Allegheny County Department *of* Human Services

RFP Response Form

RFP for Alternative 9-1-1 Emergency Response Pilot

PROPOSER INFORMATION

Proposer Name: Resources for Human Development, Inc.

Authorized Representative Name & Title: Linda Donovan-Magdamo, Chief Program Officer

Address: 4700 Wissahickon Avenue, Suite 126, Philadelphia, PA 19144-4248

Telephone: (215) 951-0300

Email: Ldonovan@rhd.org

Website: www.rhd.org

Legal Status: ☐ For-Profit ☐ [X] Nonprofit ☐Sole Proprietor/Individual ☐Partnership

Women Owned: ☐ Yes ☐ No

Minority Owned: ☐ Yes ☐ No

If yes, select the ethnicity:

☐ American Indian or Alaska Native
☐ Black or of African decent
☐ Hispanic or Latino/a
☐ Native Hawaiian/Pacific Islander
☐ Western Asian/Middle Eastern
☐ East Asian/Far Eastern
☐ South Asian/Indian (Subcontinent)
☐ Southeast Asian
☐ Other Asian
☐ Multi-racial

Self-Describe: Click here to enter text.

Faith Based: ☐ Yes ☐ [X] No

How did you hear about this RFP? *Please be specific.* Email announcement

SUBCONTRACTING

Partners/subcontractors included in this Proposal: Not applicable.

If you have identified partners, how will you utilize them? Describe why it is best to subcontract for the roles/tasks you identify. Describe your organization's experience subcontracting with

service providers, including examples of how you have identified high-quality subcontractors and managed the performance of those partners in the past.
Not applicable.

PROPOSAL INFORMATION

Total dollar amount requested: $2,296,121.00
Which pilot area(s) are you proposing to service?

☐McKees Rock Pilot Area ☐Penn Hills and Monroeville Pilot Area ☐ [X] Both

REQUIRED CONTACTS

	Name	Phone	Email
Chief Executive Officer	Marco Giordano	(215) 951-0300, ext. 3643	Marco@rhd.org
Contract Processing Contact	Gary Vinson	[redacted]	Gary.Vinson@rhd.org
Chief Information Officer	Currently Vacant	N/A	N/A
Chief Financial Officer	Deanna Cerwin	(215) 951-0300, ext. 3644	Deanna.Cerwin@rhd.org
MPER Contact*	Crystal Bacon	[redacted]	Crystal.Bacon@rhd.org

** MPER is DHS's provider and contract management system. Please list an administrative contact to update and manage this system for your agency.*

BOARD INFORMATION

** For the Board Chairperson, you must list an address, phone and email address different than the organization.*

Board Chairperson Name & Title: Diane Menio, Executive Director (for The Center for Advocacy for the Rights and Interests of the Elderly (CARIE))

Board Chairperson Address: [redacted]

Board Chairperson Telephone: [redacted]

Board Chairperson Email: Partners included in this Proposal: [redacted]

How did you hear about this RFP? *Please be specific.* Email

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, including a brief description of the prior work you have done with them.
Please do not use employees of the Allegheny County Department of Human Services as references.

Reference 1	Contracting Jurisdiction/Agency	New Orleans Department of Health
	Name and Role	Travers Kurr, Behavioral Health Special Projects Coordinator
	Email Address	tkurr@nola.gov
	Phone Number	[redacted]
	Project Description	RHD has a contract with the New Orleans Health Department to provide a community responder model service, New Orleans Mobile Crisis Intervention Unit (MCIU), as the fourth branch of the emergency response system.
	Project Start and End Dates	September 2022- September 2025 with an option for renewal.
Reference 2	Contracting Jurisdiction/Agency	Jefferson University
	Name and Role	Catherine VanFossen, Grants Principal Investigator, Project Director, Project Evaluator
	Email Address	Catherine.vanfossen@jefferson.edu
	Phone Number	[redacted]
	Project Description	SAMHSA CCRP Grant Recipient- partner with RHD. This funding is to expand mobile crisis services in Monroe County. An aim of this project is to improve partnerships with first responders in the County, including developing alternative diversion programming.
	Project Start and End Dates	9/30/22-9/30/26
Reference 3	Contracting Jurisdiction/Agency	Mercy Behavioral Health CTT
	Name and Role	Eric Hess, Forensic Specialist
	Email Address	ehess@pittsburghmercy.org
	Phone Number	[redacted]
	Project Description	Mercy Behavioral Health CTT has been working closely with RHD to support Glassport LTSR CTT consumers in the program since it was opened in 2019.
	Project Start and End Dates	2019 – ongoing

CERTIFICATION

Please check the following before submitting your Proposal, as applicable:

☐ [X] I have read the standard County terms and conditions for County contracts and the requirements for DHS Cyber Security, EEOC/Non-Discrimination, HIPAA and Pennsylvania's Right-to-Know Law.

☐ [X] By submitting this Proposal, I certify and represent to the County that all submitted materials are true and accurate, and that I have not offered, conferred or agreed to confer any pecuniary benefit or other thing of value for the receipt of special treatment, advantaged information, recipient's decision, opinion, recommendation, vote or any other exercise of discretion concerning this RFP.

Choose one:

☐ My Proposal contains information that is either a trade secret or confidential proprietary information and I have included a written statement signed by an authorized representative identifying those portions or parts of my Proposal and providing contact information.

OR

☐ [X] My Proposal does not contain information that is either a trade secret or confidential proprietary information.

ATTACHMENTS

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

- Partner commitment letters, if applicable - *(Not applicable.)*
- MWDBE and VOSB documents - *(Not applicable. These forms were submitted in 2022 with RHD's proposal response to START RFP that we were selected for a contract)*
- W-9 - *(Uploaded as a separate attachment)*

REQUIREMENTS

This is the Response Form for Proposers proposing to provide the Alternative Response Team AND the Follow-Up Team. Please respond to the following. The maximum score a Proposal can receive is 275 points. Your response to this section should not exceed 20 pages. (Pages 1-4 are not included in the page count).

THIS RESPONSE FORM IS ONLY FOR PROPOSERS PROPOSING TO PROVIDE THE ALTERANTIVE RESPONSE TEAM AND THE FOLLOW-UP TEAM.

CATEGORY 1: QUALIFICATIONS, EXPERIENCE AND CAPACITY (50 Points)

1. Qualifications and Experience (10 points)

a. **Overall qualifications**

Founded in 1970, Resources for Human Development is a nonprofit, tax-exempt organization registered to conduct business as a 501(c)(3) corporation. RHD has more than 50 years of experience providing a variety of programs, with particular emphasis on serving populations with mental illness, substance use disorders, developmental disabilities, and homelessness. As a diversified organization RHD currently operates 133 programs and has contracts with federal, state, county, and city agencies to operate programs in 12 states. Over 80% of our programs are in Pennsylvania. RHD has extensive experience in a wide range of human services including the development of community-based mobile crisis programs and alternative dispatch programs. Over the course of its history, RHD has focused its organizational energies toward developing innovative and effective systems and services that enable individuals with disabilities to participate in life to the fullest extent.

RHD is uniquely qualified to take on this scope of work due to our existing presence in Allegheny County, our expertise in delivering mobile crisis and alternative dispatch programs fueled by an organization-wide passion for this work, and the advantage of being able to draw on expertise from multiple disciplines across the country. RHD has served the residents of Allegheny County for over 15 years providing peer-run services, adult Long-Term Structured Residences (LTSR), addiction recovery, and services for people with intellectual and developmental disabilities. We have been operating mobile crisis programs for over 25 years and have successfully launched a similar program in New Orleans, the Mobile Crisis Response Unit (MCIU). RHD also provides follow-up services in a number of programs and is prepared to do so in Allegheny County.

b. **Experience:**

As a trusted provider in the field, RHD has expertise in providing and innovating services for people experiencing behavioral health crises, along with a constellation of other services for people experiencing homelessness, addiction recovery, physical health care, and for those with intellectual and developmental disabilities (IDD). During that time, in order to elevate service delivery, RHD has gained significant experience building coalitions of diverse stakeholders which focus on implementation and evaluation. RHD has been operating community-based mobile behavioral health programs such as Assertive Community Treatment (ACT) teams for over 20 years and is currently the 988/Lifeline provider for 27 counties in Pennsylvania. We operate four mobile crisis programs in two states and were recently contracted to provide START in Allegheny County, the first mobile crisis team in Pennsylvania specifically for people who are dually diagnosed with IDD and severe, persistent mental illness. Our mobile crisis teams and follow-up teams provide trauma-informed services in the community, literally meeting

people where they are. This includes homes, libraries, fast food restaurants, shelters. RHD staff are prepared to dispatch to any location that is within the service area and is safe. At their core, RHD's mobile crisis services are dedicated to keeping residents in the least restrictive environment: in the community and out of psychiatric hospitals.

