along with a summary of the client suggestions and how the program worked to implement the recommendations. Client satisfaction and feedback may also be collected and assessed via suggestion boxes, a client council, and program websites.

- **Staff and Provider Satisfaction**
  BHS values its relationships with its network of providers, both contracted and civil-service-operated programs. Providers are considered important partners in delivering

quality services to clients. BHS promotes effective communication, problem-solving, involvement in decision-making, and support of staff and providers. BHS providers will be responsible for empowering staff and providing adequate support to deliver excellent care, adapt to new practices and approaches, and grow professionally. It will be important for providers to implement practices for effective communication among leadership and staff members to support staff satisfaction. Additional strategies for ensuring staff satisfaction may include, for example:

  - Appropriate staffing levels at clinics
  - Initiate clinical supervision program
  - Adopt professional development initiatives
  - Enhance staff training and coaching; orient new hires to the values and priorities of services
  - Include staff feedback during design and implementation of new practices

- **Client-Outcomes Oriented**
  BHS is committed to measurably improving clients' well-being, functioning and quality of life. BHS A/OA SOC utilizes the Adult Needs & Strengths Assessment, and other data sets derived from the Avatar electronic health record, to assess, plan and track for favorable client outcomes. Effectiveness is supported, not only at the client-level, but also at the clinician, program and system-of-care levels, through supervision, continuous quality improvement initiatives and employment of effective clinical practices.

- **Cultural and Linguistic Competence**
  Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.

- **Trauma-Informed System of Care**
  BHS subscribes to the principles of a trauma-informed system of care that starts with an understanding of trauma and stress and leads to compassionate interactions, dependable and trustworthy relationships, informed steps toward wellness, safety and stability, collaboration and empowerment, cultural humility and responsiveness, and resilience and recovery – for both clients and staff.

- **Integrated Care**
  BHS recognizes the necessity of attending to clients' overall health, to include not just mental health, but physical health and co-occurring substance use disorder. Chronic mental health conditions have resulted in poorer health and shorter life expectancy for individuals with serious mental illness. Substance use disorder compounds mental health problems. Overall health functioning is impaired by mental disorders and is an important focus of mental health treatment and rehabilitation services. This includes connecting clients to primary care and substance abuse treatment services as necessary, and assisting clients toward overall wellness.

- **Access to Services**
  In line with BHS' designation as the provider of specialty mental health services in San Francisco county to individuals and families on Medi-Cal, BHS promotes unhindered access to care to clients whose mental health condition and impairment meet medical

necessity criteria for services. Clients' right to receive care, and in a timely fashion, are protected by beneficiary grievance and appeals processes, and promoted by BHS policies, such as the advanced access policy that requires clients requesting appointments to be seen within 24-48 hours. The right to access care extends to poor, uninsured and undocumented individuals covered by the county's safety net of health services.

- **Priority to the Most Seriously Mentally Ill**
  BHS' Medi-Cal specialty mental health services are designated for moderate to serious mental health conditions that meet medical necessity for services that cannot be provided by primary care providers. To the extent that resources are available, BHS prioritizes serving individuals and families with the most serious and chronic mental illnesses, who have experienced the most adverse impairments in functioning and reduction in quality of life, such as homelessness, incarceration and institutionalization, due to their mental illness.

- **Clinical Case Management**
  BHS A/OA mental health services involve not just treating mental health symptoms but improving clients' quality of life and achievement of personal aspirations through overcoming barriers from serious mental illness. BHS services employ a whole person approach that address clients individual in their psychosocial environment – taking into account not only their psychiatric condition, but also the effects of this condition on their: ability to function in the community; housing situation; family life; social relations and environment; physical health; employment and/or education; income; socio-economic status; legal and criminal justice involvement; and their safety and potential for exploitation. Clinical case management includes not only assessment, therapy, rehabilitation, collateral contacts, and medication support services, but also intensive outreach and follow-up in the community, and case management brokerage services to link client to resources.

- **Collaborations and Transitions across Levels-of- Care**
  BHS clients are often high users of multiple health and human services, including of behavioral health services across different levels of care (crisis, inpatient, jail, residential treatment, long-term care) within the BHS mental health and substance abuse systems-of-care. BHS requires that providers collaborate effectively in the transitions of clients across different modalities of healthcare (such as from psychiatric inpatient to outpatient care) to facilitate an effective, seamless and coordinated continuity of care.

- **Harm Reduction**
  BHS abides by the harm reduction philosophy adopted by the San Francisco Health Commission, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community. Harm reduction methods and treatment goals are free of judgment or blame and directly involve the client in setting their own goals.

- **Continuous Quality Improvement**
  BHS supports continuous quality improvement in patient experience, client outcomes, clinical quality and provider satisfaction. Initiatives that improve the quality of practices at the service delivery team, program, agency and system-of-care levels are encouraged. These include the use of evidence-based practices and practice-based knowledge.

- **Cost Containment**
  BHS supports clients' wellness and recovery in the community, and in the most independent and least restrictive settings. Toward this end, BHS providers work with clients to stabilize periods of acute crisis and disability, and to reduce expensive incidences of psychiatric emergency, inpatient, locked and institutional care.

- **Utilization Management**
  As required by Medi-Cal regulations, BHS has a set of policies and procedures for utilization management that evaluates the appropriateness and medical need for different modalities and levels-of-care of mental health services (such as outpatient, intensive case management, inpatient, day and residential treatment), and that authorizes service utilization.

- **Medi-Cal Compliance**
  BHS providers must adhere to Med-Cal regulations governing site and staff certifications, program and staff practices, including billing compliance, and clinical chart documentation standards.

- **Privacy**
  BHS providers must comply with the Privacy-related policies of the San Francisco Department of Public Health (DPH) developed to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and with other federal, state, and DPH-specific rules and regulations pertaining to patient confidentiality.

- **Meaningful Use of Electronic Health Record**
  BHS requires its mental health providers to use the certified NetSmart Avatar electronic health record (EHR), and to have an in-house informaticist to oversee the accurate, effective and meaningful use of EHR to improve quality, safety and efficiency; ensure regulatory compliance; engage with clients and families; improve care coordination; maintain privacy and security of patient health information; improve client population health; and liaison and work in partnership with BHS IT to ensure consistent and reliable data outcome reporting.

- **Accessibility of Services (Americans with Disability Act)**
  BHS providers must comply with Title II of the Americans with Disabilities Act, as well as with all other laws and regulations that require all programs offered through state and local governments to be accessible and usable to people with disabilities.

B. Contract Term, Funding and Schedule

Candidates can bid to be selected for one or multiple ICM sub-population categories (see list of ICM sub-programs below, as well as *Section II. Scope of Work* for program details). Candidates will be expected to provide the spectrum of ICM service described in the Scope of Work (*See Section II*) in this RFP. The degree to which a Candidate meets the minimum qualifications of the RFP will be determined through a review process to evaluate the Candidate's application materials (*see Section V. Evaluation and Selection Criteria*).

