RFP Response Form

Long Term Structured Residential Program for Individuals with Serious Mental Illness Including Individuals Being Diverted or Released From Inpatient and Criminal Justice Facilities

PROPOSER INFORMATION

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PROPOSAL INFORMATION

Date Submitted 6/24/2016

Amount Requested: 1,877,607

REFERENCES

Provide the name, affiliation and contact information [include email address and telephone number] for three references who are able to address relevant experience with your organization.
Please do not use employees of the Allegheny County Department of Human Services as references.

Lisa McCoy Deputy Administrator Beaver County Behavioral Health Phone: [redacted] Email: [redacted]	**Deborah A. Nunes** HealthChoices Coordinator Northampton County 2801 Emrick Blvd. 3rd FL Bethlehem, PA 18020 office [redacted] FAX [redacted]	**Steve Warren** County MH-IDD/D&A Administrator York/Adams Mental Health-Intellectual and Developmental Disabilities Program York/Adams Drug and Alcohol Commission York County Human Services Center, Suite 301 100 West Market Street York, PA 17401 Telephone: [redacted] E-Mail: [redacted]

RFP Response Form

Long Term Structured Residential Program for Individuals with Serious Mental Illness Including Individuals Being Diverted or Released From Inpatient and Criminal Justice Facilities

REQUIREMENTS

Please respond to the following questions. The maximum score a Proposal can receive is 150 points. Your response to this section should not exceed 15 pages.

Organizational Experience (15 points, 2 pages)

1. Provide a brief summary of the adult behavioral health services your organization provides and any innovative services your organization has developed.
   NHS provides Recovery Oriented and Person Centered adult behavioral health services that align with the more traditional continuum of care, as well as, numerous innovative services developed in response to community-specific needs. Our program offering includes Community Based Extended Acute Care, Long Term Structured Residence, Assertive Community Outreach, Crisis Intervention, Outpatient (Mental Health & Drug and Alcohol), Personal Care Homes, Community Residential Rehabilitation (CRR), Assisted Living, Transitional Living Services, Partial Hospitalization, Psychiatric Rehabilitation, Social Rehabilitation, Peer Support Services, Adult Recovery Housing, Adult Self Pay Transitional Housing, Case Management (Blended Case Management and Drug & Alcohol), Supported Employment, Addiction Services (D & A Adolescent, Intensive Outpatient (IOP) Drug Free, IOP Medication Assisted Treatment (MAT), Outpatient Drug Free, Outpatient MAT, Integrated Health, Veterans Transitional Housing, Veterans Shared Permanent Housing, Veteran Mobile Care Coordination, Integrated Health, In Jail Clinical Services, Sequential Intersect, and Dual Diagnosis Treatment Team (DDTT).

   DDTT is the most recent innovative service developed by NHS in partnership with Community Care Behavioral Health. DDTT was developed to support the needs of individuals who are dully diagnosed with a serious and persistent mental illness and an Intellectual Disability. This program offers a team approach to service coordination and treatment for individuals who have encountered challenges succeeding in more traditional treatment settings. Staff, the individuals and other supporters work together using person-centered and recovery oriented approaches to promote the principles of everyday lives with individuals, family members, and the community.

   Drug & Alcohol Case Management (DACM) is another innovative service serving individuals with addictive and co-occurring disorders who present with multiple needs and require advocacy and assistance in accessing needed services and supports. The purpose of DACM is to assist the individual/family with increasing resilience and self-sufficiency toward recovery. The primary goals of case management services are to increase retention in and completion of substance abuse treatment and increase access to ancillary support services to enhance recovery.

2. Describe how your organization collaborates with other services (e.g., service coordinators, peer specialists, housing providers, etc.).
   The NHS approach to collaboration begins fundamentally with the understanding that the best outcomes are realized when an identified treatment and support team works in partnership with an individual to achieve his or her identified goals and objectives. Identifying and ensuring continuity

with established healing relationships and supports over time and across episodes, programs, and agencies is a significant area of focus in the effort to support an individual along thier recovery path.

NHS collaborates with other service providers both formally and informally. The first step toward providing optimum collaboration is in the process of identifying other service providers and supports; both current and by history. This is achieved through inquiry during the referral, intake, and ongoing assessment (relationship building) process with the individual and their identified support team, including natural supports. Written provider contracts and agreements are utilized when necessary to clarify roles and responsibilities and are designed to offer proactive clarification and avoidance of miscommunications that could negatively impact service delivery. In addition, individual treatment plans incorporate task and action item specific references, as well as, who (person/agency) is responsible for completing them to ensure proper understanding, follow up, and coordination. NHS values positive relationships with other service providers and stakeholders and appreciates how these relationships help facilitate effective collaboration when working to meet an individual's needs. Leadership within NHS strives to develop staff toward this understanding and consistent level of performance.