2. Staffing, Capacity and Oversight (40 points)

a. Team and staffing overview

Staffing

Staffing for the program will include: Program Director, Assistant Director, Program Assistant, Licensed Mental Health Professionals and Crisis Workers. Crisis Workers may be Certified Peer Specialists, Bachelor's level clinicians, or Mental Health Technicians. Teams will ideally include a master's level crisis worker/master's prepared clinician and a peer specialist. RHD will hire for these positions; full qualifications for each position are below. RHD proposes the A9ER program consist of two 8-hour shifts each day. Each shift will consist of one alternative response team at each location, one "floating" team available to serve either location, one follow-up team member per location, and one licensed clinician serving both locations. This staffing pattern is based on DHS's prediction of 2-6 dispatches per day per location.

Key Team Members

RHD's strength lies in its leadership and staff. The leaders listed below have significant experience in implementing and overseeing mobile crisis programs, Allegheny County service provision, financial planning and oversight, and effective quality assurance.

Gary Vinson, MA, Service Line Director Behavioral Health and Housing, Pennsylvania.
Gary has over 30 years of experience leading various Behavioral Health programs for 3 Nationally recognized organizations in Pennsylvania. He has over 10 years' experience leading diverse and complex Behavioral Health programs including mobile crisis teams, residential crisis, outpatient services, homeless services, Assertive Community Treatment (ACT) teams, and residential services.

Michael Usino, Regional Director, Behavioral Health and Housing, Pennsylvania
Michael has over 25 years of experience providing direct services and leadership to a diverse workforce, and has been with RHD for over 9 years. During that time, Michael has provided leadership and support to multiple programs within the PA BHH+ Service Line. Michael oversaw the crisis programs in NE PA, including Crisis Residential, Crisis Mobile Response and Crisis Telephones and is currently overseeing the START program in Allegheny County. As a Regional Director, Michael provides leadership and support to 6 additional programs within the division.

Claire Ryder, Director of Business Development and Innovation
During her time at RHD, Claire has supported the design and implementation of nearly a dozen new programs including the New Orleans Mobile Crisis Intervention Unit (MCIU). She is a member of the International Crisis Response Association (ICRA) and has presented this model to

988/911 workgroups and community advocacy organizations. Claire is currently completing her course work for a doctorate in Population Health at Jefferson University. Her dissertation explores staff safety in civilian crisis response models. Claire has a master's degree in clinical psychology and has six years' experience in mobile crisis response and community trauma.

Lisa Feldman, Director of Program Implementation
Lisa is a Licensed Clinical Social Worker with more than 24 years' experience working both clinically and administratively in the human services field in Pennsylvania and New York City. At RHD, she has worked in both direct service and leadership roles. Her current role includes working within the Behavioral Health and Housing division on all new program development, as well as all expansions of existing services. She is also liaison with our Property department regarding renovations and construction at current sites.

Qualifications for positions not yet hired

For each position below, preference will be given to those with crisis and/or public safety experience and a strong understanding of local needs. All positions require a valid driver's license.

Program Director: The Program Director is accountable for ensuring that the program is managed and held to the highest standards. This includes clinical quality, quality assurance, financial management, funder requirements, recruitment and retention, communications, compliance, revenue cycle, and general program operations. Master's degree in social work, psychology, counseling or closely related field, LCSW or LPC preferred. Minimum 5 years' experience in human services, with 2 years supervisory experience.

Assistant Program Director: The Assistant Program Director provides leadership to staff in collaboration with the Program Director. The APD will assist the director with staff supervision, training, and hiring. The APD is responsible for helping to ensure all program operations are conducted in an ethical and professional manner. Bachelor's degree with a major in human services or business management. Minimum of three years of experience in a human service agency in which they provide supervision, direct service, and program planning.

Licensed Clinician: The Clinician ensures that all operating procedures and regulations are followed. Clinicians support Crisis Workers in the field either virtually or as needed. Clinicians are often required to collaborate with family members, psychiatrists, law enforcement, Coroner's office staff, hospitals and others. Master's degree in social work, psychology, counseling, or a closely related field and an LMSW or PLPC is required. LCSW or LPC is preferred. Clinicians must have a thorough knowledge of substance abuse intervention and treatment, crisis management, case management, family dynamics and familiarity with psychiatric diagnosis per the DSM-IV. They must have a minimum two years of clinical experience.

Crisis Worker: The function of the Crisis Worker is to provide clinical services to consumers. The Crisis Worker job responsibilities include assessment, mental status exams, crisis intervention, treatment planning, and provision of therapeutic intervention, including follow-ups. Bachelor's degree in a health or human services field and three years of related experience or be a certified recovery specialist or certified peer support.

b. **General capacity:**

RHD is confident in our capacity to serve both pilot sites and to successfully expand the A9ER program including extended hours and additional municipalities and call types. We have a long history of expanding programs, adding locations, and hiring staff to meet the growing needs of the communities we serve. Program expansion is supported by the same structure that supports new program implementation: vast internal resources that draw on the expertise of directors and staff with decades of experience in the field and in Allegheny County. RHD's leadership supports expansion in this area in particular; a program expansion will have the full weight of the organization behind it to ensure success. Leadership will assess the capacity of current regional staff and respond accordingly by hiring an additional Regional Director if needed. RHD will also work with our community partners and stakeholders to assess the unique needs of other municipalities.

c. **Program structure:**

The A9ER program will be housed within RHD's regional Behavioral Health and Housing (BHH) Division, which serves all of Allegheny County. The BHH division implements and oversees all programs related to behavioral health including mobile crisis, addiction recovery, and mental health services. Gary Vinson, BHH Service Line Director and Mike Usino, Regional Director will oversee implementation. They each have decades of experience implementing and managing crisis programs. Gary and Mike also oversee the START program, a collaboration between RHD, Allegheny County DHS, and The Center for Start Services. The A9ER program will not only be supported and bolstered by the expertise in our BHH division but also by the capacity of the entire organization.

d. **Management, administrative and technical capacity:**

Management Structure

RHD's management structure is organized along two service lines, the Behavioral Health and Housing Division (BHH) and the Intellectual and Developmental Disabilities Division (IDD). BHH manages all of RHD's mental health, substance use disorder, and housing services nationwide. The BHH division is internally organized by geographic area to promote synergy between these services in any given city, state, or region. Regional Directors provide support and oversight to program directors and their staff, with the full weight of the organization supporting implementation.

Implementation

BHH leadership meets regularly as a national team to share lessons learned and ensure strong relationships between the regions. This allows programs in different parts of the country to support each other, especially with the development and implementation of new projects. The leadership team is made up of experts in a variety of behavioral health specific subjects and is further supported by the Business Development (BD) department which takes the lead on RHD's social innovation, as well as the Outcomes and Data department, and the Department of Clinical

Innovation and Quality (DCIQ). RHD's most recent innovative program, MCIU, launched on June 1, 2023 after nine months of inter-departmental collaboration to support implementation.

Retention

Our current strategic plan highlights the importance of retaining qualified staff; RHD strives to be an employer of choice. We have instituted agency-wide wage increases for program staff, hiring and retention bonuses, support for wellness and to reduce burnout, and have recently begun emphasizing the importance of the physical environment (office space) to demonstrate RHD's appreciation of staff. Our Environmental Design specialist is consulted in program implementation to ensure we are providing staff with an environment that promotes overall wellbeing.

Service Delivery

In order to provide high-quality services across programs, RHD has engaged in a number of initiatives to support staff development, training, and supervision, as well as data driven decision making and continuous quality improvement. At RHD, we believe it is critical to have an effective training infrastructure to deliver consistent and quality training as well as monitor, track and report on training compliance. RHD has a Learning Management System (LMS), specifically Cornerstone, that provides access to synchronous (live, virtual instructor-led) and asynchronous (eLearning courses, videos, micro-learnings and recorded webinars and videos) content. RHD's Cornerstone LMS offers access to a robust Behavioral Health library of eLearning content that includes, but is not limited to topics such as de-escalation, behavioral interventions, clinical approaches, motivational interviewing, autism, crisis prevention and intervention, and many related topics available to our employees to support skill development appropriate to their role and enhance the quality of service provided. Providing experiential and social learning opportunities assist our employees in practical application of concepts. This includes the opportunity to shadow other employees, group discussion and reflection, practicing skills, receiving regular feedback and coaching from peers and their supervisor. RHD programs engage in CQI, described in more detail in Category 4 below. Our supervision strategy is outlined in the Supervision section.

e. **Recruitment and retention:**

Recruitment

The driving force behind a successful program is a qualified, supported workforce. RHD has instituted significant wage increases and other recruitment and retention measures and continues to look for innovative ways to attract the highly skilled workforce needed to deliver high-quality services. RHD has budgeted for salaries in line with the competitive human services labor market, in order to recruit and hire qualified civilian crisis responders as quickly as possible. RHD has a creative and talented Talent Acquisition Team who continuously tracks and assesses recruitment and retention data and trends internally as well as in the field overall. In addition, RHD has a very strong employee referral network and will leverage this to increase applicant flow. Positions will be posted in our Applicant Tracking System (ATS) and to external job boards and posted on Better Teams which posts to over a thousand job boards. The TAR Specialists also use Indeed Resume sourcing to invite candidates to apply and can post positions on specialty boards such as PA Certification website, Career Link, and NASW. On average, RHD has been able to recruit and hire for positions within 80 days of posting.

