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**State of Vermont**  
**Department of Mental Health**  
108 Cherry Street, PO Box 70  
Burlington, VT 05402-0070  
healthvermont.gov/mh

*Agency of Human Services*

# **Vermont Department of Mental Health Vermont State Hospital Futures Project**

## **Request for Proposals**

### **Clinical Design Services for Adult Mental Health Care Management System**

**February 22, 2008**

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### **Clinical Design Services for Adult Mental Health Acute and Intensive Care Management System**

#### **OVERVIEW**

The Vermont Department of Mental Health, Vermont's single state agency mental health authority, is seeking proposals to design an adult mental health clinical care management system for a continuum of care ranging from acute inpatient care to community residential recovery care.

During its 2004 session, the Legislature set in motion a strategic planning process for the future of Vermont's public mental health system. The Secretary of Human Services was charged with creating a comprehensive plan for the delivery of services currently provided by the Vermont State Hospital (VSH), within the context of long-range planning for a comprehensive continuum of care for mental health services. This plan was titled the "Futures Plan".

The core of the plan is proposed new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings that promote recovery.

The Futures Plan, work group reports and other planning documents may be viewed at the Department of Mental Health's web site: <http://healthvermont.gov/mh>

#### **The Futures Plan: Context for this Request for Proposals**

The Vermont Mental Health Futures Plan calls for the transformation of our service system towards a consumer-directed, trauma-informed and recovery-oriented system of mental health. When fully implemented, the plan will transform inpatient and recovery services for the most severely ill, will improve coordination of services and increase capacity for all adults with mental illnesses. The result will be a continuum of care in which:

- The individual is actively engaged in their own recovery
- Prevention, early intervention and alternatives to more acute levels of care are pursued aggressively
- Peer supports are expanded and recognized as essential to recovery
- All the elements are coordinated
- Individuals with complex, co-occurring mental health, substance use and physical disorders are treated in an integrated approach

The Futures Plan envisions the following services components:

### ***New Acute Inpatient Capacity***

New inpatient capacity for evaluation, stabilization and treatment of acute mental illness will be developed in partnership with Vermont's existing general care hospitals. This new capacity, the exact scope of which has not yet been defined, will reflect full integration with medical care and more intensive programming for assessment and treatment than currently exists at VSH or at current Designated Hospitals<sup>1</sup> psychiatric inpatient programs. This new inpatient care capacity will be configured with high staff-to-patient ratios, flexibly scaled environments, and specialized clinical programming. Current planning proposes developing this capacity with at least two of Vermont's general hospitals.

### ***A Range of Residential Recovery Programs***

The plan proposes to create different types of residential options for meeting the needs of a longer-term population in need of intensive recovery services, supervision and/or security. A new residential recovery program with an 11 bed capacity has been created and a second six bed program is being planned. In addition, a proposed 15-bed secure residential recovery program is being considered.

### ***Crisis Beds for Stabilization and Diversion***

The existence of an adequate number of crisis stabilization/inpatient diversion beds throughout Vermont is crucial to the success of the Futures plan. The goal of this service is to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. During 2007, DMH funded the addition of 9 additional crisis beds to its system, bringing the total number of crisis beds geographically dispersed throughout Vermont to 27 beds.

### ***Care Management***

The Futures plan includes a *Care Management Program* to ensure that the system can manage and coordinate movement within the system so that individuals have access to the appropriate level of care needed. The care management system will also ensure that the system's resources are used most effectively and efficiently. The system will help to ensure that the most integrated and least restrictive care consistent with safety is being delivered. The care management function will provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols

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<sup>1</sup> A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Mental Health to provide treatment to individuals involuntarily committed to the commissioner's care and custody.

among all partners (designated mental health agencies<sup>2</sup> and designated hospitals) as well as the ability to convey common information for clinical services, utilization management, quality assurance/improvement and conflict resolution. The care management system will integrate a service network that coordinates the following components:

- General and specialized psychiatric inpatient beds in Vermont hospitals
- Various levels and types of residential treatment and care
- Crisis stabilization / inpatient diversion beds.