3. Provide a brief summary of your organization's experience working with criminal justice system partners and individuals involved in the criminal justice system, including persons with sexual offending histories.
   Criminal justice collaboration occurs on a regular basis and across multiple programs at NHS within Allegheny County and surrounding counties. Working closely with court appointed personnel and probation and parole officers within NHS's current LTSR and ACT programs is imperative whenever supporting individuals who are under court supervision. In Beaver County alone, NHS provides site-based services within the courthouse, jail, and in community teams that penetrate the jail. When individuals are incarcerated, co-occurring evaluations are conducted to assess the need for community based support and then linkages are made to appropriate resources in the community as appropriate. In the jail based setting, criminogenic risk is also evaluated and communicated to the District Magistrate scheduled for arraignment. Pre Trial services are notified of clinical/safety concerns in the event the individual is scheduled for release from the Regional Booking Center and may require further evaluation.

   In some areas, blended case management services have identified specialized teams to serve individuals that have been identified as a re-offender (multiple interactions with the criminal justice system), a sex offender (including Megan's Law and Sexual Violent Predators) and individuals being released from the State Correctional Institution (SCI) or the county jail. NHS residential sites have also been successfully facilitating early release from jail to support individuals in a secure facility while continuing to provide a therapeutic environment. NHS is proud to be actively advancing the connection between re-entry services and probation from a positive collaboration to a truly

integrated approach. We provide active team members for teams consisting of one probation officer, a re-entry worker, and a peer. Sharing a caseload, meeting on a regular basis, sharing assessments, and using findings from those assessments helps to develop complementary plans to support a successful re-entry for individuals being served.

Program Planning and Implementation (10 points, 1 page)

4. Provide a detailed description and timeline of your organization's Program development and implementation, including project start date, first admission and admission ramp up schedule. The below timeframes for completion may change upon collaboration with Allegheny DHS and CCBH.

   Licensing/Contracts/Funding

   Week of 8/15/16 Submit program description to OMHSAS and complete Supplemental Plan Application and licensing application for LTSR, and finalize start-up and ongoing budget for NHS

   Human Resource Management

   Week of 9/19/16 Complete final interviewing for all positions and make offers

   Week of 10/24/16 Complete all staff training and orientation

   Facilities Management/Purchasing

   Week of 10/21/16 All renovations, furniture & purchase/lease of vehicles completed, as well as, install of phone systems and connection to all utilities

   Relationship Building/ Outreach

   August 2016 Begin regular implementation meetings with CCBH and other external Stakeholders in order to solidify the first admission target date and ramp up schedule.

   First Admission and Admission ramp up schedule to be determined in collaboration with Allegheny DHS and CCBH. Target date of first referral would be November 1, 2016.

5. Describe your organization's plan for hiring, training and maintaining qualified staff for start-up and on-going operations.

   Staff recruitment is done both internally and externally to NHS. Recruitment includes advertising activities with local newspapers, Internet Job Services, college job fairs and other appropriate resources for potential employees. In adherence with regulatory guidelines, all required credentials are validated before any candidates are offered positions. In addition, the following strategies to recruit and retain staff will soon be implemented:

   1. Enhanced pay that gives employees the option (if they are receiving benefits through another means) to increase their pay by $2/hr.
   2. Partnership with 3rd party media/marketing company to help improve our digital footprint and get our positions onto more computer screens.
   3. New applicant tracking system that brings advantages to attracting and finding candidates and new talent. The new system is much more user friendly from the applicant's standpoint and is optimized for mobility so that the information can be filled out easy on smart phones.

   Training will be provided in accordance with NHS policy and will comply with staff orientation and training requirements outlined in Pennsylvania Code Title 55 Chapter 5320.45. Trainings will

include, but not be limited to, the following: Integrity, Fire and Safety, First Aid/CPR, OSHA/Infection Control, Incident Reporting, De-escalation, Safe Behavioral Interventions, HIPPA, Trauma Informed Care, Recovery and Recovery Oriented Documentation, and Shared Decision Making.

6. Attach a recent version of your organizational chart which clearly indicates where the proposed program would be located within the organization and what the chain of command would be (this chart will not count toward the page limit).

7. Attach job descriptions for each of the following positions (these descriptions will not count toward the page limit): 1) Board Certified Psychiatrist; 2) Master's level mental health professional to serve as the Program Director; 3) Master's level mental health professional to serve as the Coordinator; 4) Direct Care Staff; 5) Dietary aide and 6) Licensed Practical Nurse (LPN).

Approach (80 points, 10 pages)

8. The RFP provides flexibility in the program size and number of individuals served, from eight to 12 individuals. How many Long Term Structured Residential (LTSR) beds will your organization provide? NHs will mirror the current NHS operated LTSR within Allegheny County offering eight (8) beds.