Retention

Creating a workplace that is supportive, equitable, appreciative, and creative helps to keep staff engaged and committed to the program. Staff wellness is a priority for RHD and a special focus has been put on staff wellbeing as a tool for both quality assurance and retention. Staff wellness spaces in the office, a welcoming office environment, and financial investment in the program and staff all serve to support this priority. They are encouraged to attend to their health including taking time for appointments, rest, and balance. Both the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Center for Disease Control and Prevention (CDC) recognize the risk for compassion fatigue or burnout in emergency responders, including crisis counselors. EAP is available for all staff and supervisors will encourage the use of it, especially after particularly difficult interventions.

f. **Supervision**

Effective supervision promotes high-quality services and higher staff satisfaction and retention rates. RHD's mobile crisis program's supervision is done "in real time." Clinical supervisors are available during each intervention and provide supervision both before and after. RHD supervisors use the acuity level (risk indicator, location, clinical picture and severity) to determine appropriate supervision. Supervisors may be present on site for support or may do virtual supervision. It is critical that our mobile crisis and follow-up staff feel supported. One example of our supervision model's success comes from the Mobile Crisis Intervention Unit (MCIU) in New Orleans. Multiple opportunities for staff and participant feedback are built into the program model from informal conversations to more formal surveys and other methods. Through these feedback mechanisms, RHD has learned that real-time on-site supervision (whether in-person or virtually) boosts staff morale. Staff have expressed that this model helps them grow professionally which elevates the quality of services and lets them know they are not alone in this work. Residents served by our mobile crisis programs have also expressed that knowing a supervisor was on scene or readily available made them feel like a priority and that their crisis was being taken seriously.

CATEGORY 2: SERVICE DELIVERY (55 Points)

1. Service Delivery and Approach

a. **Mission:**

RHD has devoted extensive time and organizational energy to creating and implementing mobile crisis and alternative dispatch programs and is invested in supporting the growing movement for community responder models in place of police intervention for behavioral-health focused 911 calls. These models align with our organizations values and our commitment to wellness and recovery services provided in the least restrictive setting. We envision programs such as A9ER becoming the fourth branch of the emergency response system nationwide. Expanding crisis continuum services is a key part of RHD's Business Development Social Innovation strategic plan.

As stated in the RFP, 911 is the default resource residents turn to in a crisis, and police are the default response even though their training is not designed for behavioral health intervention. By implementing community responder models in Allegheny County, partnering closely with stakeholders to make the pilot successful, and expanding county-wide, we have the opportunity

to improve behavioral health crisis intervention for the County's 1.2 million residents. Improving the response to behavioral health crises in this way reallocates police resources toward crime and crime prevention and, ultimately, has the potential to save lives.[1]

Allegheny County's crisis continuum of care is a cutting-edge, comprehensive approach to improving health for its residents. The A9ER program is a key element of that continuum. Alternative response and community responder models staffed only by behavioral health professionals (as opposed to a co-response model with law enforcement or EMS) are a relatively new advancement in the field. Allegheny County is a leader in human services in Pennsylvania; this pilot is an opportunity to contribute to establishing best practices and to provide valuable information to other counties in Pennsylvania, and the country at large, as they consider adopting similar models. RHD would be proud to partner with the County in this effort as it is aligned with our values, experience, and strategic plan.

b. **Methodology**

RHD will provide a comprehensive array of crisis services including rapid response, face-to-face assessment, de-escalation, crisis stabilization, emotional support, trauma support, referral to appropriate agencies, transportation, and follow-up.

RHD proposes to implement Alternative Response Teams (ART) and Follow-up Teams (FUT) in both locations, McKees Rocks and Penn Hills/Monroeville, with the capacity to expand hours of operation and to additional locations across the County in the future. Based on our experience providing crisis services, we would like to propose an enhanced operating schedule, but we are fully prepared to operate under the hours outlined by the County in the RFP.

<u>Operating Hours and Staffing Schedule</u>

We suggest staffing the program with two eight-hour shifts each day: a day shift and an evening shift. Each shift will have a dedicated two person team at each pilot site, in addition to a "floating" team that will be available to either pilot site as needed based on call volume. One follow-up staff person will be assigned to each region, for each shift.

As the program expands, we would anticipate offering 24-hour services, as needed. We would like to propose operating from 9:00am to 11:00pm, with service hours from 10:00am to 10:00pm, seven days per week. The Follow-up Team will flex their hours across the 40-hour work week. The table below outlines the proposed hours.

	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
taking calls		taking calls													
day shift	admin time	calls						call wrap up							
evening shift							admin time	calls						call wrap up	

In this model, ART will be available for dispatch 12 hours per day, bookended by one hour of admin time for each shift. The teams overlap for two hours for warm handoffs between shifts.

In our experience, 8-hour shifts are more desirable to behavioral health workers. Accommodating that preference helps with recruitment and retention, making the position more attractive to candidates and preventing burnout. High burnout and turnover is expensive for the

[1] Andrew Selsky, "How some encounters between police and people with mental illness can turn tragic," PBS NewsHour, September 2, 2022, accessed June 22, 2023, https://www.pbs.org/newshour/health/how-some-encounters-between-police-and-people-with-mental-illness-can-turn-tragic#:~:text=Nearly%20one%20in%20five%20U.S.,said%20in%20a%202015%20report.

program and can ultimately drive down the quality of service. RHD places high value on collaborative decision-making; our staff have expressed a strong preference for an 8-hour day.

Location

During the time that teams are taking calls, they will be located in hotspot areas. In our New Orleans program, we partnered with the fire department and were invited to use local fire houses when in the areas to meet basic needs: take a break, use the bathroom, get water. This has been more effective in supporting a fast response time than having office-based dispatch. It also allows the teams to shift neighborhoods in response to utilization data as hotspots shift. RHD will look for similar partnerships in Allegheny County.

The teams operate every day of the week including weekends and holidays and in all weather. In other regions with mobile crisis response, RHD has protocols in place for responding safely in natural disasters. As part of implementation we would expect to develop local versions in partnership with the County and our other first responder partners. Teams will respond to those in need wherever they are, as long as staff safety isn't compromised. In these cases, the teams will radio to dispatch (or whatever protocol is developed) for support in securing staff safety so we can respond. Locations we might expect to provide care in are public spaces such as parks, other professional environments such as family doctor offices or schools, resident homes, or local businesses.

Service Methodology

All services are to be provided in a culturally competent and trauma-informed manner. Empathy and respect are at the heart of every interaction. Staff are reminded that we are seeing people on what may be one of the worst days of their lives. We treat them with the compassion and professionalism we would expect for ourselves and our loved ones, regardless of challenging behaviors in that moment. Through training and ongoing supervision, RHD staff become expert in rapport building and de-escalation techniques.

This program will follow a "dispatch first" model. When the call comes in, staff will immediately begin heading to the scene while obtaining additional information about the situation. In a crisis, time is of the essence. **The goal is for staff to be en route within 4 minutes of receiving the call.**

Once on scene, crisis workers use their clinical judgement and experience to support the individual. Staff will address any immediate needs when arriving on scene, such as providing water, snacks, blankets, before conducting their assessment. The assessment will include a risk assessment and mental health and substance use screening. This brief assessment will guide the crisis workers' next steps in de-escalation, conflict mediation, and/or resource connections. The supervisor, a licensed clinician, will be available for support before, during, and after each call.

Teams will have supply kits in their vans to help resolve immediate needs such as providing Narcan, water, snacks, blankets, home pregnancy tests, etc. The contents of these kits were suggested by our focus groups in New Orleans. In addition, team will have items to assist the individual in self-regulation using sensory tools such as fidgets, stress balls, iPads with music and soothing videos, sensory devices, color books, etc. Crises may involve family, friends, loved ones, or neighbors.

The goal of every intervention is to provide support to the participant that will allow them to continue their **recovery in the least restrictive setting possible**. Whenever possible, staff will work with the participant and their natural supports to develop a plan to keep them safe at home. If the crisis worker was unable to confirm a referral appointment at the time of the crisis, the follow-up team will ensure a warm handoff on the next available day. Referrals may be to physical health, behavioral health, or a community-based organization addressing other social needs. Both the ART and Follow-up Teams will encourage residents to contact Resolve Crisis or 988 instead of 911 for future crises.

If remaining at home in the moment is not safe, the crisis workers will develop a plan for treatment in a care setting that can meet the needs and wants of the individual. This will include transportation to a facility if the participant is willing. Crisis staff never transport an unwilling participant. If none of the above are possible, the crisis team will facilitate an involuntary hospitalization, as a measure of last resort. The team will walk the participant and natural supports through the process and stay with them until they are transported.

Follow-up Teams

Follow-up crisis workers will meet the same qualifications and take the same trainings as mobile crisis workers. This allows for team cross training to ensure coverage as needed.

The follow up teams will flex their schedules in ways that meet the needs of the program and fit the life of the staff member. Follow-up is offered 7 days a week, with an expectation of higher volume during the week and business hours when there are more referral connections to be made. Follow-up will occur in the manner that reflects the preferences of the participant (text, call, video call, in person, etc.). In person visits will occur at any safe location of the participant's choice. If participants ask to meet in a public space or an area with little privacy, staff will remind participants about confidentiality challenges but defer to their preference. Follow-up crisis workers will encourage participants to meet with them in person at least post-intervention.

