# Ocean County Board of Health
# Request for Proposals
# Alcohol and Drug Treatment
# 2019 – Round II

# OCEAN COUNTY BOARD OF HEALTH

## Announcement of Request for Proposals - CY2019

**Subject**

Announcement of availability of approximately $150,000 for Alcoholism/Drug Treatment Services from the County of Ocean, through the Ocean County Board of Health and with the review and advice of the Local Advisory Committee on Alcoholism and Drug Abuse (LACADA).

**Program Timeframes**

The programs to be supported by the respective funds are anticipated to commence on January 1, 2019 and terminate on or before December 31, 2019.

**Summary**

The Ocean County Board of Health announces that proposals are being accepted for the purpose of awarding grant funding received by the Ocean County Health Department to provide fee for service Alcoholism and Drug Abuse Treatment Services which includes: **Adult Intensive Outpatient Level II.1, Adult Outpatient-Level I, Halfway House Services for Men and Women Level III.1,** consistent with the needs identified in the Comprehensive Alcohol and Drug Abuse Plan

The Ocean County Board of Health reserves the right to not award funding or to cancel funding in full or in part in the event of budget restrictions due to a change in State funding, county funding or other justifiable cause. All funding is contingent upon availability of funds from the State and is at the sole discretion of the County of Ocean and the Ocean County Board of Health. Additionally, funding for the 2019 calendar year is contingent upon successful performance reviews and approval of applications by the County Alcoholism and Drug Abuse Services Unit and LACADA recommendations.

**TERMINATION OF AGREEMENT FOR CAUSE**

If the SUCCESSFUL BIDDER shall fail to fulfill in a timely and professional manner the obligations under this agreement, or if the SUCCESSFUL BIDDER shall violate any of the covenants, provisions, or stipulations of this agreement, the OCEAN COUNTY HEALTH DEPARTMENT shall thereupon have the right to terminate this agreement by giving written notice to the SUCCESSFUL BIDDER of such termination and specifying the effective date thereof, at least thirty (30) days prior to the effective date of such termination.

**Process**

1. The Announcement and Request for Proposal (RFP) packets will be available on September 11, 2018 on the Ocean County Health Department website at www.ochd.org.

2. On October 3, 2018 at 4:30 PM local time, an original proposal and 4 copies shall be received, opened and publicly read aloud. Proposals cannot be considered if they are late or incomplete. No substitute forms will be accepted. All charges for services to eligible clients must be included in funds requested. NO ADDITIONAL

FEES beyond the approved fee schedule can be reimbursed, if client is found to be eligible for county funding through the Division of Addiction Services Income Eligibility module in NJSAMS.

3 The Ocean County Health Department will convene a committee to review each submission for completeness and accuracy. The submissions will then be forwarded to the Allocations Review Sub-Committee of the LACADA who will review them and make recommendations to the full LACADA. The LACADA will then vote and make recommendations to the Board of Health and the Board of Chosen Freeholders. The Alcoholism and Drug Abuse Coordinator may request further information from the applicant in writing or in person.

**Applicant Eligibility Criteria**

1. All applicants must provide their service(s) and have a business address in the State of New Jersey.

2. Applicants must submit proof of appropriate licensure or certification/credential for levels of care services provided. Additionally, requirements may be included in the body of the RFP.

3. Applicants must submit separate proposals for each level of care in which they are submitting a proposal.

4. Applicants may apply for a specific population or all target populations unless otherwise noted.

5. All awardees must maintain a minimum of $3 million/aggregate and $1 million/per incident of both general/commercial liability insurance and malpractice/medical professional liability insurance. They must also have the Ocean County Board of Health, Ocean County Health Department, its Officers, Employees and Agents named as an additional insured and provide the Ocean County Board of Health with a Certificate of Insurance showing the same.

6. All awardees are expected to adhere to all applicable State and Federal cost principles. Budgets should be reasonable and reflect the scope of responsibilities in order to accomplish the proposed goals and objectives.

7. All awardees must be a Medicaid reimbursable provider except for early intervention, new programs (depending on program description) and recovery support services.

**Purpose**

Through the award of these funds and other programs and projects, the Ocean County Board of Chosen Freeholders and the Ocean County Board of Health hope to reduce the incidence, prevalence, and impact of alcoholism and drug abuse in Ocean County. It is the intent of the Ocean County Board of Health to provide funding support in 2019 dependent on State and County funding availability, satisfactory performance of the applicants, and compliance with providing the adequate services proposed.