### ***Peer Services, Transportation, Supportive Housing, and Legal Services***

The Futures Plan proposes new *Peer Programming*. These services offer effective, recovery-oriented supports. Peers are an integral part of the planning and provision of traditional and new services. The expansion of stand-alone peer services will also be explored. The plan provides resources to continue enhancing options for alternative secure *Transportation* other than the former system of using sheriffs.

The plan provides new *Supportive Housing* resources. The lack of decent, affordable housing has been consistently identified by the Futures Advisory Group as one of the most significant unmet needs of Vermont's citizens with mental illness. Based on the broad consensus in the stakeholder community that safe and adequate housing is crucial to reducing hospitalization and supporting recovery, housing supports in the form of flexible funds and rent subsidies have been appropriated and implemented..

### **Clinical Design Services Sought through this Request for Proposals**

The Department of Mental Health (DMH) is seeking clinical design services to develop the **Care Management** component of the Futures Plan. A work group composed of Mental Health community stakeholders including consumers, clinical leaders, and service providers has met for over a year and has developed many of the underlying concepts necessary to create a care management system, such as overall system principles and the rules by which individual patients or clients would move between levels of care. Initial work has also been completed to define some of the levels of care, clarify admission criteria, and identify protocols necessary to operationally implement the care management system.

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<sup>2</sup> A designated agency is a comprehensive community mental health center designated by the Commissioner of Mental Health to provide treatment and support services to adults with severe and insistent mental illness and children, youth and families with severe emotional disturbance.

The Department of Mental Health seeks clinical design services to:

- 1) Identify options for management structures for Vermont's care management system.
- 2) Develop consistent documents and protocols for:
  - Descriptions for programs at each level of care in the system
  - Clinical admission, continued stay, and discharge criteria for each level of care
  - The operations of the system (for instance, dispute resolution, census management, and access to emergency screening services).
- 3) Based on the variables of program capacity, identify the most significant gaps in the system of care and any redundancies.
- 4) Identify the data elements required for documentation and communication of needed clinical information.
- 5) Propose a design for efficient and effective quality improvement, assurance and utilization management systems.

The design work must be carried out in a collaborative fashion with Vermont's community of mental health stakeholders. Preliminary design work must be reviewed by consumers, family members, and other key stakeholders and their feedback incorporated into final products.

The outcomes of this clinical design work will be:

- A management framework for a care management system
- Consistent policies and protocols to implement the system
- Quality improvement, assurance and utilization review systems that facilitate a design for continued improvements in the system and effective allocation of resources.
- Products that will be readily usable and appropriate for Vermont.

## SCHEDULE FOR ISSUING RFP AND CONDUCTING REVIEW

February 22, 2008	Issue RFP
March 7, 2008	Deadline for receipt of letter of intent to bid
March 28, 2008	Proposals due by 4:30 pm
April 11, 2008	Review Committee recommendations to Commissioner
April 18, 2008	Contract negotiations with top-ranked applicant begin
May-November, 2008	Clinical Care Management System Design work conducted
December 3, 2008	Draft Report for review
January 2, 2009	Final Report Delivered

## INSTRUCTIONS TO BIDDERS

### Proposal Format

Use standard 8.5" X 11" white paper. Documents must be single-spaced and use not less than a twelve-point font. Pages must be numbered. The program narrative should not exceed 25 pages, excluding attachments, required schedules or forms. The narrative must follow the sequence of information requested in the "Proposed Narrative" Section below. State your organization's name on each page of your program proposal and on any other information you are submitting.

### Letter Of Intent – Pre-Requisite

In order to ensure all necessary communications with the appropriate bidders and to prepare for the review of proposals, one letter of intent to bid must be submitted per bidding agency.