9. Describe your organization's proposed location and structure of the site. If a potential site (or sites) has been identified, please attach one set of color photos. (Photos are attached)
   a. Geographic location
   NHS currently has three other residential programs in operation in close proximity to this location; one being an LTSR program with a comparable population and program set up. The geographic location offers a more rural atmosphere which, for many individuals who have spent significant time either incarcerated or hospitalized, is a favorable transition into the community. The building, physical site, and grounds will comply with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.81
   b. Living and sleeping quarters, bathroom and shower facilities, and common areas
   The physical set up of the program has been designed in a manner that provides each resident with independent and private space while supporting healthy boundaries and positive social interactions. Individuals will have their own sleeping quarters and share a bathroom with one other peer. There are also several shared common areas including a dining area, living room, group/activity room, and laundry room. There is an open kitchen area; an inside ventilated smoking area; and also an outside area that individuals will have access to with staff supervision. All living/sleeping quarters will comply with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.83
   c. Furnishing and equipment in each room/area
   Each room is furnished with all the necessary furniture (per code regulations) and individuals will be encouraged to personalize their space. Furnishing and equipment will comply with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.84
   d. Housekeeping and maintenance procedures
   The site's housekeeping and maintenance needs are coordinated and provided internally by NHS. All general housekeeping will be completed on a daily basis during the overnight hours. Individuals will

be encouraged to clean their bedrooms and personal areas. Staff will provide modeling and support as needed to help encourage skill development and independence in this area. The NHS maintenance department services all other site maintenance needs and holds contracts with a variety of specialty companies. Housekeeping and maintenance services will comply with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.85

e. Laundry service

Individuals will have identified days when the laundry area is available to them. Staff will also provide guidance and support in completing these tasks as needed. Laundry services will comply with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.86

f. Food service

All meals will be prepared on site by staff that have been trained and certified in safe food preparation. The site cook will work collaboratively with the clinical team to address all dietary needs or restrictions and ensure a healthy, well-balanced diet. Food service will comply with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.91

g. Outside area for use by the residents

This site would have a fenced outside area for use by the residents. This area is currently a blank canvas and would be developed with the input of individuals residing there to determine how it would best benefit the program. Other NHS residential sites have developed therapeutic gardens, outdoor group areas and recreational space.

10. Describe your organization's plan for health and wellness education.

    Health and wellness education will be provided on a regular basis. This education will include individualized (one-to-one) sessions, as well as, group discussions focused on tobacco use, drugs and/or alcohol and their impact on the individual's well-being, life styles, symptom management, use of medication, treatment, daily exercise, nutrition, and weight management. Individualized needs will be addressed in each individual's treatment/recovery plans as needed and agreed upon between the treatment team and the individual.

11. Describe how your organization will assist consumers in their development and maintenance of independent living skills

    To assist with each individual's plan for recovery, they will participate in an Activities of Daily Living Assessment. This assessment will be completed within 10 days of admission. Program staff will use this as one measurement tool to evaluate skills and abilities that will help identify the needed education and training to prepare for community living.

    Skills teaching will occur both one-on-one with the individual and in a group setting. The modality of service delivery will be determined by the individual and the way in which he or she deems best. All staff will be involved in the skill teaching and building process. Skills teaching will occur both within the facility and out in the community to ensure skills learned can be transferred into community living.

    Skills training can be provided in the following areas:

    - Self- administration of medication
    - Self management of medical and psychiatric signs and symptoms as well as program care.

- Diet and nutrition
- Exercise
- Social skill and activity development
- Vocation skill development
- Problem solving
- Time management
- Communication skills
- Relationship development
- Budgeting and money management

12. Describe how your organization's nursing care will monitor overall health and care management, including coordinating behavioral and physical health needs

    Medical care will include routine medical involvement such as evaluation, assessment of treatment response, recovery planning, and medication management. Nursing staff will help monitor and maintain physical health care, both internal to the program, as well as within the local community. NHS will seek out and coordinate with providers such as dentists, vision care providers, and other specialized medical services as needed. NHS has engaged with the local medical community and has formalized agreements with them for our other programs. We will pursue the same for this LTSR. In addition, ongoing coordination will occur between the nursing professionals and the individual's existing primary care physician in the community. Nursing care will be provided 24/7 to monitor overall health and care management. Nursing staff will work to develop relationships with local specialists, primary care physicians, and emergency rooms. This will be of utmost significance for individuals with complex chronic diseases.

13. Describe how your organization will collaborate with the criminal justice system and will utilize peer, family and natural supports and the clinical team (service coordination, community treatment team (CTT) and other specialized support services).

    NHS strives to develop effective working partnerships among probation, parole, the courts, service coordination, community treatment teams, neighborhood businesses, community housing organizations, and other service providers offering opportunities for released offenders to participate in restorative and therapeutic activities and community service projects. NHS also values and encourages engagement with natural supports and the use of peer support for ex-offenders with mental illness. Peer support provides a ready and accepting personal connection, as well as, access to a network of others who share similar experiences with the criminal justice system and reentry. Finding out that one is not alone while facing these challenges is an important aspect to achieving a successful outcome.

    Collaboration with formal and informal supports will include ongoing communication and inclusion in the development and implementation of treatment/recovery plans so that behavioral health and criminogenic needs can be met. Treatment/recovery plans will be tailored to the risks and needs that each individual presents and attention will be given so that individuals are not set up for failure and that any necessary conditions be recovery oriented, realistic, and enforceable when safety is of concern.