The funding for these programs will come from a combination of county General Funds, State Realignment, Medi-Cal federal financial participation, and MHSA. MHSA, in particular, funds the FSP service model within this ICM modality RFP.

Contracts awarded under this RFP/Q shall have an initial term of one and a half (1.5) years. At the end of the initial term, it is anticipated that the contract term will be extended by another three and a half years (3.5) years, for a maximum term of five (5) years.
Subsequent extensions to the contract terms may extend the contract for an additional five (5) years, 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 these options
The maximum term for the contracts awarded under this RFP/Q may not exceed ten (10) years.

RFP/Q Authority	Contract Term	# Years	Term Begin	Term End
	Initial term	1.5 years	January 1, 2018	June 30, 2019
	Option 1	3.5 years	July 1, 2019	December 31, 2022
	Option 2	5.0 years	January 1, 2023	December 31, 2027
No more than 10 years	Total Contract Term	10.0 years	January 1, 2018	December 31, 2027

An estimated annual amount of about **$16,160,000** is available under this RFQ for the following five (5) FSP/ICM sub-categories of programs.

1. **Adult ICM Programs** – A final budget to be determined. The funding for this sub-category type is estimated at **over $11,000,000.**
   a. **FSP programming (about $1,600,000)**
   b. **Non-FSP programming (about $9,400,000)**

2. **Older Adult ICM Programs** – A final budget to be determined. The funding for this sub-category type is estimated at **about $1,360,000.**
   a. **FSP programming (about $970,000)**
   b. **Non-FSP programming (about $390,000)**

3. **Forensic FSP Program** – A final budget to be determined.
   a. **FSP programming**, with MHSA FSP, county general fund, state realignment and matching Medi-Cal funding (**about $2,400,000)**

4. **Intensive Hospital to Community Linkage Program** – A final budget to be determined.
   a. **Non-FSP programming (about $900,000)**

5. **Assisted Outpatient Treatment FSP Program** – A final budget to be determined.
   a. **FSP programming**, and matching Medi-Cal funding **(about $500,000)**

The estimated budget may increase or decrease depending on funding availability. Projected funding is dependent on available funds and DPH/BHS reserves its sole right to award all or a

portion of funds available. DPH/BHS will award a contract to the top scoring qualified applicant(s) of each service category sub-program. Upon the sole discretion of DPH/BHS, DPH/BHS may award multiple top scoring qualified applicants of a specific sub-category, depending upon the needs of the community and the needs of the project.

C. Schedule

The anticipated schedule for selecting a contractor is:

Proposal Phase	Time	Date
RFP is issued by the City		June 12, 2017
Email Questions begin		June 12, 2017
Email Questions end	12:00 pm	June 26, 2017
Pre-Proposal Conference *101 Grove, Room 300, San Francisco*	1:30 pm – 3:30pm	July 6, 2017
Letters of Intent	**12:00 pm**	**July 13, 2017**
Proposals due	**12:00 pm**	**July 26, 2017**

Estimated Dates	
Technical Review Panel	*August 2017*
Contract Selection	*August/ September 2017*
Negotiations	*September / October 2017*
Contract Development & Processing	*October - December 2017*
Service Start Date	*January 1, 2018*

II. SCOPE OF WORK

This section describes in detail the mental health ICM modality services that are going to be contracted for. This Scope of Work is to be used as a general guide, and is not intended to be a complete list of all work necessary to complete the project.

The following includes the **five (5) FSP/ICM sub-categories** of programs:

Important Note:

- An agency that is applying to provide services in more than one of the five FSP/ICM sub-categories of programs, must submit separate proposals for each of the sub-categories they are applying for. A separate program narrative application has to be submitted for each FSP/ICM sub-program-category being applied for. In the Appendix A-1c "Agency Cover Sheet," interested applicants must check the sub -category/categories they are responding to, and provide a separate narrative for each sub-category.

- If your agency is applying within the first two sub-categories of "Adult FSP/ICM Programs" and "Older Adult FSP/ICM Programs, please also indicate in your proposal if you are applying for either FSP or Non-FSP Programs, or both. FSP-only funded

programs carry some unique program attributes, such as in data collection and a richer array of wrap around services (including housing and flexible funds for various community services), that are not present in the non-FSP programs. *Please refer subsection D. of this Section (Scope of Work) for more description.*

Program Descriptions

1. **Adult FSP/ICM Programs**
   a. **FSP programming**
   b. **Non-FSP programming**

(For program Description of this category please refer to 'Subsection A: Mental Health ICM Modality Description')

2. **Older Adult FSP/ICM Programs**
   a. **FSP programming**
   b. **Non-FSP programming**

(For program Description of this category please refer to 'Subsection A: Mental Health ICM Modality Description')

3. **Forensic FSP Program**
   a. **FSP programming**

   The Forensic FSP Program works with individuals with severe mental illness in need of intensive treatment and who are justice system involved or offenders of crime. This program works in collaboration with a system of partners that may include the Office of the Public Defender, Adult Probation Department, Parole Department and Jail Psychiatric Services. In addition to the services outlined in the Scope of Work below, this program may offer services specific to the forensic population including, but not limited to; courtroom consultation, community re-integration, support groups for frequent offenders, and vocational rehabilitation with a focus on criminal justice involvement.

4. **Intensive Hospital to Community Linkage Program**
   a. **Non-FSP programming**

   The Intensive Hospital to Community Linkage Program will work to stabilize clients at Zuckerberg San Francisco General Hospital following their discharge from the Inpatient Psychiatric Units and Psychiatric Emergency Services. The program will link clients to the appropriate level of long-term community-based treatment and provide short-term clinical case management services. The program must engage the client before being discharged from the hospital.

5. **Assisted Outpatient Treatment FSP Program**
   a. **FSP programming**

   In July 2014, San Francisco's Board of Supervisors authorized Assisted Outpatient Treatment, most commonly referred to as Laura's Law, as a response to Mayor Ed Lee's 2014 Care Task Force. Implemented November 2, 2015, the San Francisco AOT Model is utilized as an intervention and engagement tool designed to assist and support individuals with mental illness (www.sfdph.org/aot). The program has been constructed to employ

principles of recovery and wellness, and has a particular focus on community-based services and multiple opportunities for an individual to engage in voluntary treatment. The ultimate goal of the program is to improve the quality of life of participants and support them on their path to recovery and wellness, as well as prevent decompensation and cycling through acute services (e.g., psychiatric hospitalization) and incarceration.

The following are general work tasks necessary to provide ICM modality Services. Proposing teams may suggest specific scope of work in their proposals.