Letters of Intent must be **submitted by Friday, March 7, 2008 by 4:30 p.m. EST** to:

Trish Palmer  
 Department of Mental Health  
 108 Cherry St.  
 Burlington, VT 05402-0070  
 RE: Clinical Design Services for Care Management System

An electronic copy of the Letter of Intent should also be submitted to:  
[tpalmer@vdh.state.vt.us](mailto:tpalmer@vdh.state.vt.us)

### Proposal Content

In responding to the information requested in the narrative section of this RFP, please ensure that the following information is included.

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- Applicant's experience and qualifications for performing the clinical design services and documenting these in a final report and the qualifications of assigned staff to this project,
- A description of the approach and methodology to be used,
- Specification of discrete activities to be undertaken
- Maximum hours anticipated for the design activities, broken out by task areas,
- Hourly or project rate for work performed,
- Estimates of other expenses (for example travel) connected with carrying out the study,
- Total projected costs,
- Relevant supporting material (if any),
- References that can provide information about prior, similar work performed by the bidder.

#### Delivery of Proposals

Proposals must be received **no later than 4:30 p.m. EST on Friday, March 28, 2008** at the following address:

Trish Palmer  
Department of Mental Health  
108 Cherry St.  
Burlington, VT 05402-0070  
RE: Response to RFP – VSH Futures Clinical Care Management System Design

An electronic copy of the Application should also be submitted to:  
[tpalmer@vdh.state.vt.us](mailto:tpalmer@vdh.state.vt.us)

#### Public Disclosure

All proposals shall become the property of DMH.

All public records of DMH are available for disclosure. The proposals sought by the RFP will be reviewed by DMH staff as well as a review panel composed of stakeholders such as DA staff, consumers and advocates. Applicants should be aware that information submitted will be shared with the review panel, so proprietary information should not be included in the proposal.

#### Costs of Proposal Preparation

DMH will not pay any bidder costs associated with preparing or presenting any proposal in response to this RFP.

#### Receipt of Insufficient Competitive Proposals

If DMH receives one or fewer responsive proposals as a result of this RFP, DMH reserves the right to select a Contractor, which best meets DMH's needs. The Contractor selected need not be the sole bidder but will be required to document their ability to meet the requirements identified in this RFP.

### Non-Responsive Proposals/Waiver of Minor Irregularities

Read all instructions carefully. If you do not comply with any part of this RFP, DMH may, at its sole option, reject your proposal as non-responsive.

DMH reserves the right to waive minor irregularities contained in any proposal or to seek clarification from bidding agency.

### RFP Amendments

DMH reserves the right to amend this RFP. DMH will mail any RFP amendments to all bidders who sent a letter of intent.

### Right To Reject All Proposals

DMH may, at any time and at its sole discretion and without penalty, reject any and all proposals and issue no contract as a result of this RFP.

### Authority To Bind DMH

The Commissioner is the only person who may legally commit the Department of Mental Health to personal services, client service, and information service contracts. The Contractor shall not incur, and DMH shall not pay, any costs incurred before a contract is fully executed.

The Department of Mental Health reserves the right to accept or reject any or all bids. The proposals will be evaluated by the staff of VDH and other mental health stakeholders. If an organization is selected, representatives will be invited to negotiate a contract.

### Information about the Futures Project and the Department of Mental Health Activities

Prospective applicants are referred to the Department's web site for information about the Futures Project, its work to date and all related reports from Department staff and consultants. The Futures Project web site address is:

<http://healthvermont.gov/mh/futures/futureshome> .

## **PROPOSAL NARRATIVE**

### **1. Organizational Capacity, Experience, and Strength of the Design Team**

Please describe your organization and its capacity to provide clinical design services to public mental health systems. Include descriptions of experience that is relevant to the clinical design services described in this RFP. Please identify the design team that you propose including each member's relative contribution to the project, and summarize their individual qualifications (resumes should be included in the attachments). Please provide references for your organization's recent work.

## 2. Scope of Work and Expected Outcomes

The following (A-H) Describe the key research, systems analysis and deliverables sought by this RFP. Please describe the key activities, methodologies and timeframes that your organization proposes to use to complete the following scope of work and outcomes.