Follow-up services begin as quickly as possible. While most follow-up is resolved within 90 days of the initial crisis, when needed, follow-up may extend beyond 90 days. If a follow-up worker feels additional care is needed from the team beyond the 90 days, the situation should be reviewed with a supervisor to ensure that a more appropriate referral isn't available.

When a participant already has a provider in the community, the follow-up team is responsible for contacting and coordinating with them. The follow-up team may facilitate an interagency meeting with the participant, their natural supports, and their existing community providers to discuss how to manage any future crisis or to avoid them entirely. If the participant would like to switch community based providers, the follow-up team will assist them.

Follow-up, especially when there is no community provider to support, includes a wide variety of services. The follow-up team will start by asking the participant what they need and want from the service. This may require supports around housing, transportation, employment, physical health connection, behavioral health services, etc. The team will follow-up on any referrals made by the mobile crisis team at the time of the initial engagement. If the participant has not connected with these referrals yet, the follow-up crisis worker will ensure the connection is made. They will then follow-up to ensure the participant's needs were met from the referral. The follow-up team can also support the individual in creating or updating a WRAP plan or developing and practicing coping tools.

Feedback from the follow-up teams to the mobile crisis teams is ongoing. Communication between the two teams is essential to the success of both services. Mobile crisis teams will notify follow-up teams of key needs for follow-up in addition to follow-up crisis workers reviewing the mobile crisis documentation prior to beginning follow-up. Follow-up teams will notify the mobile crisis teams of any individuals who are at high risk of needing another mobile crisis intervention.

Recommendations

RHD would like to offer the following recommendations for consideration. We are prepared to implement the pilot as outlined in the RFP and look forward to collaborating with the County to develop and implement a successful program.

1) "Gun on premises" as an exclusionary criterion can create barriers to service as many people keep a gun at their home. Consider narrowing the criteria to gun on person or threats with a gun where a gun is on the premises.
2) Co-responding with law enforcement can create a blurred understanding of the program in the community. One of the key safety precautions for a mobile crisis team is that they are not seen as an extension of the police. We recommend civilian crisis responders (CCR) maintain a separate relationship with the community.
3) As we understand it, ART will receive calls from police dispatch. We recommend that the calls go from 911 dispatchers to a CCR dispatcher who can 1) do a brief behavioral health assessment to determine if we can safely respond, and 2) may be able to resolve the issue over the phone. RHD's crisis workers have extensive training in assessing for safety and de-escalation over the phone and are often able to resolve crises that way, which allocates more resources to higher acuity level situations.

c. **Staff Safety:**

RHD's commitment to employee safety is uncompromising. Our staff receive extensive training in assessing and maintaining safety in the field. If awarded, RHD can provide established safety protocols for alternative dispatch and mobile crisis, and work with stakeholders to tailor those protocols for the ART and Follow-up Team in Allegheny County. Under the model proposed in the RFP, a strong working relationship with police dispatch will be critical to maintaining safety.

Safety for ART and Follow-up Teams

Crisis workers follow several safety guidelines upon arrival at each call. First and foremost, they are to respond in pairs and are not to exit their vehicle until both team members are on site. Harm potential includes but is not limited to: participant's history of violence, availability of weapons, and the presence of other people or pets. The team will assess the situation, identify any potential safety risks, and respond accordingly.

Team members will always approach the site together. If the resident is inside a home or other building, team members will assess safety inside before asking to come in. When inside, team members will always maintain an unobstructed path to the door. Team members will remain in sight of each other until both are confident that there are no potential safety risks. If at any point during an intervention, staff notes the presence of anything that appears to present a danger to themselves, participants, or others in the environment they are to leave premises, get to safety and call supervisor and/or police. Team members are to keep their communication devices with them at all times. The software RHD uses, Behavioral Health Link, has an "SOS" button on

every screen, which they can discreetly tap to alert the team they need help, which also sends their GPS location. RHD staff also use code words that alert office staff or supervisors that they need police assistance.

Safety during transport

RHD staff will arrange for or provide transportation necessary for implementing the participant's crisis recovery plan, holding the safety of participants and staff paramount. RHD's policies include but are not limited to:

- Participants are never to be transported in a personal vehicle.
- Participants will only be transported if they are willing and staff determines that they are psychiatrically and medically stable enough to travel safely.
- If staff determines that transporting the participant is unsafe, we engage with our partners in public safety or EMS to arrange safe transportation.

d. **Staff Wellbeing**

Staff wellbeing is a core element of RHD's crisis response model. Civilian Crisis Responders are susceptible to the significant risk of burnout that both behavioral healthcare professionals and first responders experience. Among the efforts to increase staff wellbeing are: competitive wages, regular supervision, work schedules that include admin time for paperwork and debriefing, opportunities for additional training and professional development and wellness spaces. Each office will have a staff wellness space, curated by our environmental specialist, to create a place for staff to rest, decompress, and recharge. The office space is designed to support staff health by meeting basic needs such as refreshments and provides an atmosphere designed to promote sensory-motor regulation. The program model also includes opportunities for staff to attend local activities outside of work such as art museums, aquariums, and sporting events.

Wellness is often referred to as "self-care" but RHD believes that we must care for each other. Supervisors are trained to check in with staff not just on clinical cases or administrative tasks but to ask about their emotional health. Financial stability is one of the strongest influencers of mental health. The model includes salaries that reflect the challenges as well as the value and importance of this work. Finally, there is a staff experience survey which is implemented in the mobile crisis programs every six months. This survey asks about safety, workload, education/training, support, team, compensation, effectiveness, and wellness. In addition, after each face-to-face intervention, staff are asked to complete a brief questionnaire embedded within the EHR:

"Did you feel safe on this call? Were you able to successfully provide assistance/support to the individual? Did you have enough support on this call? Are there any training topics that would have made you feel more prepared for this call? Open text about the experience of this call:"

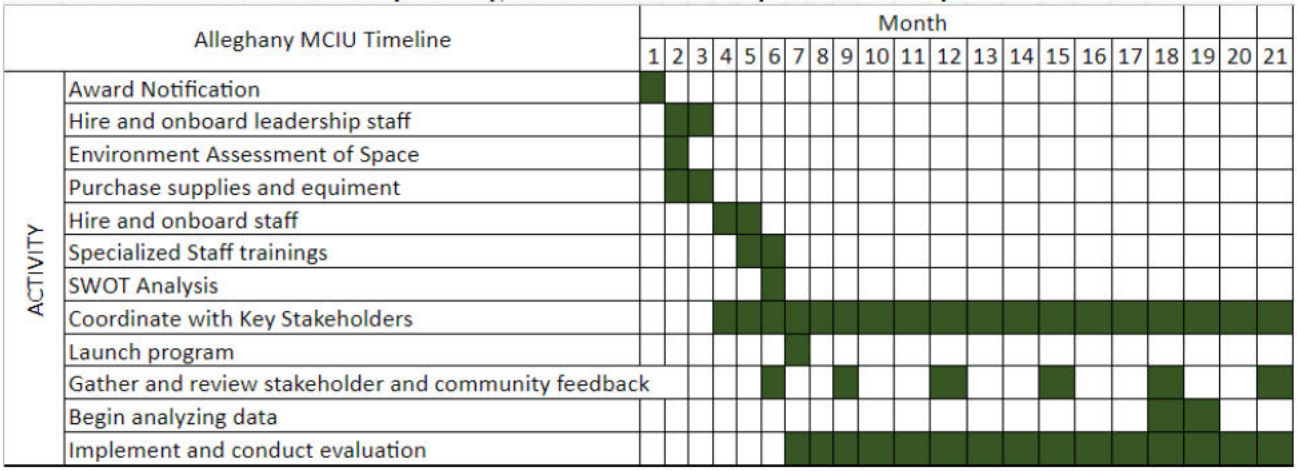
These answers are reviewed quarterly and follow-up on as needed. The civilian crisis response model is still new to the field and RHD is committed to adapting as we learn more about best practices and grow from our lessons learned.

e. **Expectations of government**

To ensure the success of the program, RHD needs support from the County and other branches of the emergency response system. The three main needs are related to communication, relationship building, and data sharing. Regarding communication, RHD staff will need access, equipment, and training on CAD. The other communication effort we have built into our model is communication with the public. We've found a public awareness helps residents be receptive to our support. The team must have strong, trusting relationships with 911 dispatch, police officers, fire departments, and EMS in addition to our relationships with other healthcare providers. The County can help facilitate these initial connections, as needed. RHD would request regular, standing meetings with representatives from 911 dispatch, the other three branches, the County, and the RHD team. This meeting would focus on the processes in place, although specific cases may be used as examples of breakdowns or successes in the existing processes. This work, especially in its pilot phase, will require significant data. Data sharing helps everyone better understand the impact of the study. Explicit data sharing agreements help avoid later issues.

f. **Implementation timeline**

Based on our experience, RHD recommends a 6-month ramp up period. The program will be launched in month 7, with feedback collected and analyzed at regular intervals. The final three months are for evaluation and planning for continuation/expansion if the pilot is successful.