A. Mental Health ICM Modality Overview (FSP and Non-FSP Programs)
B. Mode and Service Functions Definitions (FSP and Non-FSP Programs)
C. Guiding Service Delivery Principles for ICM Modality(FSP and Non-FSP Programs)
D. Special Program Attributes for MHSA FSP-funded Programs(FSP Programs only)

A. Mental Health ICM Modality Description

BHS invites single agency and multi-agency collaborations to provide *intensive* mental health outpatient modality (intensive Mode 15) services to individuals who are experiencing the most severe mental health challenges, and including with a focus on unserved and underserved populations for successful proposals that are to be funded in particular by the MHSA FSP funding. BHS encourages both competition and collaboration among different agencies to meet the needs of adult (ages 18 through 59) and older adult (ages 60 and older) residents of San Francisco. *Note that FSP programs for Transition Aged Youth (ages 16 through 25) will be included in a RFP for Transition Aged Youth.*

Behavioral health ICM services are provided to clients with the most acute, severe and chronic behavioral health problems resulting in the most serious and persistent functional impairments – including co-morbid health conditions such as substance use disorder, and serious and chronic diseases; repeated use of emergency services, acute and institutional care; homelessness; incarceration; and grave disability, and severe risk to themselves or others. These services offer a lifeline to some of the most vulnerable behavioral health system consumers with the goal of empowering individuals to remain safe in the community, preventing acute crisis or avoiding institutional care, and promoting wellness and recovery.

BHS ICM programs are a particular type of intensive mental health outpatient services with low caseloads, multi-disciplinary team approach, and a comparatively richer array of wrap-around services (such as relatively greater access to supportive housing, vocational rehabilitation and other health and human services), in order to be able to do whatever it takes to assist clients who are the most severely impacted by serious mental illness achieve wellness and recovery. All ICM programs are required to conduct aggressive outreach and to engage those clients who have been referred to them for care. Proposals must describe the agency's capacity to serve these high-need clients.

BHS ICM providers work collaboratively with other BHS service modalities and levels-of-care within a larger BHS system of behavioral health care – accepting referrals from other parts of the

system (i.e. emergency, inpatient, institutional, residential, etc.), coordinating concurrently with other types of services and exiting clients into lower levels of care when clinically appropriate.

ICM programs deliver the following types of BHS-contract-reimbursable service functions to their clients.

B. <u>ICM Mode and Service Function Definitions</u>

Definitions of mental health billable/reimbursable service unit(s) from the California Code of Regulations, Title IX are as follows:

Assessment
"Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

Plan Development
"Plan Development" means a service activity which consists of development of client plans, approval of client plans, and / or monitoring of a beneficiary's progress.

Mental Health Services
"Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

Therapy
"Therapy" means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Rehabilitation
"Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and / or medication education.

Collateral
"Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Case Management
"Targeted Case Management" (Case Management / Brokerage) means services that assist a beneficiary to access need medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are or limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Crisis Intervention
"Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the department or a Mental Health Plan to provide crisis stabilization.

Medication Support Services
"Medication Support Services" means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications of biologicals which are necessary to alleviate the symptoms of mental illness. The series may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and / or assessment of the beneficiary.

Mode 60 Client Support and Care
Other wrap-around health and social services.

C. <u>Guiding Service Delivery Principles for Mental Health ICM Modality</u>

Along with the general principles described in the above Introduction General Section I of this RFP, that govern all mental health services provided under the BHS Adult/Older-Adult Systems-of-Care, the specific principles described below additionally govern BHS ICM Mental Health Modality services.

In addition to the following Section I-described BHS A/OA SOC general principles of:

- *Wellness & Recovery*
- *Client Satisfaction*
- *Staff and Provider Satisfaction*
- *Client-Outcomes Oriented*
- *Cultural and Linguistic Competence*
- *Trauma-Informed System of Care*
- *Integrated Care*
- *Access to Services*
- *Priority to the Seriously Mentally Ill*
- *Clinical Case Management*

- *Collaborations and Transitions across Levels-of- Care*
- *Harm Reduction*
- *Continuous Quality Improvement*
- *Cost Containment*
- *Utilization Management*
- *Medi-Cal Compliance*
- *Privacy*
- *Meaningful Use of Electronic Health Record*
- *Accessibility of Services (Americans with Disability Act)*

BHS ICM mental health services must additionally subscribe to the following ICM modality-specific principles:

Wellness-Recovery Perspective for ICMs

All ICM programs must subscribe to the wellness-recovery and evidence-based principles as outlined for FSP programs funded under the MHSA. MHSA is funded through a 1% tax on any personal income in excess of $1 million. The 'system transformation' envisioned by the MHSA is founded on the belief that all individuals - including those living with the challenges caused by mental illness – are capable of living satisfying, hopeful, and contributing lives. MHSA provides the resources necessary for California counties to realize the vision of recovery for individuals and families served by the mental health system.

The principle of recovery is grounded in the belief that individuals with serious mental illness can overcome behavioral health challenges and live meaningful, independent, and fulfilling lives with the appropriate level of "ongoing contact and support services, either through professional support or through a community of recovering peers."

The model of MHSA FSP programs reflect an intensive and comprehensive model of case management based on a client-and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with severe mental illness (SMI) or severe emotional disturbance (SED) to lead independent, meaningful, and productive lives. Examples of doing "whatever it takes" include meeting clients wherever they are, during unconventional business hours (e.g., meeting clients at their homes or in hospitals or clinics early in the morning or into the evening), engaging clients in socialization activities and outings (e.g., taking a client out to lunch or to a cultural or sporting event), providing transportation assistance so clients can attend school or seek employment, providing advocacy services and foster connections with medical and housing service providers.

Following the MHSA FSP model, *all* BHS ICM programs will implement recovery-oriented treatment approaches for clients in the public health system who require more intensive levels of support than regular mental health outpatient clinics can provide. These MHSA-FSP-inspired recovery-oriented services are grounded in the belief that recovery is possible and an expected outcome of treatment. These services must also be client-focused and –driven, culturally competent, and respectful of racial, cultural (including religion and language), gender identity and sexual orientation. Clients must be involved at every level of service, including in the

program planning, delivery and evaluation of services.

It is the MHSA's, and therefore BHS', philosophy that mental health needs are not defined by symptoms but rather by a focus on achieving, maintaining, and promoting the overall health and well-being of the individual and family. Proposed programs that reflect the wellness and recovery model should be able to demonstrate that their consumers and their family members are empowered to 1) establish, work toward, and achieve their personal goals; 2) learn new skills and strategies to manage the challenges in their lives; and 3) draw strength and growth from their lived experiences.

MHSA requires that consumer input play a significant role in the development of MHSA-funded programs. Behavioral health consumers, former consumers, or family members of consumers must be involved in areas of mental health policy, program planning, implementation, monitoring, quality improvement, evaluation and budget allocations regarding these programs. In addition, the MHSA programs should be developed with cultural humility and wellness and recovery principles. The programs should be strengths-based, consumer-led, youth-guided and family-driven.