14. Describe how your organization will identify and treat consumers with co-occurring mental and substance use disorders.

The LTSR program will have the capacity to provide specialized support services including co-occurring mental and substance use disorders. Staff will have on-going training and experience in the following areas: Co-occurring disorders, Completing Drug and Alcohol Assessments, Recovery and Recovery oriented practices, and Motivational Interviewing. Individuals will also be provided the opportunity to attend weekly dual-diagnosis meetings offered at an external location to be used in conjunction with the treatment offered at the LTSR. Staff will accompany individuals to these weekly groups.

15. Describe how your organization will engage and coordinate with a consumer's probation officer.
    Appropriate information sharing between mental health and criminal justice systems ensures that criminal justice officials make informed decisions and that providers become better positioned to address the treatment needs of people with mental illness involved with the criminal justice system. Collaboration is critical to developing cross-system strategies that will advance public health and safety goals, as well as, meet individual treatment and support needs. Strong collaboration between our two systems emphasizes the shared understanding that each one has unique roles and responsibilities in addressing the needs of individuals involved with the criminal justice system. Information sharing with agents of the criminal justice system will be conducted in accordance with state and federal requirements and for the purpose of arranging appropriate treatment and not to jeopardize a person's rights in criminal proceedings.
    Mental health staff will be prepared to work with individuals who have been involved in the criminal justice system through training that will help to overcome the stigma attached to incarceration, address the special needs of individuals who have been incarcerated, and promote appropriate coordination with criminal justice agencies. Just as staff in the criminal justice system must recognize the need to learn new skills that will allow them to provide appropriate care for people with mental illness with whom they have contact, those who work in the mental health field must develop awareness of the special needs of people with mental illness who have been arrested and/or incarcerated. In order to help people with mental illness that have criminal histories to live in the community at large, NHS staff must understand the implications of those histories along with the imprint arrest and incarceration may leave on a person. They also must understand the criminal justice system itself so that they can interact productively with their counterparts in that system.

16. Describe how your organization will engage individuals who do not want to participate in group sessions.
    A successful engagement strategy begins prior to admission to the program. Meeting people who are being referred, building a relationship, and completing necessary assessments and other paperwork before someone is actually admitted to the program provides an opportunity to describe the program and services, explain expectations, and answer questions raised by the person. It also provides an opportunity to discuss their dreams, desires, and preferences in order that we may begin using and applying language that demonstrates how we will listen and regard them in a person-centered and recovery oriented manner throughout their course of treatment. Establishing

a working partnership with individuals that reinforces a process of shared decision making affords the person an opportunity to build trust and a sense of empowerment.

Collaboration and shared decision making between members of the treatment team, individuals, and their natural supports to come to an agreement about healthcare decisions will be a routine practice of the program. The practice of shared decision making involves offering the person information that will help them:

- Understand the likely outcomes of various options;
- Think about what is personally important about the risks and benefits of each option; and
- Participate in decisions about mental and physical health care.

Shared decision making has been practiced in general health care and is being adapted for us in mental health settings. It combines transparent information and decision making aids with respectful two-way conversations between a person and his or her service provider. The outcomes are treatment decisions that fit and reflect the person's personal values and preferences.

And since the application of shared decision making may also include areas of non-negotiation where safety and security is concerned, NHS staff will learn and be expected to navigate through more challenging areas and points of resistance through the ongoing and active involvement of the person's identified treatment team. Treatment information (including interventions and modalities imposed by the court), progress related to goals, objectives, and action items will be discussed routinely amongst the team so that innovative approaches can be attempted and adjusted as needed.

Communication and coordination with Allegheny County Department of Human Services and Community Care Behavioral Health will also be initiated during points of critical concern as it relates to a person's engagement of treatment services while at the LTSR so that all stakeholders are fully informed and engaged in appropriate treatment planning for the individual.

17. Describe how your organization will provide 24-7 crisis intervention, crisis planning, and hospital diversion.

    The LTSR will meet staffing levels in accordance with requirements outlined in Pennsylvania Code Title 55 Chapter 5320.42 and ensure timely and appropriate crisis response by applying strategies and techniques identified within an individual's Personal Safety Plan. The program will provide standards and practice guidelines for how staff and residents of the LTSR will enter into a "partnership of safety" through personal safety planning. Plans will be developed based upon information gathered through the completion of a Personal Safety Questionnaire. (It is preferred that questionnaires be completed whenever possible by a peer specialist.)

    Personal Safety Plans are developed within 72 hours of admission and then reviewed and enhanced within 10 days after staff have had the opportunity to get to know an individual better. Reviews of Personal Safety Plans will occur at regular intervals which align with the treatment planning process, as well as, within 24 hours following any crisis event. The objective is to learn alongside the person

what works best to avoid a crisis situation and then deescalate as soon as possible when one cannot be avoided.

While the focus of Personal Safety Planning is on the individual gaining insight into their own personalized methods and approaches for sustaining wellness, it also serves a shared system objective to implement effective hospital diversion strategies.