**Ocean County Board of Health**
**Alcoholism and Drug Abuse Services Request for Proposal**

Name of Applicant

Program Applying For:

**MANDATORY ATTACHMENTS**

**All documents must be submitted in the following format. Any deviations from the format may result in the application being rejected from the review process.*
** All proposals must be done in a professional, organized manner as outlined and submitted in a binder. Please follow the order of Section I and Section II below.*
**All pages of the submission must be numbered sequentially.*

**SECTION I**

**Failure to submit any of these documents may be cause for rejection of proposal:**
A. Copy of proposer's New Jersey Business Registration Certificate
B. NJDMHAS License or documentation of application
C. Board of Director's List
D. Charitable Registration Certificate
E. Most Recent Financial Report

**Failure to submit any of these documents is mandatory cause for rejection of proposal:**
A. Affirmative Action Certificate or Letter of Approval
B. Non Collusion Affidavit
C. Americans with Disabilities Act
D. Fee schedule (page 9)
E. Stockholder Disclosure Certification
F. Disclosure of Investment Activities in Iran

**Scoring Topics**

**SECTION II: Failure to submit any of these documents may be cause for rejection of proposal**

A. Applicant's Organization
B. County-wide accessibility
C. Program Plan that meets the identified needs in the Comprehensive Alcohol and Drug Abuse Plan

1. Description of each program and how it meets an identified need in Ocean County
2. Eligibility Requirements for Client
3. Measurable Goals & Objectives
4. Methods
5. Staff and Administrative Support (resumes, professional licenses and credentials must be included)
6. Evaluation

D. Community Linkages & Continuum of Care Services
E. History Providing Ocean County Funded Services

F. Budget and Proposed Level of Service

**Reminder** – Format the Sections as listed above. If it is your intent to leave a Section empty, the Section should be included with a note to indicate "Intentionally left blank." A separate application is needed for each level of care.

## SECTION II (DETAILS)

A. Applicant's Organization

Describe the agency's history and track record providing substance abuse treatment to Ocean County residents. Supply statistical information on the total number of unduplicated clients served on an annual basis, including demographic information if available. Treatment must be provided in a DMHAS licensed facility for Outpatient Level 1 level of care and above.

Describe where this proposed service will be placed in the applicant's organizational structure and who will supervise the program. Submit an organizational chart for the program and for the entire organization, plus the point of contact for the proposed program.

Supply agency policy information on staff training, continuing education and quality assurance.

Include statistics/data on:
Client treatment completions
Treatment outcomes
Referrals for continuum of care and how these relationships are built and sustained
Recidivism percentages, if possible specific to county comprehensive grant recipients

B. County-wide Accessibility

Describe the level of accessibility to the proposed service from various regions within Ocean County. Please include addresses of all sites where *this* proposed level of care will be available and the number of days per week/month when the proposed level of care will be available at each site. Provide a marketing plan as to how the agency will reach clients including special needs population as defined by Chapter 51 (seniors, disabled clients, women, youth, co-occurring, offenders, DUII) and non-English speaking clients throughout the county. Include list of agencies for referrals.

C. Program Plan

1. Description of each program and how it meets an identified need in Ocean County

Provide information on how the program meets an identified need in Ocean County based on the Comprehensive Alcohol and Drug Abuse Plan.

2. Eligibility Requirements for Client

List all Federal, State and/or Local initiatives/grants that reimburse you for this level of care.

Describe how your agency will confirm that a client is an Ocean County resident for six months or longer, is under 350% of the Federal Poverty Level, is not eligible for other funding sources, and has not used county funding in the past 365 days of requested admission.

Describe how your agency assists clients in Medicaid Enrollment and how Medicaid eligibility is confirmed. Include information on how your agency assesses this information and describe your policies on presumptive eligibility. Describe how your agency will set protocol to ensure county funding is the funding of last resort and that Medicaid is appropriately accessed and used for eligible clients.

Provide agency policy regarding client's use of prescribed medications, urine testing, psychiatric testing and others.

3. Measurable Goals & Objectives

Please describe the goals the applicant hopes to achieve by providing this proposed level of care to Ocean County residents; including how the special needs population will be served. Use objectives to describe how the goals will be met. Objectives should be *specific, quantified and measurable.*

Clearly define the agency definition of a successful outcome. Offer specific measurable criteria such as "The client will continue to seek care and or will remain abstinent for (x amount of time)". Also include how the agency will monitor client progress through the care continuum.