### A. *Identify Options for Management Structures for Clinical Care Management Systems*

How have other public mental health systems (both county and state-level) managed the coordination and flow of individuals through and among various levels of inpatient and residential health care services? What is the range of management and governance options and how have these worked to assure access to appropriate levels of care? How have these systems been designed to ensure the proper care management of individuals with complex, co-occurring disorders (e.g. substance disorders, trauma, chronic health conditions)? What are the key pros and cons of the most widely used options? How have some of the more successful approaches been staffed, what do they cost and what is the size and scope of system of care in which these models are found? Which approaches seem most viable for Vermont?

### B. *Create consistent, written program descriptions for the following levels of care.*

Each description should clearly describe the unique role of the program in the Vermont system of care and how it differs from other related levels of care. The program descriptions should include basic staffing information, core treatment (including treatment for co-occurring mental health and substance abuse) and support modalities provided, and expected client outcomes<sup>3</sup>.

- Inpatient Care: General hospital care, intensive inpatient care and specialized care
- Crisis Stabilization Bed / Inpatient Diversion bed care
- Secure Residential Recovery
- Community Residential Recovery
- Other community residential programs

### C. *Identify Key System Gaps and Redundancies Based on the Program Descriptions Developed in B (above)*

Are there additional levels of care necessary for a network of collaborating intensive care programs in a small rural state? Are there redundancies in the Vermont system described in “B “above? How existing or new intensive substance disorder treatment programs should be part of or interconnected to the proposed system of care?

### D. *Create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions (in B above).*

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<sup>3</sup> Some of these noted levels of care are more clearly developed and defined than others. The contractor, in consultation with the MH stakeholder community and DMH, may suggest changes to these general categories.

Each set of admission, continued stay, and discharge criteria should be based on objective observation of clinical status, role functioning, and available support. Vermont has some experience using the LOCUS assessment tool to assist in creating a common language to describe clinical status and to help objectify clinical observations and judgment.

Are there other care assessment tools (in addition to LOCUS), that Vermont should consider? What are the pros and cons of applying these tools in the Vermont system of care?

Describe how the proposed criteria and other care assessment tools are compatible with criteria used by substance disorder treatment programs (e.g. ASAM PPC-2R)

*E. Develop uniform protocols to operationalize the following functions and activities in the care management system, based on the overall principles developed.*

The following protocols have been proposed for development. The Department expects that the contractor will develop these protocols in close consultation with Vermont service providers and stakeholders using a combination of key informant interviews, focus groups, and review of existing documents. These protocols need to be written to apply to any adult client entering the system of care. Each protocol should articulate standards for care with measures to assess whether or not the standard is met.

Standards should also include timeframes for accessing care and client satisfaction / evaluation. The standards should reflect high quality care, even if these cannot be met currently. (For example, no one shall be discharged from the hospital without safe housing). While such standards should exist, they cannot be prescriptive.

Protocols should be inclusive of processes for care management of individuals with a complex co-occurring disorder in need of intensive substance use services (e.g. detoxification, residential substance use treatment).

Each protocol should be considered from a perspective of how peers could be used to help support better outcomes for clients (for instance peers may assist in communicating the impact of self neglect of medical conditions in a manner that is more powerful than can professionals). Finally, each protocol must reflect the unique circumstances of the Vermont services system.

1. Crisis/emergency screening (not just for involuntary treatment)
2. Census management (at each level of care)
3. Transportation
4. System-wide discharge planning for a person not connected to community services.
5. Payment for services for people with no insurance, or for care that is not covered by insurance.
6. Conflict resolution between entities
7. Client rights and dissemination of this information

*F. Identify Design Options for Quality Assurance, Quality Improvement and Utilization Review for the Clinical Care Management System.*

In order to be effective, the Vermont Clinical Care Management system requires a quality assurance and improvement system that can identify effective and less effective practices, provide feedback to programs and management on the performance of the system as a whole and identify issues in the allocation of clinical and program resources. In addition, it will require utilization management capability in order to assure that clinical and program resources are used as effectively as possible.