On call support is available as needed to provide appropriate clinical and administrative support whenever a crisis occurs during an evening or overnight shift.

18. Describe how your organization will develop individualized treatment plans based on consumer needs and strengths. Provide a sample of a treatment plan.
    Treatment planning within the LTSR is a recovery focused process that is driven by the individual. As such the treatment plan will abide by any and all regulatory standards relevant to both the residential and treatment setting. The overall plan NHS will use will be title a *Recovery Plan.* Recovery plans will be based upon the comprehensive assessment of the individual's medical, psychological, social, cultural, behavioral, familial, educational, vocational, spiritual/religious and developmental strengths and needs, abilities and preferences. Plans will include the following:
    1. Life Domains
        a. Living
        b. Learning, Working, Recreation
        c. Mental Health
        d. Physical Health
    2. Identification of long and short term goals, including discharge;
    3. Objectives and strategies for each goal;
    4. How the resident's strengths, needs, abilities and preferences will be utilized and built upon;
    5. The person responsible for identified actions or tasks; and
    6. Time frames in which the goals and objectives will be evaluated for completion;

    Each resident will choose elements within 4 Life Domains to build their recovery plan on. These Domains include Living, Learning/Working, Mental Health, and Physical Health. Each plan will also incorporate a discharge plan and a Wellness Recovery Action Plan should the individual choose. Individuals will work on one formal short term goal within each domain where a recovery goal has been identified. Each individual will also have the opportunity to participate in other skill building and learning opportunities. These will be documented and evaluated in progress note section of an individual's record. Some examples of these opportunities that are available within the EAC include Educational Groups, Skills Training, Counseling/Support Groups, and Recreational/Leisure Group and Activities.

19. Describe your organization's plan for consumers to participate in vocational or educational programming, paid employment or volunteering.
    Participation in vocational or educational programming, paid employment or volunteering will be integrated throughout the treatment and recovery planning process. This includes deliberate information gathering during the intake and assessment process, as well as, incorporation into

individual plan development and ongoing reviews. Opportunities will be explored on an individualized basis based upon the goals, desires, and preferences of the person, as well as, contingent upon the assurance of safety for the person and community. Local community vocational and educational resources will be utilized along with the exploration of more non-traditional opportunities as identified by members of the individual's treatment team.

20. Describe your organization's strategy for involving the consumer, family and other providers in treatment planning.

    As previously mentioned, program staff will actively seek involvement and participation from the person, their family (as identified by them), and other providers in treatment planning process. This will include inquiries and information gathering from the referring entity related to supports already engaged in providing treatment or support to the individual, dialog with person related to supports they find or have found helpful, and outreach to other identified providers and community supports as appropriate to ongoing treatment or for the purposes of discharge planning and engagement.

    With the individual's permission, identified providers and natural supports will be invited to participate in treatment planning and other meetings to address progress towards meeting the individual's needs. Other communication and collaboration will also occur as needed while serving the individual.

21. Describe your organization's discharge planning procedures.
    Discharge planning will begin upon admission to the program. As part of the treatment planning process, discharge planning will include the individual, family and/or supports as identified by the resident, LTSR program staff, county case management, managed care staff, and other community resources. Community resources and natural supports will be engaged and educated so that individuals transitioning from the program are afforded a greater degree of continuity of care and higher probability of success.

    Aftercare planning and coordination with MH/MR providers, educational/vocational programs, housing providers, alternative services, support groups, therapeutic activities, community programs and natural supports will occur as identified in each individual's recovery plan. Primary responsibility for coordinating discharge, after care and transition planning will be with the designated Mental Health Professional (MHP). With each discharge plan, LTSR staff will work with individuals to identify goals and services that will support and encourage recovery, as well as, focus on integration within their community. The MHP will assist in identifying community resources and supports and work towards facilitating a successful transition for discharge. This facilitation will include active stakeholder engagement, mental health/recovery and LTSR education, and coordination of care and supports.

    The MHP will engage and collaborate with the Certified Peer Specialist in support of achieving each individual's recovery goals. Community providers, stakeholders and natural supports will be

engaged in the discharge process and offered education so that an individual's recovery plan can be sustained following transition. This education will include information about mental health, recovery, and the strengths, needs, abilities and preferences of the individual so that continuity of care and support can be provided.

The MHP will to ensure follow through on actions pertaining to recovery plan implementation and discharge planning. This could include formal supports such as substance abuse providers, parole officers, residential providers, Assertive Community Treatment teams, Case Management, etc. This will also include any and all informal and natural community supports such as family members, a neighbor, a faith community or community organization.

22. Describe your organization's therapeutic program activities and the role of the interdisciplinary treatment team.
Each individual will have the opportunity, several times each day, to participate in individual, group and family therapy, whereby the clinicians will utilize Clinical Practice Guidelines to ensure best practices. The type and frequency of these sessions will be identified in each Recovery Plan. A weekly schedule will be posted in the facility to assist individuals in identifying which groups they plan to attend. They will be offered as follows:
    - Individual therapy: The frequency will be determined by the needs of the individual and can be scheduled as often as daily if requested by the individual. Therapy will be provided a minimum of two times per week.
    - Group therapy: Daily
    - Family therapy: The frequency will be dependent on the family's level of involvement, as well as their availability and ability to come to the facility. Teleconference will also be available for families who are unable to travel to the program.