4. Methods

Methods describe all the activities the applicant will undertake to achieve the desired objectives.
Methods describe the "process," i.e., how many, how often, etc. Please number objectives and methods so their relationship to each other is clear to the reviewers. Include the level of care applicant is applying for and how it will be reached by this proposal as well as how often will the treatment be offered for that level of care.

Provide agency policy on any exclusionary criteria for admission, information on standards for length of enrollment, wait times to access services after initial referral is made and reasons for early termination from services, if applicable for which you are applying.

**Please report on how your agency will meet the requirements for submitting clinical extensions and how clinical extension forms will be submitted BEFORE the client exceeds the lengths of stay outline.**
Length of stay:
Intensive outpatient services level II.I, clients are eligible for 8 weeks of treatment
Outpatient services level I clients are eligible for 12 weeks of treatment
Co-occurring partial care services level II.5 clients are eligible for 6 months of treatment.
Detoxification level III.7D are eligible for 5 days of detox
Inpatient Residential level III.7 and halfway house to follow number of days stated on client initial form/approval code.
(Clinical extension forms will be provided electronically if awarded)

5. Staff and Administrative Support

Describe the staffing and supervision structure. Indicate who will provide administrative and clinical supervision and direction. Provide job descriptions, credential requirements and salary ranges for all positions related to the proposed program. Provide resumes of staff members identified to work in the proposed program. Provide staffing pattern for level of care and supervision plan for interns.
Provide the following:
Agency Contact for Grant
PACADA representative
Fiscal Contact

6. Evaluation

Describe how the applicant will measure the quality, effectiveness and outcomes of the proposed program. All objectives must include the *output measures* that will be used to assess the extent to which desired service delivery has been met.

D. Continuum of Care and Community Linkages

For all levels of care, describe the criteria for discharge and discharge planning or referral procedures including accessing community resources and provide information on re-integration plans back to Ocean County. Please describe how services will be provided to clients or how linkage will be made to the next level of care. Describe what type of community linkages the applicant anticipates will be needed by the population to be served and how those linkages will be facilitated. Letters of support or existing letters of agreement may be submitted to substantiate affiliation with the applicant.

E. History Providing Ocean County Funded Services

Describe the applicant's history providing services for Ocean County residents that were funded by an Ocean County government entity, i.e. Ocean County Board of Health, Department of Human Services, Youth Services Commission, Board of Chosen Freeholders, etc.

F. Budget and Level of Service

Complete and submit the attached: Proposed Budget and Level of Service
The Ocean County Health Department will only review submissions that do not exceed the following cost structure for the associated level of care:
Short Term Residential Level III.7 -$183.75/day
Sub-Acute Detoxification, Level III.7D - $252.50/day
Outpatient Opioid Detoxification (Suboxone) OMT1 with treatment- fee schedule to be included by applicant including medication cost, evaluation, doctor appointment cost and cost of treatment session
Adult Intensive Outpatient Level II.1 - $65 a session
Adult Outpatient-Level I - $40 a session
Adolescent Intensive Outpatient with Educational Component - $65 a session
Level II.1, Halfway House Services for Men and Women Level III.1 - $70/day
Co-Occurring Disorders-Partial Care Level II.5 - $57.50 a session
Recovery Support Services – based on services - please provide a rate
Early Intervention – based on services – please provide a rate
New programs or support to existing programs – please provide a rate

In 2019, providers can add additional rates to their fee for service for psychiatric evaluation, substance abuse evaluation and medication monitoring. Please see above under F. Budget and Level of Service for more information.

Additionally, if applying for Recovery Support Services, please add additional Budgets and Level of Services for program enhancements.

## Requirements:

All agencies must screen clients using the Division of Mental Health and Addiction Services Income Eligibility (DASIE) module in NJSAMS to ensure equal access to all clients of all funding sources before proceeding with a clinical assessment for admission. All clients served under these funds must be entered in NJSAMS. All clients must have a completed ASI Narrative or other DMHAS approved instrument, DSMV IV/V diagnosis with justification and a Level of Care Index in NJSAMS and in the client's record in order to determine the appropriate level of care. This information must be kept in client charts for review. Funds are to be used for

Ocean County residents only who have resided in the county for at least six months. Residency verification is required. County funds can be accessed once in a 12-month period per client for the same level of care. County funding to be accessed when other funding sources are not available if eligibility criteria is met: Ocean County resident for 6 months or longer, 350% under Federal Poverty Level (unless otherwise indicated), and cannot have used county funding in past 365 of current admission request.