g. **Equitable service delivery**

RHD is committed to creating a service culture in which participants are viewed as leaders and partners in treatment and experts in their own lives. Self-determination is central to our service delivery philosophy. Participant input on program components or attributes that facilitate progress are, to the maximum extent possible, integrated into the program structure. RHD is a values-driven organization. Our philosophy includes (but is not limited to) upholding several main pillars of best clinical practice including: focusing on identifying strengths and building resiliency skills in every person, adopting an ecosystemic framework by recognizing the powerful influence of family relationships and community on emotional and behavioral health, providing trauma informed services in every interaction and ensuring staff capabilities in all areas through ongoing training, support and supervision. Although many values are important to the organization, some specific values serve as the cornerstone for our programming: 1) Respect

for the Dignity and Worth of Each Individual, 2) Quality Service, 3) Safe and Open Culture, 4) Diversity and Inclusion. Using census and other county data, RHD strives to hire staff that reflects the communities we serve, giving hiring preference to people with lived experience and those who live in the program area. Participants self-select for the ART by calling 911 when they are in need. RHD will conduct a public awareness marketing campaign regarding A9ER to ensure all community members are aware of how to access the service. Response protocols are based on situation and specific criteria and should not be influenced by any other personal descriptors of the individual in need. A9ER staff will receive cultural awareness, diversity, and inclusion (CADI) training to support in adhering to this requirement. There are no populations that would be excluded from A9ER services.

CATEGORY 3: SERVICE DELIVERY SCENARIOS (45 Points)

1. **Respond to the following service delivery scenarios by explaining what actions your organization and staff would take, and why.**

Scenario A

As the program manager, I would take the feedback from the resident seriously and immediately review documentation to identify the resources and supports provided to the individual. When possible, I would meet with the resident in person to assure them that their feedback is valuable to us, and listen to their specific concerns. I would gather information about the incident by speaking to the team members who responded to the resident as well as any other staff at the scene. I would assess the resident's immediate needs and ensure they receive the desired support. In the week following, I would conduct a thorough review of the incident, taking into account the feedback provided by the resident, staff, and any additional information gathered. This review would help identify any potential gaps in training, protocols, or communication that may have contributed to the resident's negative experience and provide additional training accordingly. I would follow up with the resident to inform them of the steps taken in response to their feedback. On an ongoing basis, I would collect and analyze feedback from residents through regular satisfaction surveys and through focus groups, if needed. These insights would inform ongoing program improvements and help address any recurring issues. Performance reviews, case reviews, and on-site observations are in place to assess strengths and challenges.

Scenario B

I would respond to Lacy's statement with empathy and guidance to ensure a productive and compassionate approach to her interactions with residents. I would acknowledge Lacy's commitment to maintaining honesty and avoiding manipulation. I would emphasize the complexity of working with individuals in crisis and the importance of maintaining a trauma-informed approach. I would emphasize the value of empathy and building trust with residents, encouraging Lacy to approach each interaction with an open mind, empathy, and a non-judgmental attitude. I would provide Lacy with additional training or resources to enhance her communication and observation skills. This could involve workshops on active listening, non-verbal cues, and recognizing patterns of behavior. I would offer her opportunities to role play as both the Team member and the resident. I would promote reflective practice as an essential component of professional growth. Regular supervision meetings can provide a platform for Lacy to discuss challenging cases, seek guidance, and learn from the experiences of her colleagues. I would ensure that Lacy has access to ongoing support, including regular

supervision, team debriefings, and opportunities for peer learning and mentorship. This approach will contribute to building stronger connections with residents and ultimately enhance the effectiveness of the AR Team or Follow-Up Team in providing support to those in need.

Scenario C

The first steps to supporting Josh are to establish rapport and ensure safety. I would introduce myself as a crisis worker from the Alternative Response Team and assess the immediate safety of the situation. Then I would engage in active listening, showing empathy and understanding towards Josh's situation, validate his feelings, and let him know that I am there to support him. Next I would inquire about Josh's emotional state, level of intoxication, and any immediate physical concerns. I would assess risk for suicide using the Columbia Suicide Severity Rating Scale (C-SSRS)-screening version. If there were no safety needs to manage I would utilize crisis intervention techniques. Which may include sensory regulation techniques. The next step would be to inquire about Josh's support system, such as friends, family, or other community resources. I would help him identify people he can reach out to for additional support and offer to contact them with him. Once Josh had de-escalated, I would collaborate with him to develop a plan that addresses his immediate needs. This might include connecting him with appropriate community resources, such as substance abuse treatment programs, mental health services, or LGBTQ+ support organizations. If the referral sources were open at the time of the crisis I would offer to assist in setting up any needed appointments. If the needed supports were not available, I would offer Josh follow-up services available through the Follow-Up Team for a warm hand-off.

Scenario D

To come to a solution that addresses the concerns of both the Alternative Response Team members and the stakeholders, I would start by looking for a compromise. I would encourage an open dialogue where everyone feels heard and respected. Looking for a compromise could involve finding alternative ways to balance the visibility of the Alternative Response Team while considering residents' self-consciousness and maintaining safety, such as magnetic decals that can be easily added or removed as needed. As suggested by DHS, I would conduct a survey to gather feedback from residents who have previously been responded to by the Alternative Response Teams. I would explore other identification methods for the ART that balance visibility and safety concerns. I would engage in discussions with Public Safety to better understand their concerns. After we evaluate the results of the resident survey, feedback from Alternative Response Team members, and input from Public Safety we would engage all relevant stakeholders in a collaborative decision-making process.

Scenario E

I would engage in open and transparent communication with law enforcement to understand their concerns, motivations, and desired outcomes. This would involve discussing their rationale behind the request and exploring potential areas of collaboration. Based on that discussion, we would look for alternative means to address their concerns. Because this is a pilot program, it is important that we maintain fidelity to the community responder model. Uniform co-response with law enforcement does not adhere to the principles of community responder models. However, the model will not be successful without law enforcement’s buy-in, so we must attempt to find a mutually agreed on solution. I would review the program objectives, protocols, and guidelines that were established at the outset of the A9ER program to assess whether the

proposed change aligns with the program's core principles and objectives. I would consult with key stakeholders, including members of the ART, DHS, mental health professionals, community advocates, and residents to seek input and perspectives on the potential impact of law enforcement responding alongside the ART. As part of the program model, there are established mechanisms for continuous evaluation and feedback, including regular meetings and debriefings involving the ART, law enforcement, and other stakeholders. These mechanisms allow us to monitor the impact of joint responses on outcomes, community perceptions, and the overall effectiveness of the A9ER program and make adjustments as needed based on data, feedback, and best practices.

Scenario F

I would collaborate with the ART to gather any information they may have about the resident's whereabouts or any changes in their circumstances. I would send a team to the resident's home to conduct a wellness check and leave a card in the door or mailbox with the team's contact information. I would review the referral and any available records for alternative contact information. Finally, I would reach out to any community partners or organizations that may have connections or relationships with the resident. Once successful in establishing contact with the resident, the first conversation would focus on building rapport, establishing trust, and understanding the resident's needs and current situation. I would assess their immediate needs, including their mental health, safety, housing, and any other concerns they may have expressed in the referral and engage the resident in a collaborative conversation to identify their goals. Based on the resident's needs and goals, we would work together to establish a plan of action. This may involve scheduling a follow-up meeting, connecting them with appropriate services or resources, or coordinating with other team members or community partners to address their specific needs. Before ending the conversation, I would confirm the participant's preferred method of contact and discuss how the resident would like the follow-up team to proceed if they are unable to be reached in the future. Whenever possible, the next appointment is scheduled during each contact.

CATEGORY 4: PROJECT MANAGEMENT, PERFORMANCE IMPROVEMENT, PARTNERSHIPS AND COMMUNICATIONS (50 Points)

1. Project Management & Quality Improvement (15 points)

a. Program management approach

As an organization, we strive to create an environment that fosters success for our employees and the individuals we serve. RHD's overall approach to program management emphasizes collaboration, inclusivity, ethical practices, and focuses on elevating service delivery, in line with our values and mission. We have found that this approach encourages innovation, creativity, and determination among staff, which can lead to improved outcomes for residents. RHD values professional development and will provide opportunities for skill development and mentorship. RHD's Regional Director and Service Line Director will provide high-level oversight of the program, The Program Director is responsible for the day-to-day implementation, with support from the Assistant Program Director. Clinical supervision will occur at regular intervals and be delivered in a within a trauma-informed, values-based framework. The Program Director and Assistant Program Director will offer opportunities for inclusive decision-making, acting as facilitators as opposed to authoritative figures. Programs are encouraged to cultivate an open and

safe environment where staff are free to contribute ideas and question existing practices. There will be opportunity for continuous quality improvement; RHD actively seeks opportunities to enhance processes, systems, and outcomes.

b. **Performance improvement approach**

RHD's core values allow for ongoing flexibility and adaptability. We continuously promote and encourage Multi-Level Thinking, The Empowerment of Groups, and Creativity, which promote a "win-win" thinking process and allows for multi-disciplinary/group approach to service delivery and program operations. Ideas, feedback, and changes to operations and service delivery are discussed at monthly staff meetings and supervisions, monthly site visits from organization leadership, and advisory boards and residents councils. Quarterly multi-disciplinary Regional, Quality Assurance, and Financial meetings are held to plan for and adapt to changes and improve performance. The organization's Outcomes and Quality Assurance Departments also use the data collected from satisfaction and staff meeting surveys, internal and external audit findings, as well as individual programs' Goal or CQI Plans.