MHSA, and by adoption all of BHS services, including all ICM programs, is guided by five principles:

1. Cultural Competence – Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
2. Community Collaboration – Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
3. Client, Consumer, and Family Involvement – Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery, and evaluation.
4. Integrated Service Delivery – Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers, and families.
5. Wellness and Recovery – Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

The goal of Wellness and Recovery is for consumers to feel empowered to take charge of their own care and wellness while learning new skills and strategies for managing difficulties and challenges in their lives. The model encourages consumers to draw upon personal strengths, better utilize natural supports, explore new strategies to cope and better navigate the behavioral health system of care. The programs should operate under the belief that consumers can recover from their struggles and promote a sense of empowerment, self-direction and hope. The programs should also operate under the assumption and expectation that clients can graduate from the FSP program and ultimately be linked to a lower level of care.

Additionally, the program content of ICM service-delivery should be include specific wellness and recovery practices, such as: Wellness Recovery Action Planning, Illness Management and Recovery, vocational rehabilitation and employment strategies, and meaningful niches and activities in the community. Please refer to this link for more details on the MHSA vision and

guiding principles:
http://www.dhcs.ca.gov/services/MH/Documents/Vision_and_Guiding_Principles_2-16-05.pdf

ICM Intensive Level-of-Care

Selected ICM providers shall provide comprehensive, integrated mental health and non-mental health services to all clients, based on the needs of each individual client. Reimbursable according to the mode and service function definitions outlined previously above, the full spectrum of ICM services consists of the following types of services:

1. Mental health services and supports, including, but not limited to:
    a. Comprehensive psychosocial and psychiatric assessment.
    b. Individualized treatment, services and supports plan development that results from a comprehensive assessment of needs, and from a client-centered approach, and that is monitored, at a minimum, on a quarterly basis for progress toward meeting client goals, and re-evaluated when a major life change or event occurs.
    c. Mental health treatment provision, including therapy, rehabilitation, case management, collateral, crisis intervention and medication support services.
    d. Low client-to-staff ratio.
    e. Multi-disciplinary team that includes licensed psychosocial staff, case managers and mental health workers, psychiatrist and medical staff, peer support staff, vocational counselors and substance use disorder counselors. The multi-disciplinary team addresses integrated behavioral health, health and social service needs.
    f. High frequency and long duration, as needed, of face-to-face and other services, varying dependent upon clients' stages of recovery, levels of engagement and degrees of success in achieving treatment plan goals. Services can include daily contact, aggressive outreach, crisis intervention and urgent medication services as often as needed.
    g. Low threshold interventions (outreach and support) aimed at engaging clients who need mental health services but refuse or are unable to immediately avail of formal mental health treatment.
    h. An after-hours on-call system in order to provide 24/7 coverage and provision of services in the office or in the community by staff known to the clients;
    i. Coordination of care with emergency, crisis and acute care providers – including having crisis plans that may incorporate clients' preferences, individuals identified by consumers as important in their lives, and a hierarchy of crisis interventions deemed to be most appropriate for avoiding, de-escalating or resolving in crisis situations.
    j. Continuity of care of the client through transitions of levels-of-care, such as through institutional, acute, emergency, transitional residential treatment and outpatient episodes of care.
    k. Aftercare services to ensure clients graduate successfully and are linked to the community and natural supports they need to live healthy, productive lives.
    l. Regular contact with client in community settings (not in a provider clinic), in keeping with the goal of ICMs to assist clients to integrate with and graduate to a

broad array of community services.

m. Peer-to-peer support programming component.
n. Wellness center- programming.
o. Consumer rights advocacy.
p. Consumer and family engagement in treatment and service planning, delivery, and evaluation, including family education services.

2. Non-mental health services and supports, including, but not limited to, *personal service coordination/case management brokerage*, as well as *direct provision of services*, to assist the client (and when appropriate the client's family) obtain and maintain needed housing, medical, vocational rehabilitation, employment, education, social and other community services. In support of mental health wellness and recovery, non-Medi-Cal reimbursable (but MHSA FSP or county general fund reimbursable) expenditures can be incurred, or supportive services provided, to clients in the areas listed below. RFP proposals will also describe the ICM applicant's capacity in the area of collaborative partnerships to access these supportive services from other providers that consumers may need to achieve plan of care goals.
    a. Food.
    b. Clothing.
    c. Housing, including assistance with securing temporary or permanent housing; acquiring federal, state, and local housing assistance; temporary respite housing; rent subsidies; completing proposal forms and procuring necessary and required housing proposal documentations; move-in assistance; security deposits; purchasing of basic housing supplies; temporary financial assistance to pay for utilities and other costs to prevent eviction; regular wellness check-ins at client's housing by ICM staff to ensure client's success within the housing environment; and with other matters that may arise that would place the client at risk of homelessness. Proposals may describe any existing partnerships with housing providers, such as with housing placement procedures, tenant-landlord conflict resolution processes, monitoring of client housing by ICM staff to mitigate tenant issues, and with any other supportive services collaboratively provided to clients at housing sites.
    a. Physical health care.
    b. Substance use disorder treatment.
    c. Alternative therapies, such as self-help communities, yoga, acupuncture, martial arts, herbal therapy, art therapy, aroma therapy or homeopathic treatments.
    d. Respite care.
    e. Education, such as assistance with studying for and obtaining a GED high-school equivalency diploma; enrolling in colleges and universities and applying for financial aid; choosing vocational or trade schools; participating in workshops or trainings about mental health or behavioral health issues; and accessing public or school libraries, and learning internet searches.
    f. Access to other supports and services, such as money management and legal representation.
    g. Income generation**,** such as obtaining county general assistance or Supplemental Security Income, vocational rehabilitation services to attain job skills, training in

job interviewing techniques, assistance with resume writing, job placements, ongoing employment supports to help retain jobs and education about personal finances and budgeting.

h. Social, leisure and recreational activities.
i. Assistance with learning or relearning basic daily living skills, such as hygiene and personal cleanliness, doing laundry, cooking, taking public transportation, grocery and personal shopping, and personal safety.

Selected ICM providers are expected to deliver a spectrum of the above mental health and non-mental health services to the target population. Please describe in the RFP proposal the spectrum of services to be provided.

Graduation of Clients from ICM

Intensive ICM services must demonstrate effective engagement with and treatment of clients, leading to achievement of favorable mental health, functioning and quality of life outcomes, and to eventual successful discharge and stepping-down of clients from the ICM program to less-intensive levels-of-care, such as to regular outpatient mental health or to primary care. Proposals must describe the engagement, treatment, services and transition approach towards clients' eventual graduation from the program.

ICM programs must employ evidence-based practices (EBP) that integrate clinical expertise, scientific evidence and client perspectives to provide effective services. . EBP draw upon clients' strengths, enable clients to use effective coping strategies and natural supports. Examples of EBP are: self-help support groups, chronic disease self-management, Seeking Safety, Harm Reduction, Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Assertive Community Treatment and Motivational Interviewing. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) is a resource that may be helpful to providers.