23. Describe your organization's intake and admission process.
PRE-ADMISSION:

A. Referrals:

1. The LTSR Director or designee will submit the Weekly Residential Vacancy Report via email on the Monday of every week to Allegheny County (Office of Behavioral Health) Housing team to provide notice of anticipated discharges and current vacant beds to be filled.

2. The Allegheny County – OBH Residential Referral Form (Attachment B) is then faxed to the LTSR and reviewed by the Director or designated MHP.

3. The Director or designated MHP will meet with the individual being referred within 72 hours. The purpose of this meeting is to:

    a. Establish a relationship with the person being referred;

    b. Provide information about the program and answer questions;

    c. Meet with referring program staff (most often inpatient) to gather additional information, address program admission requirements and schedule a discharge meeting as needed; and

d. Identify preliminary treatment and recovery goals.

4. Whenever possible, a tour of the program will be scheduled with the individual.

B. Review & Admission Planning:

1. **Eligibility Review:** Prior to approving an admission, the Director or designated MHP will verify that required program admission criteria have been met according to Pennsylvania Code Title 55 Chapter 5320.31. Verification must include a review of provided documentation to ensure all of the following:

a. The individual is 18 years of age or older (included in admission packet).

b. Serious Mental Illness criteria are met.

c. The person's psychosocial needs significantly inhibit independent living in the community per the referring entity (psychosocial assessment provides, at a minimum, the mental, physical and social needs of the person).

d. A Physical examination has been completed not more than 6 months prior to date of admission;

e. A Psychiatric examination has been completed not more than 6 months prior to date of admission.

f. Current commitment documents for Involuntary treatment or qualification for voluntary treatment under section 201 of the act (50 P.S. § 7201). **Prior to admission, involuntary commitment documents must reflect an order for treatment at the LTSR.*

g. Physician's Certification that the individual does not require hospitalization, nursing facility care or a level of care more restrictive than an LTSR, written within 30 days before admission.

Clinical (MHP) and Medical (Nursing) Review: In addition to the regulatory requirements above, the designated MHP and Nurse staff will ensure the following information is requested, obtained and reviewed on or before the date of admission.

1. A completed MA 51 within 30 days before admission indicating that the person *is capable of self-preservation with minimal assistance* as verified by Item #20 on the form. The physician must have selected "other" on the form and documented "LTSR" for the NHS Human Services LTSR
2. Insurance Information (copy of card when available)
3. Most recent Treatment Plan from current provider
4. Aftercare/Discharge Summary from previous placement (may not be immediately available)
5. Current Medications with Prescriptions
6. PPD or recent chest X-ray screening for Tuberculosis.
7. Recent Laboratory Results (i.e. Complete Blood Count and Differential, Thyroid, Cholesterol, Glucose, Etcetera, and Clozaril level when applicable)

8. Hepatitis screen results should be requested, but may not be available
9. Authorization from the County

Admission Planning: When a determination is made to move forward with admission (the individual, LTSR, and inpatient treatment team or referring entity are in agreement), the MHP (or Director if MHP is not available) will:

1. Coordinate with the referring entity to ensure all required documentation above is provided.
2. Fax the completed Admission Response Form (Attachment - provided upon referral) to the Allegheny Housing Office providing the planned date for admission.
3. Request all current prescriptions from the referring entity along with a 30 day supply to arrive with the individual upon admission.
4. Coordinate date of admission giving consideration to the following:
    a. It is the responsibility of the referring entity to coordinate transportation for all individuals being admitted to the LTSR.
    b. Admissions are typically scheduled on Tuesdays, Wednesdays, or Thursdays due to the psychiatrist's schedule and program requirements to ensure that an evaluation occurs within 72 hours of admission per the LTSR regulations. However, other arrangements can be made in advance with the psychiatrist as needed and agreed upon.
    c. Admission times will vary based upon transportation services.

24. Describe your organization's record management system.

All documentation is completed within 24 hours of the date of service and all clinical documentation is reviewed for quality prior to filing. The program's filing and charting is completed and maintained on site in compliance with the Pennsylvania Code Title 55 Chapter 5320.64. NHS follows a corporate record retention policy and procedure for records relocated off site.

<u>Program Evaluation and Quality Improvement</u> (10 points, 2 pages)

25. Describe specific outcome measures related to evaluation, including the method and means of collection and reporting of these measures. At a minimum, these outcome measures should include: 1) clinical functioning; 2) community functioning and 3) consumer/family satisfaction.

The LTSR Program will serve individuals with severe and persistent mental illness and have a history of psychiatric hospitalizations as a result of their illness. The following are critical outcomes that reduce the likelihood of more intense, restrictive modes of treatment, such as hospitalizations or incarceration.