A recent operational change as a result of these feedback systems was the development of an Electronic Health Record (EHR) Optimization Team. Program staff expressed need for additional support and resources for successful implementation, additional reporting to help assess and improve productivity, as well as billing accuracy. This team provides training, hands-on support during implementation, workflow support, tangible job aids, open office hours, etc.

2. Reporting (15 points)

a. **Metrics**

In addition to the metrics suggested in the RFP, RHD plans to use the below data to evaluate the program:

- times when the team needs to request other first responder backup and the reasons why
- staff turnover
- staff vacancy rates

To supplement our own data, we hope to be able to be able to use our partners' data to evaluate the impact of the program as well.

- # of arrests for people with behavioral health issues (pre/post)
- # of involuntary hospitalizations from 911 calls (pre/post)
- # of voluntary hospitalizations from 911 calls (pre/post)
- # of police allegations of abuse/brutality/excessive force (pre/post)
- # of behavioral health issues presenting to ERs (pre/post)

b. **Method**

RHD uses the crisis specific EHR Behavioral Health Link (BHL). BHL is a crisis management software that was developed to meet the SAMHSA National Guidelines for Behavioral Health Crisis Care. BHL includes several modules that would support this program such as a call center-crisis line intake, mobile dispatch and monitoring, and follow up. Features include multimodal call management (call, text, chat), risk assessment, GPS enabled mobile crisis dispatch, real time performance dashboard (KPIs, reporting, analytics), an SOS call feature, and HIPAA compliance. RHD is working with BHL and other partners, including the New Orleans 911 dispatch center and New Orleans Health Department to build APIs which will allow BHL to speak to other systems such as CAD. RHD's goal is for the community to be able to access the

aggregated data in close to real-time. This not only holds the emergency response system accountable, but shows the incredible work that the team is doing. RHD considers this level of accountability and public sharing of data as an essential element of the program model and hopes to be able to create a similar data dashboard in Allegheny County. Until a PowerBI dashboard can be created, RHD's data analytics team will pull weekly and monthly reports with the agreed upon metrics and email them to DHS. Participant experience data is collected and stored outside of the health record for confidentiality purposes.

3. Communication and Partnerships (20 points)

a. **Communications approach**

Proactive and regular communication with other partners is critical to the success of this program. With the goal of being the fourth branch of the emergency response system, the team must function as part of the crisis continuum and of emergency services. Relationship building and regular communication are essential for both implementation and ongoing work. During the implementation period, RHD plans to meet repeatedly with all levels of the other branches and 911 dispatch from their frontline staff to leadership. This allows us not only to get to know those we'll be working with, and for them to get to know us, but gives us an opportunity to hear their expectations, hopes, and fears for this pilot. Maintaining these relationships throughout the life of the program will support RHD staff in reaching out when process issues are first identified, taking a preventive approach, and we encourage our partners to do the same. We recommend regular meetings with partners to discuss systems issues and successes as we learn more about the pilot's successes and challenges. All partners will have direct access to the program director for any special requests or to resolve any issues in real time.

b. **Partnerships**

RHD will work with our partners to develop specific protocols for different situations. For example, some EMS departments have rules about when they can leave the scene or who they can pass a call to. RHD will work with EMS leadership and staff to determine the best processes to facilitate EMS passing calls to RHD when appropriate. Another example of partnership with other first responders is our dispatch first policy. While we need to collect some basic information about a call in advance, **our policy is to get on the road immediately** and let the passenger crisis worker obtain the information while en route. This gets us to the scene as quickly as possible and shows our partners that we are responsive when they call.

A particularly nice example of first responder partnership in our New Orleans program is with the Fire Department. The crisis teams were invited to use the local firehouses as a touchdown spot, where crisis workers can get water, get out of the vans, and use the bathroom. During slower shifts, the crisis workers will bring drinks and snacks to the firehouse with them and get to know the firefighters and medics there. This has been a source of comradery that we hope to be able to replicate in Allegheny County.

c. **Collaboration**

RHD's most successful programs have been those developed and maintained in close partnership with our funders and regulators. This is especially true for pilots because they require ongoing attention to adjust as more information is learned. Our New Orleans civilian crisis response program is a good example of the benefits of such a partnership. The New Orleans Health Department and RHD meet every two weeks starting at the beginning of implementation and ad

hoc in between standing meetings. Both organizations bring different perspectives and expertise so having everyone able to collaborate, brainstorm, and research best practices fosters success. RHD policies and practices are intended to be aligned with public safety and community needs. When we find this is not the case, we explore any needed internal changes. Our County partners have often aligned themselves with public safety and community needs. This provides a common ground for RHD and the County as we are all focused on the same population health goals. The expectation that multiple perspectives serves RHD and its mission aligns well with County collaboration on a project such as this pilot. While RHD brings expertise in this civilian crisis response model, the County brings the local systems expertise. Neither organization will be as successful working independently as we can be in collaboration.

CATEGORY 5: DIVERSITY, EQUITY AND INCLUSION (DEI) CONSIDERATIONS (40 points)

1. Target Population & Community Engagement (25 points)

a. **Target population and needs**

RHD has decades of experience providing community-based behavioral health crisis response. The participants we serve are historically marginalized based on income, disability, race, and other social determinants. Many of our members are initially reluctant to seek assistance due to cultural background, prior bad experiences, lack of trust, and/or language barriers. The guiding principles and strategies employed by our mobile crisis programs include: triage approaches, a foundational understanding of the brain's response to stress and resolution planning, person-centered approaches in crisis response, foundational understanding of mental health, the importance of safety, crisis de-escalation, connecting to resources, and self-care. According to the 2021 Allegheny County Community Need Index, McKees Rocks and Penn Hills are identified as "extreme need" areas. Census data indicates McKees Rocks has a poverty rate more than four times that of Allegheny County as a whole. RHD will work closely with our community partners and through focus groups will enhance our knowledge of the pilot communities. Many of the participants we will work with have experienced complex trauma. Team members will be encouraged to participate in ongoing dialogue systemic oppression, cultural learning, and inclusion topics. All staff will be trained in Foundations of Trauma and Trauma-Informed Principles. Refreshers and other trauma specific trainings will be provided annually. Trauma informed principles are infused throughout RHD program culture in reflective supervision, team meetings, and program policies and procedures.

b. **Community input**

RHD offers a number of avenues for participant and family voices to lead and influence service delivery.

<u>Focus Groups</u>

Prior to launching the program in New Orleans, RHD conducted multiple focus groups with a diverse set of community members, to obtain feedback on how behavioral health crises have been handled previously and what are people's hopes and fears for the new program. The lessons learned helped to shape the program and service delivery methods. For example, participants noted that they would be more comfortable working with a crisis team whose presence was "low-profile": plain clothes with small logo and small decals on vehicles. RHD will conduct similar focus groups in the target areas and use information learned to guide implementation.

Participant Satisfaction Surveys
At the time of intervention, participants are offered either a card with a website and QR code to provide feedback electronically, or a paper copy with self-addressed, stamped envelope. Both these methods provide a brief participant experience survey as well as an invitation to be contacted for additional feedback and/or participate in the Participant Experience Committee.

Participant Experience Committee
The Participant Experience Committee is a group of people who have used the service and want to help guide that work moving forward. The group meets in person four times a year to discuss the program. The people on the committee are asked brainstorm ways this program could better serve the community. Members of this group are paid for their time and expertise. Transportation to and from the meetings is covered.

c. **Ongoing community engagement**

One way to support ongoing community engagement would be to host an annual wellness event in each target location. RHD would recruit local services, public safety, providers, and community-based organizations to table at the events, giving residents the opportunity to learn about numerous resources. RHD would also look to participate in ongoing events such as the McKees Rocks Feastival, the NAMI walk in Monroeville, the Out of the Dark and Recovery Walks in Pittsburgh, and the annual Where to Turn Resource Fair for service professionals.

In addition to the open community engagement efforts described above, RHD prioritizes the voices of residents. Those who have used our service and their natural supports are a key stakeholder group for RHD. The Participant Experience Committee (PEC), which will meet quarterly, provides a forum for RHD to receive feedback from those who have used the service. It allows the program to proactively seek advice about any proposed protocol changes within the program. Finally, the PEC is a place to present data and get an alternative perspective on how to interpret the data.