ICM Utilization Management

ICM programs will operate within BHS utilization management policies and procedures that authorize and review the appropriateness of clients for their higher-level intensive outpatient services. All clients have to be authorized by BHS to receive ICM level of care, according to BHS admission criteria, via verification of level-of-care and medical necessity. Clients admitted to ICM services will have the requisite severity and quantity of impairments to justify the relatively higher intensity and frequency of services provided by ICM programs.

ICM programs will work collaboratively with regular BHS mental health outpatient programs, and with BHS central administration, in order for clients to receive the right level-of-intensity of outpatient care commensurate with their need.

ICM providers are also required to maintain an active Program Utilization Review and Quality Committee (PURQC). The PURQC ensures behavioral health services received by beneficiaries are accessible when clients need support (timely access), effective (leading to improved program practice, quality of care and client success), and appropriate (best value).

The PURQC process applies to all behavioral health providers that provide regular outpatient mental health and ICM services.

Over the course of their enrollment in an ICM programs, clients will experience changes in the intensity of service provision needed. The different intensities of services within ICMs include high intensity services (more than 1-2 contacts per week on average), medium intensity services (between 1 contact per week to 3 times per month), and low intensity services (three or fewer contacts per month). Proposals must will describe the movement of clients through high, medium and low intensity service provision.

RFP proposals will state the proposed capacity of numbers of client slots to be served, including the proposed annual client graduation and discharge turnover rate of clients in order to be able to take new clients.

Proposals will also describe their transition plans for clients ready to be discharged to lower levels of care, including the coordination with the receiving mental health outpatient or primary care program.

Opening Up of Client Flow In and Out of ICM Programs

In recent years, demand for behavioral health ICM services has exceeded available resources. In order to help expand capacity, BHS has increased ICM slots, and also established utilization review processes and discharge and step-down strategies for clients who have recovered to the point where they do not require the full scope of ICM services. Despite these actions over the past several years, demand continues to exceed ICM service availability, resulting in waiting lists for ICM programs.

It is essential to create openings on an ongoing basis for the incoming new ICM referrals from hospitals, long-term care providers, jail and community programs. In particular, BHS has a priority need for proposals that demonstrate the ability to provide intensive case management services for the high-end Users of Multiple Systems Services project in the county Department of Public Health.

While BHS recognizes that there are clients who may require indefinite prolonged ICM services, the goal of ICM services is to assist clients to move toward independence and less intense levels of behavioral health services. Service providers must be committed to working with BHS to review plan-of-care progress regularly to ensure that clients who have met treatment plan goals and exit criteria are discharged to regular outpatient services.

All selected ICM service providers shall also use Adult Needs and Assessment (ANSA) and Milestones of Recovery Scale (MORS) scores to monitor clients' progress in treatment and to assess clients' readiness to transition to a lower level of care. The ANSA/MORS must be completed by the ICM services provider for all consumers at intake, specified periods thereafter, and at discharge. ANSA/MORS will be incorporated into the ICMs' procedures for monitoring client treatment progress, and gauging readiness for graduation to community services. All ICM staff are to be trained and supported in the use of ANSA/MORS. Data from the ANSA/MORS,

and from the BHS criteria for clients deemed possibly ready for discharge, will be used to determine when to explore linking clients to lower levels of care. Proposals should describe how the use of the ANSA/MORS is to be operationalized.

ICM Client Outcomes

ICM client outcomes include, but are not limited, to the following:

- Improved mental health
- Reduced use of alcohol, tobacco and other drugs
- Improved health and connection to health care services
- Increased engagement and involvement with behavioral health treatment
- Reduced risk to self and others
- Reduced acute inpatient hospital episodes
- Reduced use of emergency services and crisis
- Reduced psychiatric institutionalization
- Reduced days of incarceration and criminal justice involvement
- Reduced days of homelessness, increased housing stability
- Reduced involvement with child welfare dependency proceedings
- Improved functioning in basic and instrumental activities of daily living
- Increased percentage of treatment plan goals met
- Increased employment and/or vocational involvement
- Increased social, family and peer connections
- Increased linkage to needed services and resources, including income
- Increased involvement in community
- Improved satisfaction with service

D. Special Program Attributes for FSP Programs (MHSA-funded)

Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client-and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with severe mental illness (SMI) or severe emotional disturbance to lead independent, meaningful, and productive lives.

FSP-funded programs carry some unique program attributes, which include (a) Data Collection and Reporting, (b) Housing Service Partnerships (c) Flexible Funds.

a. Data Collection and Reporting for MHSA FSP-funded Programs

RFP applicants who are particularly interested in obtaining FSP funding can indicate so in their proposal. Providers who are selected to receive FSP funding shall comply with all county and state MHSA reporting requirements, including using the Data Collection and Reporting (DCR) system to report on client and program outcomes on an ongoing basis. FSP service providers are expected to complete and submit quarterly assessments to report on client and program outcomes. Outcomes to be reported in DCR for FSP clients include, for example, time spent in different residential settings and the occurrence of emergency events requiring intervention (e.g.,

arrests, mental health/psychiatric emergencies). These data shall be entered into the DCR using Key Event Tracking (KET) assessments as they occur, and in the regular quarterly assessments.

The San Francisco DCR Workgroup has developed several data quality and outcome reports to help monitor and increase the level of completion for KETs. These reports are shared monthly with FSP providers and discussed, with the expectation that they are used to identify and address gaps in KETs in effort to improve DCR data quality. Selected FSP program may need to participate in monthly meetings to share best practices and challenges in DCR data collection.

b. Housing Service Partnerships for MHSA FSP-funded Programs

MHSA provides funding to FSPs for Housing Service Partnerships (HSPs) that provide housing for adults and older adults who are enrolled in the FSP programs. It is expected that FSP providers will collaborate closely with the Housing Service Partnerships program to ensure that FSP clients have access to stable housing, and are able to maintain their housing.

c. Flexible Funds

FSPs have a pool of flexible funding that may be used to provide community services for a client to attain recovery.

III. 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 (LOI)

Prospective applicants are requested to submit a Letter of Intent (LOI) using the form located *Appendix A1-c* to the DPH Office of Contracts Management and Compliance by **12:00 Noon**, on **July 13, 2017** to indicate their interest in submitting a proposal under this RFQ. 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.
Letter of Intent can be emailed to sfdphcontractsoffice@sfdph.org or mailed at the address below.

B. Time and Place for Submission of Proposals

Proposals must be received by **12:00 p.m.**, on **July 26, 2017**. Postmarks will not be considered in judging the timeliness of submissions. Proposals may be delivered in person and left with SF DPH Office of Contracts Management, or mailed to:

Mahlet Girma, Contract Analyst
San Francisco Department of Public Health
Office of Contracts Management
1380 Howard St. Rm. 421
San Francisco, CA 94103

Applicants shall submit **one (1)** original and **six (6)** copies of the proposal narrative, and **one (1)** copy, separately bound, of required CMD Form Minimum Agency Requirement including attachments in a sealed envelope clearly marked **"RFP 11-2017 – Intensive Case Management – FSP and Non FSP Programs"** to the above location. The original copy of the proposal must be clearly marked as **"ORIGINAL"** and emailed to the contracts office at sfdphcontractsoffice@sfdph.org. Proposals that are submitted by telephone or electronic mail (other than the original emailed) will not be accepted. Late submissions will not be considered.