Funding is based on a client's household income as per DASIE. Funding must be substantiated by provider through the DASIE and copies of household income and income verifications are to be maintained in the client chart. Agencies shall not discharge clients in order to receive alternate clients at a higher reimbursement rate. Funds made available under this contract cannot be used to supplant other funding, nor can it be used for insurance co-pays. Attach agency's sliding fee or co-pay scale, or no show fee.

All clinical staff must maintain all required licenses and professional liability insurance during this contract. Failure to maintain required licenses may be cause for immediate termination of this contract. Applicant will be responsible for all training and updates on the NJSAMS network and on DMHAS regulations for treatment agencies at their own expense. All required complete documentation for all clients must be fully completed by all clinical staff in NJSAMS.

Applicant is responsible for tracking clients in our monthly report, identifying those clients that are new or return clients, assessing for the proper level of care at the beginning of treatment, and provide a complete discharge summary that links clients to either the continuum of care or community support networks, as appropriate.

**Allowable costs**: Only bill for a unit of service such as cost per bed day and per session.

# OCEAN COUNTY BOARD OF HEALTH
## Alcoholism and Drug Abuse Services Request for Proposal

## Proposed Budget and Level of Service – 2019

| Section | | Amount |
|---|---|---|
| **A. Total Budget – Requested Funding** | | $_____ |
| | **Units (Specify per hour, per session, per bed)** | |
| B. **Statistical Client Data**<br>1. Number of Clients to be Served<br>2. Average number of Session Per Client | _____<br>_____ | |
| C. **Total Level of Service Units**<br>(Line B1 multiplied by line B2) | _____ | |
| D. **Costs Per Unit of Service**<br>(Line A divided by Line C) | | $_____ |
| **Please define unit of service:** | | |
| Additional Enhancements: | FFS Rate | |
| **Psychiatric Evaluation – when clinically indicated, client will be referred for a psychiatric evaluation** | | |
| **Substance Abuse in-take/evaluation– onetime cost for client for either in-take into level of care or a substance abuse evaluation** | | |
| **Medication Monitoring – covers psychiatrist/APN visit – not medication** | | |

If applying for Outpatient Opioid Detoxification (Suboxone) OMT1, please specify specific rates for psychiatrist, medication and other potential costs.

**The undersigned hereby declare that he/she carefully examined the advertisements, specifications and conditions for the furnishing of Alcoholism and Drug Abuse Services and if awarded the contract, will complete the said contract in all respects according to the specifications and conditions.**

## *TYPE OR PRINT NEATLY*

| |
|---|
| **Company Name:** |
| **Address:** |
| **Telephone Number:** |
| **Name of individual authorized to submit proposal:** |
| **Title:** |
| **Signature** |

# THIS FORM MUST BE COMPLETED AND SIGNED

**PROPOSAL DOCUMENT CHECKLIST**

**Proposal Title**: Alcohol and Drug Treatment 2019 - Round II

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Items required ↓ | Items submitted with proposal ↓

***A. FAILURE TO SUBMIT ANY OF THESE DOCUMENTS MAY BE CAUSE FOR REJECTION OF PROPOSAL.***

| | | |
|---|---|---|
| ____ | Copy of Proposer's New Jersey Business Registration Certificate | _____ |
| ____ | NJDMHAS License or documentation of application | _____ |
| ____ | Board of Director's List | _____ |
| ____ | Charitable Registration Certificate | _____ |
| ____ | Most recent financial report | _____ |

**B. FAILURE TO SUBMIT ANY OF THESE DOCUMENTS IS MANDATORY CAUSE FOR REJECTION OF PROPOSAL.**

| | | |
|---|---|---|
| __X___ | Affirmative Action Certificate or Letter of Approval | _____ |
| __X___ | Non-collusion affidavit | _____ |
| __X___ | Americans with Disabilities Act | _____ |
| __X__ | Fee Schedule | _____ |
| __X___ | Stockholder Disclosure Certification | _____ |
| __X___ | Disclosure of Investment Activities in Iran | _____ |

**PROPOSER :**_____

**SIGNED BY:** _____

**DATE:** _____