2. Workforce and Organization (15 points)

a. **Workforce**

RHD prioritizes hiring local to the service area and places an emphasis on including positions for people with lived experience, such as Certified Peer Specialists. For example, RHD's Allies is a Forensic Certified Peer Specialist program that provides peer-based recovery supports to people who are involved with the criminal justice system. In hiring for A9ER, RHD will post on local job boards and sites, in addition to the more global sites. We will work closely with our current programs in the County and our community partners to ensure that our hiring practices will result in a staff that reflects the pilot sites and Allegheny County as a whole.

b. **DEI**

As a trauma-informed organization that serves vulnerable people, we work to create welcoming and inclusive environments. RHD's Diversity, Equity, and Inclusion department (DE&I) ensures that RHD operates in a culturally responsive manner that aligns with our corporate values. As a department, we have three primary functions. One is to foster a culture of belonging through thoughtful and strategic practices—two, to provide opportunities to increase intercultural

competency with training and staff development. The third is celebrating the variety of human experiences among staff, participants, and communities through engaging and values-centered programming. Through intentional measures, we aim to create a work environment where all RHD community members are welcome, included, and affirmed.

RHD believes that having meaningful and substantial participation of minority, woman, disabled, veteran, service-disabled veteran, and LGBTQ-owned business enterprises among our vendors and consultants affirms and celebrates such a commitment to diversity and to creating economic opportunities. To that end, RHD has an annual goal of projected purchasing and/or contracting with the above of 10% of the overall dollars spent on contracting and purchasing. Our diverse procurement policies are governed by our Supplier Diversity Council, a multi-disciplinary team of RHD staff who directly influence vendor selection.

Eradicate Hate, the anti-racism taskforce of RHD works to eradicate all forms of racism, discrimination, and bias that uphold inequalities within RHD and the communities we serve. Through intentional anti-racism, discrimination, and bias efforts, Eradicate Hate creates internal transformational change and accountability. RHD provides a robust training program that develops intercultural competence among staff and leadership. Through our *DE&I Competency Series*, we provide eight hours of progressive instruction covering the following topics: identity, culture, inclusion, bias, microaggressions, and navigating challenging conversations. The competency series is open to all staff in in-person and virtual formats. The Culture Awareness, Diversity, and Inclusion training (CADI) is mandatory for all staff.

We offer a robust cultural calendar in which we provide information to staff regarding different holidays, celebrations, and remembrance days. On many occasions, we create and produce interactive programming for staff. While we rotate many of our festivals, some of our mainstays include: MLK Day of Remembrance and Service, Black History Month, Irish History Month, Women's History Month, Diversity Month, Mental Health Awareness Month, PRIDE, Hispanic Heritage Month, Values Day*- RHD Corporate Celebration for our Values, Winter Holiday/Festivals

CATEGORY 6: COST PROPOSAL AND NARRATIVE (35 points) *The Cost Proposal and Narrative are not included in the page count.*

1. **Cost Proposal and Narrative**
   a. **Cost proposal:** Complete a price schedule, budget or cost proposal in its entirety that will enable the effective delivery of the A9ER Program.
      i. Describe all direct and indirect costs associated with service delivery, including staffing, equipment, supplies, training, etc.
      ii. Describe any key cost variables for service delivery such as volume, frequency, duration or length, geographic reach and service level. (10 points)

   Please see attached proposed budget

   b. **Narrative and justification:** Present a detailed cost narrative that explains the basis and rationale for the costs proposed.
      i. Describe the rationale or benefit of the proposed cost structure.
      ii. Describe any key budgeting decisions, assumptions or calculation approaches used to develop the cost proposal. (15 points)

Start-up costs in this proposed budget are estimated costs to begin the program. For example, furnishing an office, an initial purchase of laptop computers, purchasing initial supplies for the office. **Monthly operating costs** are the anticipated cost during the first year of operation. This would include estimated salaries and benefits, housekeeping, utilities, rent, repairs, etc.

The budget estimates in this proposal were generated using a variety of information. RHD recently commenced an alternative dispatch program in New Orleans, Louisiana. RHD also has programs operating in various locations in the state of Pennsylvania. The estimates provided in this proposed budget are a combination of research and collaboration with the budget managers and staff members managing and operating these programs.

The notes provided in the proposed budget worksheet include brief descriptions of the costs and how the various start-up costs or monthly operating figures were generated.

Initial Start-up Costs: **$275,344.00** This total reflects initial expenses to start the alternative dispatch program at two locations. These proposed start-up costs reflect mostly lump-sum expenses. For example, the program proposes operating two vehicles- one at each location. The start-up costs for the motor vehicle expenses reflect an initial $3,000 estimated payment due at lease signing for each vehicle.

First-year operating costs: **$2,020,777.00** This total reflects the estimate for operating the program for the first year. These operating costs include salaries and wages for the staff to operate the program. Benefits are estimated at 30% of salaries. The benefits calculation only estimates FICA/Social Security expenses during the first three months of operations, as new employees at RHD are not eligible for benefits during that time. After the first 90 days, the 30% benefits calculation includes FICA/Social Security expenses for full-time employees.

Please note, there are many operating cost lines that also had a start-up cost. For instance, for vehicle leases, the start-up cost reflects the initial payment due at signing and the ongoing monthly payment is in the monthly operating cost. Further, some of the operating costs reflect a replenishment of a start-up cost. For instance, there are initial start-up purchases of medications/drugs and there is a monthly expense to replenish these supplies during the year.

c. **Performance payments or incentives:** Describe any proposed incentive-based or performance-based fee structures that would align compensation with the strategic goals set forth in this RFP. (10 points)

RHD proposes two elements of incentive based payments, shared savings and performance based. Shared savings is based on hospital admissions which is a common and relatively easy metric to calculate savings on. The performance payments are attached to metrics where the cost savings is to the wider system or difficult to estimate. We propose incentive payments be determined at the end of the year and paid at that time. We propose that incentive payments (total of shared savings and incentive payments) are capped at 10% of program budget. This amount is high enough to serve as an incentive to the program, but not so high as to create undue burden on the funder.

The shared savings is related to reducing hospitalizations. The assumptions are that a hospital admission costs approximately $6,000 per stay on average. If there is a reduction in hospitalizations above 5% for individuals who call 911, RHD and DHS will split evenly the savings amount.

Example Shared Savings based on a drop from 600 to 550 hospitalizations	
20	total decrease minus 5% of 600
$ 120,000.00	savings on 20 hospitalizations assuming $6000 per stay
$ 60,000.00	savings for DHS (50/50 split)
$ 60,000.00	savings for RHD (50/50 split)

Performance based incentives are focused on meeting high performance goals. Realistic goals have been set for each metric to ensure they can be met and hold the program to a high standard of care. Each goal is weighted based on its impact on participants and the program. The weight is a percentage of the total amount of incentive payments possible (10%) of the program costs. For the purposes of the example, the program cost is assumed to be $2 million annually.

Metric	**Goal**	**Weight**
Calls for police backup	<3%	15%
Successful connections to community treatment	>90%	25%
Response Time <4 minutes from dispatch	>90%	20%

Participant Satisfaction Surveys Positive Net Promotor Score	>85%	20%
Staff turnover	<15%	20%

Example Performance Based Incentives		**$ 110,000.00**
Calls for police backup	15%	$ 30,000.00
Successful connection to community treatment	not met	
4 minute response time from dispatch	20%	$ 40,000.00
Satisfaction Surveys Net Promotor Score	20%	$ 40,000.00
Staff Turnover	not met	

Using the above examples, RHD would be eligible for a total of $170,000 in incentive payments. Had RHD met all the performance metrics for a total of $200,000 of incentive payments, it would not also be able to receive an additional $60,000 for the shared savings. The total for the two elements of incentive payments combine is 10% of the total program budget.