For agencies applying for more than one sub-categories, you need to submit only one copy of the minimum agency requirements, but you will need one (1) original and six (6) copies for each narrative (item B to G), appropriately checked on the agency cover sheet.

C. Late Submissions

Submissions are due at 12:00 P.M. on the due date. Postmarks will not be considered in judging the timeliness of submissions. Submissions received after the 12:00 P.M. deadline but before 12:01 P.M. the following day may 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 P.M. 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 and on recycled paper with an easy to read 12 point font such as Arial or Times New Roman, one inch margins, double spaced printed 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, rubber band or single staple. Please do not use binders, do not bind your proposal with a spiral binding, glued binding or anything similar. You may use tabs or other separators within the document. If your response is lengthy, please include a Table of Contents.
Do not include extra attachments (other than what is requested) or go over the page limits, as they will not be reviewed.

Note: Proposals over the page limit will be declared non-responsive and will not be forwarded to the review committee. Please make sure you adhere to the page limits.

IV. PROPOSAL CONTENT

One copy - Separately bound submitted with the original proposal:

1. Cover page (Appendix A-1a)
   Note: Interested applicants must complete Appendix A-1c **"Agency Cover Sheet"** and must check the sub-category / sub-categories responding to
2. Minimum Agency Requirement – See **section A below** for details (including financial documents, monitoring reports and Medi-Cal certification as attachments)
3. Contract Monitoring Division – (Appendix A-1a) CMD Form # 3 only (Non-Discrimination Affidavit). If this form is not returned with the proposal, the proposal maybe determined to be non-responsive and may be rejected. If you have any questions concerning the CMD Forms, you may call Contract Monitoring Division (415) 581-2310.

Please organize your proposal content as follows (1 original + 6 copies):

1. Agency Cover page (Appendix A-1a)
2. Table of Contents;
3. RFP Form # 1 – Solicitation and Offer Form (filled and signed) Appendix A-1a
4. RFP Form # 2 – Contractual Record Form (filled) Appendix A-1a
5. Letter of Introduction (see section B below)
6. ICM Program Qualifications (See section C below)
7. Proposal Content (see section D to F below)
8. Budget Forms and Budget Narrative (Appendix A-1b) (see section G below) and;
9. Appendices

A. Minimum Agency Requirement *(items 1 to 9 below)*

The Minimum Agency Requirement may be no more than **five (5)** pages total, excluding forms and other required attachments. It should be clearly labeled and bound separately from program proposals. Using a half page or less for each item, please describe how your agency meets the following requirements:

1. Medi-Cal Certification Requirements (with attachments);
2. Harm Reduction Requirements;
3. Cultural & Linguistic Competency Requirements;
4. Financial Documents (attachment only, no narrative needed);
5. Electronic Health Record & Data Reporting Capacity and Assurances Requirements;
6. Prior Performance Requirements (with attachments);
7. Americans with Disabilities Act and Access Requirements;
8. City Vendor Requirement and DUNS Number; and
9. Compliance with City and County Policies, Laws, Rules and Regulations.

1. Medi-Cal Certification

All proposers are required to be Medi-Cal certified by July 1, 2017 or proof of submission for certification. Proposers must include written documentation of one of following:

a. Medi-Cal certification approval from the City and County of San Francisco;
b. Medi-Cal certification approval from another California county (DPH will accept Medi-Cal certification from other counties as written documentation for meeting this minimum

RFP requirement); or

c. Proof of submission for Medi-Cal certification to DPH.

This documentation does not count against the *Minimum Requirements Narrative* five-page limit.

2. Harm Reduction

All behavioral health 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:

a. Post in common areas where they can be viewed by clients up-to-date referral information about Syringe Access & Disposal services and schedule;
b. Have an onsite overdose response policy;
c. Post in common areas where they can be viewed by clients up-to-date referral information about naloxone access and DOPE Project schedule; and
d. 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.

3. Cultural and Linguistic Competency Requirements

All mental health outpatient treatment services and optional specialized mental health 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 mental health 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 mental health outpatient treatment services meet National CLAS Standards and related DPH policies and practices. For more information, please see: http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf and https://www.thinkculturalhealth.hhs.gov/.

4. Financial Documents Requirements

Proposers must provide one copy of the organization's two (2) most recent financial audits (FY 13-14 and FY 14-15 or FY 14-15 and FY 15-16). 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 for existing Department Contractors.

These requested fiscal documents will not count toward the *Minimum Requirements Narrative* five-page limit.

5. Electronic Health Record and Data Reporting Capacity and Assurance Requirement

Proposers must demonstrate organizational and staff capacity to enter client data within Avatar, the DPH BHS Electronic Health Record (EHR) except as noted below. This includes, but is not limited to:

a. A system for quality assurance for claim submission; and
b. Timely submission of all required documentation into Avatar (e.g. Assessment, Client Plan).

For existing DPH behavioral health treatment providers grandfather exempted for full use of Avatar, a written assurance must be provided that the proposer will submit a plan for review and approval by DPH no later than July 1, 2017, to either transition within 12 months (by July 1, 2018) to use of Avatar or a method to share client information including progress notes. In addition, written proof of HIPAA certification of grandfather exempted provider EHRs must be included in the proposal appendix.

All proposers, including DPH behavioral health treatment grandfather exempted providers, must provide a written assurance that all DPH requests for data will be submitted in a timely manner in a format prescribed by DPH no later than five (5) business days following a request for data.

6. Prior Performance Requirements

Proposers must demonstrate that they have a record of consistent quality service delivery for five (5) prior fiscal years in providing mental health outpatient treatment services, and any optional specialized mental health treatment services for which a proposal is submitted, to the populations proposed to be served. 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 most recent two years of issued reports. 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).

Proposers must provide one copy of the organization's two (2) most recent monitoring reports or copies of actual contracts (for non DPH providers). If an agency has a Corrective Action Plan, copies of the most recent Corrective Action Plan must be submitted.

Note: The Department will refer to current Corrective Action Plans on file and will consider any related correspondence in regards to Corrective Action Plans for existing DPH contractors in making funding awards.

These requested documents will not count toward the *Minimum Requirements Narrative* five-page limit

7. American 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 ADA requirements by describing in detail the proposer's access program, including specific physical, substance use and mental health disability accommodation strategies, policies and procedures.

8. City Vendor and DUNS/SAM Documentation

Proposers are strongly encouraged to submit documents as required to become entered into the City's Vendor Database, by the time of proposal submission, and no later than the date of final selection. Failure may result in contract delays and/or selection of another vendor.