<u>Outcome 1 – Increase Community Tenure</u>

Individuals receiving services through the LTSR Program will successfully manage their mental illness in the community, without the need for more intensive inpatient hospital treatment.

Outcome Measure

The ultimate success of the LTSR Program will be measured by its ability to successfully support individuals with complex service needs in the community. The LTSR Program will monitor psychiatric admissions and adapt individual *Residential Treatment Plans* and *Wellness Plans* to reduce the frequency and duration of hospitalizations.

The following monitors are related to psychiatric hospital admissions:

1. The number of individuals receiving LTSR Program services who are admitted to psychiatric hospitals.
2. The length of each stay in psychiatric hospitals for each admission.
3. Precursors to hospitalization as they relate to Program services; e.g., participation in agreed upon treatment modalities and medication management.

Outcome 2 – Maintaining Treatment

Consumers of the LTSR Program will maintain their chosen treatment regimen, as indicated in the collaborative Residential Treatment Plan, by attending 100% of scheduled appointments with psychiatrists, nurses, therapists, or external service providers.

Outcome Measure

Scheduled appointments will be tracked and compared with attendance. An attendance rate will be calculated on a monthly basis. The data will be used to adapt individual *Residential Treatment Plans* and facilitate maintenance of treatment regimens.

Outcome 3 – Consumer and Family Satisfaction/Quality of Treatment

Individuals and Family members will indicate their overall satisfaction with treatment and the LTSR.

Outcome Measure

Individual and family satisfaction survey will be sent to individual and family members twice per year. Individual will indicated that they are satisfied or highly satisfied with services.

In addition to the outcomes noted, NHS also utilizes a variety of data elements to measure other areas of quality within the LTSR programs. The NHS residential programs currently meet on a regular basis for a quality improvement meeting to review program goals and trends.

26. Explain the methods your organization will use to ensure that services are being provided in accordance with the program model.

Quality Assurance at NHS is coordinated and supported by the Quality and Compliance Organization (QCO) which is led by the Senior Vice President of Quality and Integrity. The quality assurance systems embedded in the QCO include a recurring documentation audit process in which records are reviewed

either monthly or quarterly following a PQI Audit Plan and results are analyzed within and between Programs of the same type in organization-wide recurring meetings termed "Product Teams". In these meetings corrective action plans, best practices and policy modifications are discussed. Additionally, quality assurance is included in the safety reviews and business integrity and operations hotline where any issues relating to quality and compliance are designated for review by a QCO member in collaboration with Programs.

Program leaders across the organization develop and implement performance improvement strategies that are driven by the data aggregated by the QCO and presented to the Program. The QCO assists in implementation and monitoring as well to ensure consistency and follow up to actions recommended based on the data. The QCO works directly with Program management to ensure a thorough and well defined response to all deficiencies and shares best practices identified in other parts of the organization to help strengthen the quality of the services provided. All of the above actions are cataloged and tracked within the QCO's case management database to support universal change and monitoring of efficacy.

Vignettes (20 points, not included in page count)
Using the two vignettes below, please describe how your organization would serve these individuals in the Program and provide a sample treatment plan.

Vignette 1: Sam is a 51 year old healthy African American male who was admitted to the state hospital on 5/24/09. He is diagnosed with Schizoaffective Disorder, Bipolar type 2 and Personality Disorder. His history indicates some instances of sexually inappropriate behaviors. He is currently on an all-male ward that has programing for sexual responsibility. He typically follows the rules on the unit but at times can be intimidating to others. He has little insight into his sexually inappropriate behaviors. There have been no reports of him acting out sexually while hospitalized. Although Sam denies suicidal and homicidal ideation, the team is concerned for his safety due to having little insight into his sexually inappropriate behaviors.

NHS will initiate services through relationship building with Sam prior to admission into the program. During the initial meeting(s), Sam will be provided with information about the program and his questions will be answered so that expectations are clarified as needed. Staff will also make inquiries that allow the completion of our own assessment and begin the process of identifying preliminary treatment and recovery goals. These goals will be designed to address concerns presented by the state hospital staff in a fashion that is strengths based, person centered, and in alignment with Sam's personal goals, desires, and preferences. This approach will be balanced with careful and diligent attention towards ensuring safety.

A nursing review of information provided will be completed prior to admission with follow up clarification and coordination occurring as needed. Sam's information will be reviewed by the program director and shared with the treatment team so that any of Sam's specific needs can be

prearranged. Discussion with current staff (nursing, psychiatrist, and social worker) will occur in order to attain a better understanding about effective and ineffective treatment approaches, as well as, other support nuances which may not be reflected in written documentation. Current and past service providers and natural supports will be explored and engaged in information gathering and planning as indicated.