Questions to address include the following: Which approaches to quality improvement, assurance, quality management, and utilization management have proved most effective for collaborating networks of care? How are these staffed? What specific data elements are necessary for effective clinical coordination between different programs and providers? Which measures will have the most impact and power to support utilization management and which are the most feasible to implement? To what degree must the data elements/measures be compatible with those used by substance disorder residential treatment programs .

What range of design options seems most appropriate to the Vermont context? Assume that each level of care and service provider will have different information systems and independent systems of management and governance.

How can Vermont fashion a network of collaborating programs and providers with just enough structure, QI, QA and UR capacity to support collaborative care and the efficient use of system resources? Finally, are there other areas of program design required to create an effective care management system? Please specify and address these in the bid proposal.

*G. Staffing Support for the Care Management design and development process.*

The contractor will interact regularly with the multi-stakeholder Care Management Work Group. The contractor will use key informant interviews, program visits and review of documents to assist in the development of work products.

Draft protocols, options for management and governance design, program descriptions etc. will be widely circulated for review and feedback (including consumers and family members), with final documents incorporating suggested revisions.

The contractor will plan and organize meetings of key stakeholders as necessary to carry out the design work and will provide documentation of these meetings in the form of minutes and other materials.

## *H. Final Report Detailing System Design and Program Elements*

The contractor will provide a final report detailing the products resulting from the scope of work described in this RFP.

### **3. Proposal Work Plan, Time Frame and Budget**

Please provide a proposal work plan to accomplish the scope of work in the time frame described. Identify staff who will be assigned to this project, their roles, and percentage of effort /time devoted to this project. In addition, please provide a budget for the project by major activity. Please describe the fee structure used to develop overall project costs.

## **PROPOSAL REVIEW**

### **Review Criteria**

Proposals will be evaluated using the following general criteria.

- I. Experience, organizational capacity to carry out the project, and strength of the design team.

Does the applicant have experience with similar projects? Is the applicant familiar with adult mental health systems of care? Is the applicant familiar with current and emerging trends in managed health and public mental health care? Does the applicant have demonstrated experience in collaborating with mental health community stakeholders including consumers and family members? Does the proposal identify sufficient time and expertise to complete the work within the allotted timeframe? Have team members worked together before?

- II. Overall approach to completing the scope of design work.

Does the proposal demonstrate a solid understanding of the technical aspects of the project? Is the approach logical, appropriate and comprehensive for the development of the design elements specified in "A" through "G" above? Does the proposal reflect a good balance of detailed clinical care design with overall systems design? Is the approach proposed likely to result in practical products that are feasible to implement?

- III. Budget / Fee structure.

Is the aggregate fee reasonable yet competitive? Is the hourly rate structure competitive? Are the various rates for specific tasks reasonable, complete and clear?

### **Review Process**

Staff from the Department of Mental Health will review proposals for compliance with RFP procedural requirements. If the procedural instructions are not followed, the

proposal shall be considered non-responsive. Non-responsive proposals will be eliminated from further evaluation or returned to bidding agency to address minor irregularities.

In addition to the review done by DMH staff, a review panel composed of stakeholders will be convened to review proposals, rate their merits and submit this information to the Commissioner of Mental Health. The applicant judged to have the best overall merits will be contacted and contract negotiations will begin.

### Scoring

Proposals will be scored by individual Review Panel members. The proposal's preliminary score will be the sum of the scores from individual review team members.

The following weight is assigned to each component of the RFP:

	Weight	Maximum Points	Weighted Total
(1) TECHNICAL PROPOSAL	3	20	60
(2) CONTRACTOR QUALIFICATIONS & DESIGN TEAM	3	10	30
(4) PROGRAM COST	1	10	10

Total Maximum Individual Scores 100