Budget Worksheet

Scenario: First FYProjections

Allegheny County 911 Alternative Dispatch

Commencement Month: TBD

	Start-Up Costs	Monthly Operating Costs												
		FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	FY-1 Projections	
		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	TOTAL PROJECTED
EXPENSE ACCOUNTS														
11-51100 WAGES AND SALARIES		103,385	103,385	103,385	103,385	103,385	103,385	103,385	103,385	103,385	103,385	103,385	103,385	1,240,620
Total Benefits Estimate		7,906	7,051	7,051	26,173	26,173	26,173	26,173	26,173	26,173	26,173	26,173	26,173	257,560
11-51310 STAFF DEVELOPMENT-IN HOUSE	**25,000.00**	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	18,000
11-51311 STAFF DEVELOPMENT/CONFERENCE		833	833	833	833	833	833	833	833	833	833	833	833	10,000
11-53140 HOUSEKEEPING / MAINTENANCE		1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
11-53110 RENT		6,400	6,400	6,400	6,400	6,400	6,400	6,400	6,400	6,400	6,400	6,400	6,400	76,800
Utilities		1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
Furniture for staff wellness program	**30,000.00**	100	100	100	100	100	100	100	100	100	100	100	100	1,200
11-53131 INSURANCE -PROPERTY & CONTENTS		343	343	343	343	343	343	343	343	343	343	343	343	4,115
11-53132 INSURANCE - GENERAL LIABILITY		427	427	427	427	427	427	427	427	427	427	427	427	5,123
11-53133 INSURANCE-PROFESSIONAL LIABILITY		763	763	763	763	763	763	763	763	763	763	763	763	9,156
11-53134 INSURANCE D & O		267	267	267	267	267	267	267	267	267	267	267	267	3,210
11-53210 COMMUNICATION SERVICES	**4,000.00**	750	750	750	750	750	750	750	750	750	750	750	750	9,000
11-53212 MOBILE PHONES		1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	14,280
11-53220 POSTAGE		85	85	85	85	85	85	85	85	85	85	85	85	1,020
11-53230 ADVERTISING	**5,000.00**	125	125	125	125	125	125	125	125	125	125	125	125	1,500
11-53240 PRINTING	**750.00**	25	25	25	25	25	25	25	25	25	25	25	25	300
11-53310 OFFICE SUPPLIES	**5,000.00**	200	200	200	200	200	200	200	200	200	200	200	200	2,400
11-53410 MEDICAL SUPPLIES	**10,000.00**	500			500			500			500			2,000
11-53411 MEDICATIONS/DRUGS	**4,000.00**	225	225	225	225	225	225	225	225	225	225	225	225	2,700
11-53420 CLOTHING	**10,000.00**	425	425	425	425	425	425	425	425	425	425	425	425	5,100
11-53430 FOOD	**2,000.00**	250	250	250	250	250	250	250	250	250	250	250	250	3,000
11-53440 PROGRAM-OTHER	**6,000.00**	325	325	325	325	325	325	325	325	325	325	325	325	3,900
11-53443 PROGRAM - RECREATION		250	250	250	250	250	250	250	250	250	250	250	250	3,000
11-53445 GROUP/MEETING FOOD		200	200	200	200	200	200	200	200	200	200	200	200	2,400
11-53440 PROGRAM-OTHER	**10,000.00**	0	0	0	0	0	0	10,000	0	0	0	0	0	10,000
11-53449 EMERGENCY CLIENT SUPPORT		150	150	150	150	150	150	150	150	150	150	150	150	1,800
11-53510 STAFF TRAVEL-GENERAL LOCAL		200	200	200	200	200	200	200	200	200	200	200	200	2,400
11-53570 STAFF TRAVEL - PROGRAM SUPPORT	**1,800.00**	350	350	350	350	350	350	350	350	350	350	350	350	4,200
11-53734 BACKGROUND/MOTOR VEHICLE CHECKS	**1,200.00**	50	50	50	50	50	50	50	50	50	50	50	50	600
11-53760 INSPECTIONS / LICENSE FEES	**500.00**	50	50	50	50	50	50	50	50	50	50	50	50	600
11-53661 PANDEMIC - PPE		100	100	100	100	100	100	100	100	100	100	100	100	1,200
11-54151 MOTOR VEHICLE (LEASE)	**6,000.00**	2,857	2,857	2,857	2,857	2,857	2,857	2,857	2,857	2,857	2,857	2,857	2,857	34,284
11-54122 OFFICE EQUIPMENT - SMALL	**20,000.00**	300	300	300	300	300	300	300	300	300	300	300	300	3,600
11-54123 OFFICE EQUIPMENT - LEASED		400	400	400	400	400	400	400	400	400	400	400	400	4,800
11-54132 COMPUTER EQUIPMENT - SMALL	**22,000.00**	250	250	250	250	250	250	250	250	250	250	250	250	3,000
11-54172 COMPUTER SOFTWARE - SMALL	**5,000.00**	500	500	500	500	500	500	500	500	500	500	500	500	6,000
11-54173 SOFTWARE SUBSCRIPTION SERVICE	**75,000.00**	0	0	0	0	0	0	0	0	0	0	0	0	0
11-54230 MOTOR VEHICLE - MISC		150	150	150	150	150	150	150	150	150	150	150	150	1,800
11-54231 MOTOR VEHICLE - GAS / OIL		333	333	333	333	333	333	333	333	333	333	333	333	4,000
11-54232 MOTOR VEHICLE- REPAIR & MAINT		200	200	200	200	200	200	200	200	200	200	200	200	2,400

	Start-Up Costs	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	TOTAL PROJECTED		
11-54233 MOTOR VEHICLE - INSURANCE		1,015	1,015	1,015	1,015	1,015	1,015	1,015	1,015	1,015	1,015	1,015	1,015	12,178		
11-54210 BUILDING REPAIRS	**1,500.00**	250	250	250	250	250	250	250	250	250	250	250	250	3,000		
11-54221 MAINTENANCE & REPAIR CONTRACTS		0	0	0	0	0	0	0	0	0	0	0	0	0		
TOTAL DIRECT EXPENSE	**244,750**	**135,630**	**134,275**	**134,275**	**153,896**	**153,396**	**153,396**	**163,896**	**153,396**	**153,396**	**153,896**	**153,396**	**153,396**	**1,796,247**	**0**	
11-59999 ADMIN OVERHEAD EXPENSE	30,594	16,954	16,784	16,784	19,237	19,175	19,175	20,487	19,175	19,175	19,237	19,175	19,175	224,531	0	
ST001 Overhead %	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125	0.125		0.000
ST004 Adjustment Admin Overhead		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL EXPENSES	**275,344**	**152,583**	**151,059**	**151,059**	**173,133**	**172,571**	**172,571**	**184,383**	**172,571**	**172,571**	**173,133**	**172,571**	**172,571**	**2,020,777**	**0**	

Employee #	Position
	Crisis Director
	Assistant Director/Project Coordinator
	Program Assistant
Day Follow-up	Crisis Worker
Day Follow-up	Crisis Worker
Evening Follow-up	Crisis Worker
Evening Follow-up	Crisis Worker
Office	**Mental Health Clinician**
Team 1	Crisis Worker
Team 1	Crisis Worker
Team 2	Crisis Worker
Team 2	Crisis Worker
Team 3- float	Crisis Worker
Team 3- float	Crisis Worker
Office	**Mental Health Clinician**
Team 1	Crisis Worker
Team 1	Crisis Worker
Team 2	Crisis Worker
Team 2	Crisis Worker
Team 3- float	Crisis Worker
Team 3- float	Crisis Worker
Office	**Mental Health Clinician**
Team 1	Crisis Worker
Team 1	Crisis Worker
Team 2	Crisis Worker
Team 2	Crisis Worker
Team 3- float	Crisis Worker
Team 3- float	Crisis Worker
Office	**Mental Health Clinician**
Team 1	Crisis Worker
Team 1	Crisis Worker
Team 2	Crisis Worker
Team 2	Crisis Worker
Team 3- float	Crisis Worker
Team 3- float	Crisis Worker
	VACANCY FACTOR
	New Funding

Staffing	Hours per week	% FTE	Rate	Annual Amt.
Program Director	40	100%	40.87	85,009.60
Asst. Prog Director	40	100%	31.25	65,000.00
Admin Asst.	40	100%	18.00	37,440.00
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Licensed Clinical Manager - Lead Day (8-4)	**40**	**100%**	32.69	67,995.20
Crises Worker BA MHT or Certified Peer - Day	40	100%	31.25	65,000.00
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Day	40	100%	31.25	65,000.00
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Day	40	100%	31.25	65,000.00
Crises Worker BA MHT or Certified Peer - Day	40	100%	21.63	44,990.40
Licensed Clinical Manager - Lead Evening (3-11)	**40**	**100%**	32.69	67,995.20
Crises Worker BA MHT or Certified Peer - Evening	40	100%	31.25	65,000.00
Crises Worker BA MHT or Certified Peer - Evening	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Evening	40	100%	31.25	65,000.00
Crises Worker BA MHT or Certified Peer - Evening	40	100%	21.63	44,990.40
Crises Worker BA MHT or Certified Peer - Evening	40	100%	31.25	65,000.00
Crises Worker BA MHT or Certified Peer - Evening	40	100%	21.63	44,990.40
Licensed Clinical Manager - Lead - Weekend (9-5)	**16**	**40%**	32.69	10,879.23
Crises Worker BA MHT or Certified Peer - Weekend (9-5)	16	40%	31.25	10,400.00
Crises Worker BA MHT or Certified Peer - Weekend (9-5)	16	40%	21.63	7,198.46
Crises Worker BA MHT or Certified Peer - Weekend (9-5)	16	40%	31.25	10,400.00
Crises Worker BA MHT or Certified Peer - Weekend (9-5)	16	40%	21.63	7,198.46
Crises Worker BA MHT or Certified Peer - Weekend (9-5)	16	40%	31.25	10,400.00
Crises Worker BA MHT or Certified Peer - Weekend (9-5)	16	40%	21.63	7,198.46
Licensed Clinical Manager - Lead - Weekend (11-7)	**16**	**40%**	32.69	10,879.23
Crises Worker BA MHT or Certified Peer - Weekend (11-7)	16	40%	31.25	10,400.00
Crises Worker BA MHT or Certified Peer - Weekend (11-7)	16	40%	21.63	7,198.46
Crises Worker BA MHT or Certified Peer - Weekend (11-7)	16	40%	31.25	10,400.00
Crises Worker BA MHT or Certified Peer - Weekend (11-7)	16	40%	21.63	7,198.46
Crises Worker BA MHT or Certified Peer - Weekend (11-7)	16	40%	31.25	10,400.00
Crises Worker BA MHT or Certified Peer - Weekend (11-7)	16	40%	21.63	7,198.46
	0	-25%	31.14	(16,192.80)
Total Hours				