Vignette 2: Dan is a 45 year old single Caucasian male. He was admitted to the Regional Forensic Center 10/28/15 for restoration of competency. He is currently not competent to stand trial and likely competency is not restorable. He is diagnosed with Paranoid Schizophrenia and Anti-social Personality Disorder. Dan is convinced that he is being invaded by the CIA. This delusion is also accompanied by auditory hallucinations. Upon admission to the state hospital forensic unit he was cooperative, however, his reliability was questionable due to his delusions. Dan is also diagnosed with diabetes. He presented recently with a blood glucose level of 500. He is being maintained on medications. He has made inappropriate advances to staff and peers which cause him to lose his ground card. The team is concerned for his physical health, his current delusional behavior and his little insight into his inappropriate sexual behaviors.

The same philosophical (recovery oriented and person centered) approaches described above for Sam will be utilized in the program's approach to serving Dan. Obviously, areas of particular concern relate to his inappropriate advances to staff and peers and his physical health. The program will make further inquiries with forensic center staff into these areas and incorporate effective treatment strategies for ensuring staff and peer safety. Group and individual education will be provided in order that all residents understand and have proper supervision/support related to appropriate and inappropriate behavior within the program. Personal and physical boundaries will be communicated and reinforced as needed so all individuals in the program feel safe and supported. Additional information will be requested regarding the time frames provided for competency restoration and transition to civil commitment. Any restrictive measures applied as a result of inappropriate behavior will be managed through the treatment team and documented in the treatment plan.

<u>Financial Management and Budget</u> (15 points, not included in page count)

27. Provide evidence of your organization's financial health by attaching its most recent audit or other financial documentation.
28. Attach a detailed start-up budget and annualized budget that clearly supports the proposed model and the implementation plan.
29. Provide a budget narrative that reflects a realistic estimate of the costs associated with implementing the Program.
    See attached budget with narrative detail

ATTACHMENTS

RFP Response Form

Long Term Structured Residential Program for Individuals with Serious Mental Illness Including Individuals Being Diverted or Released From Inpatient and Criminal Justice Facilities

Please submit the following attachments with your Proposal. These can be found at http://www.alleghenycounty.us/dhs/solicitations.

- Cover Page
- MWDBE Participation Statement or Waiver Statement
- W-9
- Allegheny County Vendor Creation Form
- Organizational Chart
- Job Descriptions
- Audited Financial Report
- Start-up and annualized budget

CERTIFICATION

Please read the below statement and check the box to indicate agreement with its content.

X By submitting this proposal, I certify and represent to the County that all submitted materials are my work and that all responses are true and accurate.

NHS Human Services: LTSR Budget
Date Completed: 6/24/16

Detailed Accounts	12 mth Annual	6 Month Start Up	Total	COMMENT/NARRATIVE
Personnel Expenses				
Full Time	581,558	210,011	791,569	14 FT positions.
Part Time	94,127	35,298	129,425	9 PT positions.
Straight Time/ Overtime	89,818	33,616	123,434	Estimated costs for benefit (pto) coverage for 14 FTE's.
Employee Benefits	179,893	65,547	245,441	FICA, Workers Comp, Unemployment, Pension, Estimated H&W.
Misc. Personnel Expense	10,226	5,115	15,341	Staff trainings, EAP expense, credentialing services, staff physicals.
Total Personnel	**955,623**	**349,587**	**1,305,209**	
Operating Expenses				
Rent	87,000	43,500	130,500	Estimated rental costs.
Utilities	16,571	8,285	24,856	Estimated utilities costs (electric, water/sewer)
Bldg Maint / Housekeep	32,473	31,000	63,473	Startup includes one-time renovations. Annual includes estimated R&M.
Communications	5,140	2,570	7,710	Estimated telephone costs.
Office Supplies	3,084	1,940	5,024	Estimated office supplies for staff.
Residential Supplies	-	2,500	2,500	Estimated house décor for start-up.
Rehab Supplies	625	315	940	Estimated expenses for consumer.
Insurance	11,014	5,510	16,524	Property/Liability/Auto Insurance
Transportation	6,375	3,190	9,565	Staff travel using their personal vehicles ($0.40/mile) and gas card for auto.
Food	33,195	16,600	49,795	Food costs for consumers/staff.
Client Activities	6,002	3,000	9,002	Outings/supplies for client activities.
Misc. Operating Expenses	19,226	9,615	28,841	Local site estimated costs.
Total Operating Expenses	**220,705**	**128,022**	**348,727**	
Total Direct Costs	**1,176,328**	**477,609**	**1,653,936**	
Indirect Costs				
Furniture/Equipment	5,000	50,700	55,700	Start-up includes one-time purchased to furnish home. Annual budget includes replacements.
Motor Vehicles	8,022	4,015	12,037	Auto lease and repairs/maintenance.
Admin Costs	154,615	69,202	223,817	Based on 13% of net operating costs.
Total Indirect Costs	**167,637**	**123,916**	**291,554**	
Total Expenses	**1,343,965**	**601,525**	**1,945,490**	
Revenues				
Room and Board	45,924	11,960	57,884	Estimated collections from consumers for room and board.
Other Revenue	-	-	-	
Total 3rd Party revenue	**45,924**	**11,960**	**57,884**	
Net Expenses	**1,298,041**	**589,566**	**1,887,607**	