Proposers who have a vendor number must provide it or proposers may provide proof that they have started the process. Existing vendors must show proof of good standing to do business with the City including a current business tax license, and required insurance must be attached. Please refer to Appendix A-2 for Vendor Application process or visit http://sfgsa.org/index.aspx?page=4762 to become eligible to do business with the City and County of San Francisco and refer to Appendix A-3 for Insurance Requirements.

As a prime grantee of federal awards, the City and County of San Francisco is required to comply with Federal Funding Accountability and Transparency Act (FFATA) reporting requirements and report federal sub-awards made to sub-recipients. The City must verify that prospective contractors of federal awards are not suspended or debarred or otherwise excluded from participating in obtaining contracts with the City. It is the Federal and San Francisco's Office of Contracts Administration (OCA)'s policy that Departments verify contractors using the System of Award Management (SAM). SAM is the place where all businesses must register in order to be awarded a government contract.

Proposers are required to obtain a DUNS number at the time proposals are submitted. Proposers must provide a copy of their DUNS # or proof that they have started the process.
DUNS is Dun & Bradstreet's (D&B) "Data Universal Numbering System". It is a copyrighted, proprietary means of identifying business entities on a location-specific basis.
https://fedgov.dnb.com/webform

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

Proposers 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, including all specialty mental health service policies and procedures and related policies and procedures.

***Note**: Only one copy of the above Minimum Agency Requirement (items 1-9) 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.*

Program Narratives:

Note: An agency that is applying to provide services in more than one of the five FSP/ICM sub-categories of programs, **must submit separate proposals** for each of the sub-categories they are applying for. A separate program narrative application, will include **Section B to G** and has to be submitted for each FSP/ICM sub-program-category being applied for.

If your agency is applying within the first two sub-categories of "Adult FSP/ICM Programs" and "Older Adult FSP/ICM Programs, make sure you indicate in your proposal whether you are applying for FSP or Non-FSP Programs, or both.

B. Letter of Introduction (up to 1 page)

Submit a letter of introduction for your agency's proposal. Include a brief overview of your agency and your agency's experience providing the proposed services. The letter must be signed by a person authorized by your agency to obligate your agency to perform the commitments contained in the proposal. Include the name and contact information (address, email and telephone number) for this person or another contact person at your firm. Submission of the letter will constitute a representation by your agency that your agency is willing and able to perform the commitments contained in the proposal.

C. ICM Program Qualifications (up to 2 pages)

In order to meet the requirements of the ICM programs, the agency (agencies) or multi-agency collaboration(s) must meet the following minimum qualifications:

- **a.** At least three years of proven history implementing cultural and clinical activities with the client population category for which you are applying.
- **b.** At least three years of proven history providing the services (including collaborating with partner agencies to provide the services) outlined in the Scope of Work.
- **c.** Proven experience collecting, evaluating and disseminating comprehensive data including program and participant outreach, service utilization/duration, and external referrals.
- **d.** Proven history working as a certified Medi-Cal provider (or) proven ability to obtain certification as a Medi-Cal provider.
- **e.** Proven capacity to deliver responsive services to community members in ways that are respectful and also honor each person's heritage, language and cultural worldviews.

D. Description of ICM Programming (up to 10 pages)

Describe your agency's plan to provide the continuum of services as requested in this RFP by providing a brief summary of the proposed program.

- Indicate for which particular client population sub-type of ICM program your agency is applying for – Adult, Older-Adult, Forensic FSP, Intensive Hospital Linkage (non-FSP) and/or Assisted Outpatient Treatment.

- Additionally, please also indicate if you are particularly interested in receiving MHSA-FSP funding for the client population sub-type(s) you are proposing to provide services for. MHSA FSP-funded programs come with additional requirement to employ DCR outcomes data, and also receive Housing Service Partnership resources.

Within the program description, please address the following:

- **a.** Summary of Approach: Include a summary of the approach to be taken, including strategies for ensuring adherence to the guiding principles of MHSA and the Adult and Older Adult System of Care.
- **b.** Target Populations: Describe the target population(s) to be served.
- **c.** Personnel: Include personnel descriptions, qualifications, assigned responsibilities, and reporting/supervisory structure.
- **d.** Outreach and Engagement: Describe the agency's client outreach and engagement strategies, including outreach and engagement strategies for high-need clients/those who have been referred from BHS for intensive case management level-of-care.
- **e.** Agency Capacity: Describe the agency's capacity to serve high-intensity, medium-intensity, and low-intensity consumers, including the agency's proposal of number of client slots to serve.
- **f.** Service and Treatment Planning: (1) Describe the agency's transitional plan and clinical decision making process in assisting clients in stepping-up or stepping-down throughout the service spectrum. (2) Describe how your agency will utilize the Adult Needs and Assessment (ANSA)/Milestones of Recovery Scale (MORS) in the service and treatment planning and how the MORS will be incorporated into processes and procedures for monitoring client treatment progress and gauging readiness for graduation to community services. (3) Describe how new and existing staff are trained and supported in the use of ANSA/MORS.
- **g.** Service Delivery: Describe the agency's clinical process for coordinating mental health and substance abuse outpatient services with the case management team.
- **h.** Supportive Services: Describe your agency's ability to access and provide the supportive services that consumers may need to achieve plan of care goals, as outlined in this RFP (e.g., substance abuse treatment, primary care, housing, income generation), including any collaborative partnerships. Include in this description your agency's partnerships with housing providers and procedures to collaborate with housing providers, a description of housing placement procedures, tenant-landlord conflict resolution processes, plan for regular monitoring of client housing by ICM staff to mitigate tenant issues, and any supportive services that will provided to clients at housing sites.

E. <u>Description of Performance Measurement and Reporting</u> (up to <u>3</u> pages)

Describe how the services being proposed will achieve the intended goals. Within this description, please include the following:

- **a.** What are the goals of the proposed program? What data, feedback, and information will be used to monitor achievement of program goals?
- **b.** Describe the measurable outcomes that will be used to report on the program goals.
- **c.** Describe how these results and outcomes will be measured, what information will be collected, and what tools will be used to gather this data.
- **d.** Describe how the agency will use this data to continuously improve the program.

F. <u>Memorandum of Understanding or Letter of Commitment with Proposed Agencies</u> (no more than <u>1 page for each MOU no more 3</u>)

If your agency is planning to utilize community partnerships or subcontractors in providing the proposed services, please provide a maximum of <u>three examples</u> of such Memorandum of

Understanding (MOU) or Letter of Commitment for each partner and briefly describe the collaborative relationship. (If applicable).

G. **Budget Forms** (Appendix A-1b) and **Budget Narrative** (**no more than two (2) pages**): Please complete the attached DPH Budget Forms to detail costs associated with this RFP. Please submit a 12 months budget using these forms. (See appendix A-1b). Proposers 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).

Budget Narrative (no more than two (2) pages):

- **a.** Demonstrate that the proposed budget is cost effective and reasonable for providing services proposed under this RFP and that indirect costs specified are within the 15% 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 15% 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.

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.

V. EVALUATION AND SELECTION CRITERIA

For all proposals, the Minimum Agency Requirements will be reviewed first; applications that do not submit complete documentation meeting the minimum requirements may not have their application forwarded for review. The department may request for additional clarification or may determine the application as non-responsive.

Program proposals meeting minimum agency requirements will be evaluated and scored by a selection committee comprised of parties with expertise in intensive case management and mental health services. At any time during the review process, the Department may require a Candidate to provide oral or written clarification of its proposal if needed. The Department reserves the right to review and evaluate qualifications received without further clarification.

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

PROPOSAL SCORING CRITERIA

1. Submission Guidelines — 10 Points

Did the applicant follow the submission requirement guidelines and format listed in section III page 20 & 21? 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?

2. ICM Program Qualifications — 25 Points

Does the applicant demonstrate the following?

- **a.** At least three years of proven history implementing cultural and clinical activities with the population category for which you are applying. **(5 points)**
- **b.** At least three years of proven history providing the services (including collaborating with partner agencies to provide the services) outlined in the Scope of Work. **(5 points)**
- **c.** Proven experience collecting, evaluating and disseminating comprehensive data including program and participant outreach, service utilization/duration, and external referrals. **(5 points)**
- **d.** Proven history working as a certified Medi-Cal provider (or) proven ability to obtain certification as a Medi-Cal provider. **(5 points)**
- **e.** Proven capacity to deliver responsive services to individuals in ways that are respectful and also honor their heritage, language and cultural worldviews. (**5 points)**

3. Description of ICM Programming — 100 Points

Describe your agency's plan to provide the continuum of services as requested in this RFP by providing a brief summary of the proposed program. Within the program description, please address the following:

- **a.** Summary of Approach: Include a summary of the approach to be taken, including strategies for ensuring adherence to the guiding principles of MHSA and the Adult and Older Adult System of Care. **(10 points)**
- **b.** Target Populations: Describe the target population(s) to be served. **(5 points)**
- **c.** Personnel: Include personnel descriptions, qualifications, assigned responsibilities, and reporting/supervisory structure. **(5 points)**
- **d.** Outreach and Engagement: Describe the agency's client outreach and engagement strategies, including outreach and engagement strategies for high-need clients/those who have been referred from BHS for intensive case management level-of-care. **(10 points)**
- **e.** Agency Capacity: Describe the agency's capacity to serve high-intensity, medium-intensity, and low-intensity consumers, including what proportion of each group is expected to be served, including the agency's capacity to accept new clients. **(20 points)**
- **f.** Service and Treatment Planning: (1) Describe the agency's transitional plan and clinical decision making process in assisting clients in stepping-up or stepping-down throughout the service spectrum. (2) Describe how your agency will utilize the Adult Needs and Assessment (ANSA)/Milestones of Recovery Scale (MORS) in the service and treatment planning and how the ANSA/MORS will be incorporated into

processes and procedures for monitoring client treatment progress and gauging readiness for graduation to community services. (3) Describe how new and existing staff are or will be trained and supported in the use of ANSA/MORS. **(20 points)**

g. Service Delivery: Describe the agency's clinical process for coordinating mental health and substance abuse outpatient services with the case management team, as described in this RFP. **(15 points)**

h. Supportive Services: Describe your agency's ability to access the supportive services that consumers may need to achieve plan of care goals, as outlined in this RFP (e.g., substance abuse treatment, primary care, housing, income generation), including any collaborative partnerships. Include in this description your agency's partnerships with housing providers and procedures to collaborate with housing providers, plan for regular monitoring of client housing by ICM staff to mitigate tenant issues, and any supportive services that will provided to clients at housing sites. **(15 points)**

4. Performance Measurement — 30 Points

Describe how the services being proposed will achieve the intended goals. Within this description, please include the following:

a. What are the goals of the proposed program? What data, feedback, and information will be used, and how will they be used, to monitor achievement of program goals? **(10 points)**

b. Describe the measurable outcomes that will be used to report on the program goals. **(10 points)**

c. Describe how these results and outcomes will be measured, what information will be collected, and what tools will be used to gather this data. **(5 points)**

d. Describe how the agency will use this data to continuously improve the program. **(5 points)**

5. Budget — 30 Points

a. Proposer's budget is reasonable, cost effective and justified using actual costs of providing services? Is budget narrative included with details? **(20 points)**

b. Proposer's budget leverages Drug Medi-Cal, Medi-Cal EPSDT or other services and funding **(10 points)**

6. Financial Management Capacity and Fiscal Integrity — 30 Points

Proposer's Financial Management and Fiscal Integrity (as evidenced by citywide or DPH monitoring report, corrective action plans, unqualified audit opinions,)

7. Prior Performance — 30 Points

Proposer's Prior Performance (as evidenced by DPH monitoring report, corrective action plans, and contractual record).

TOTAL EVALUATION/SCORING CRITERIA POINTS POSSIBLE:	**255 points**

VI. EMAIL QUESTION PERIOD, PRE-PROPOSAL 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 only: sfdphcontractsoffice@sfdph.org

Email questions may only be submitted from June 12, 2017 until 12:00 noon June 26, 2017.

Follow up questions or requests for interpretation will be only be accepted at the Pre-Proposal Conference in person. Additional questions will not be accepted via email after 12:00 PM on **June 26, 2017**. If you have further questions regarding the RFP, please attend the pre-proposal conference.

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

Proposers are encouraged to attend a Pre-Proposal conference on:

Date:	**Thursday July 6, 2017**
Time:	**1:30 p.m. to 3:30 p.m.**
Location:	**101 Grove, Room 300 San Francisco, CA 94102**

Follow up questions will be addressed at this conference and any available new information will be provided at that time. If you have further questions regarding the RFP, please email the contracts office at sfdphcontractsoffice@sfdph.org

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 3:30pm **July 6, 2017.**

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.

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.

VII. 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: sfdphcontractsoffice@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

The Department may modify the RFP, prior to the proposal due date, by issuing written 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 call the Department before submitting its proposal to determine if the Proposer has received 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 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.

VIII. CONTRACT 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 Requirements"** in the Agreement); the Minimum Compensation Ordinance (§**Article 10.7"Requiring Minimum Compensation for Covered Employees"** 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 http://www.sfgsa.org/index.aspx?page=6058.

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[1] subject to HIPAA and the Privacy Rule contained therein;
- A Business Associate[2] subject to the terms set forth in Appendix A-3 "HIPAA for Business Associates Exhibit";
- 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 Internet site at
http://www.sfgsa.org/index.aspx?page=6058.

J. Vendor Credentialing at San Francisco General Hospital

It is the policy of 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

---

[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.***

General Hospital must comply with Hospital Policy 16.27 "PRODUCT EVALUATION AND 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.

IX. 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 St, Rm. 307
San Francisco, CA 94102
Fax number (415) 554-2555