Behavioral Health System Baltimore

REQUEST FOR PROPOSALS:

Wellness and Recovery Centers

Release Date: November 13, 2019

Pre-Proposal Conference: December 5, 2019

Proposal Due: January 6, 2020

Anticipated Contract Start: July 1, 2020

Issued by:

Behavioral Health System Baltimore, Inc.
100 South Charles Street, Tower II, 8th Floor
Baltimore, Maryland 21201

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Wellness and Recovery Centers

I. Overview of the Project

A. BHSB'S GOALS & OBJECTIVES

Behavioral Health System Baltimore, Inc. (BHSB) is a non-profit organization tasked by Baltimore City to manage the City's public behavioral health system. As such, BHSB serves as the local behavioral health authority for Baltimore City. In this role, BHSB envisions a city where people live and thrive in communities that promote and support behavioral health and wellness.

BHSB is committed to enhancing the behavioral health and wellness of individuals, families, and communities through:

- The promotion of behavioral health and wellness prevention, early intervention, treatment, and recovery;
- The creation and leadership of an integrated network of providers that promotes universal access to comprehensive, data-driven services; and
- Advocacy and leadership of behavioral health-related efforts to align resources, programs, and policy.

BHSB is committed to promoting behavioral health equity in Baltimore City by ensuring that the behavioral health provider network is culturally and linguistically responsive to the diverse populations served; reducing behavioral health care access barriers for populations known to experience discrimination and marginalization; and supporting communities directly to develop services that are responsive to their unique strengths and needs.

B. OVERVIEW OF PROJECT

Through this procurement, BHSB is seeking qualified organizations to implement peer-run Wellness and Recovery Centers (WRCs) in Baltimore City. For clarity, some use the term "Recovery Community Center." For the purposes of this RFP, the term "Wellness and Recovery Center" is inclusive of the Recovery Community Center model.

Wellness and Recovery Centers (WRCs) are peer-run, community-based drop-in spaces that provide specialized, non-clinical services related to mental health, substance use, and/or trauma. WRCs have origins in consumer movements, which organized in the late twentieth century among people who had traumatic experiences with health systems and institutions. Consumer movements evolved

among people with lived experience of mental illness, substance use, and health conditions such as HIV/AIDS. Although these evolved separately, to some extent the movements strengthened one another and were built on the same core principles of human rights, self-help/self-determination, and mutual support. Some key milestones include:

- 1935
  - Alcoholics Anonymous groups form
- 1960s
  - Deinstitutionalization of persons living in psychiatric hospitals; increased organizing and advocacy against involuntary treatment methods
- 1980s-2000s
  - Many consumer and family groups organize at local, state, and national levels, such as the Black Mental Health Alliance, Faces and Voices of Recovery (and affiliate Association of Recovery Community Organizations), National Alliance on Mental Illness (NAMI), and On Our Own of Maryland, Inc.
  - The first peer-run drop-in center opens in Baltimore City (On Our Own, Inc.)
  - People living with HIV/AIDS organize and Denver Principles are written
- 1990s-2000s
  - Increasing evidence for peer support within a Recovery-Oriented System of Care (ROSC) model motivates more providers and funders to integrate peers into many types of care settings
- 2013
  - Maryland adopts a state-recognized peer credential that integrates mental health and substance use expertise and is recognized by the International Certification and Reciprocity Consortium.

This RFP is the first time these grants have been competitively re-procured. BHSB intends to award these grants through a fair, transparent process that rewards innovation, accountability, and performance. BHSB's primary goals are that:

- WRCs should reach the persons with lived experience of substance use, mental illness, and trauma who are <u>least well served</u> by the traditional system of behavioral health care;
- These persons should feel welcome, validated and supported by their WRC; and
- WRCs empower consumers to become peer specialists and policy leaders to reduce disparities and improve quality and accountability in the health care system.

It is BHSB's goal to maintain fidelity to the peer-run model with an emphasis on WRCs' independence from clinical services. This ensures WRCs will continue to provide an alternative or complementary pathway to recovery and will remain a force for reducing behavioral health disparities.

To this end, this RFP was designed with feedback from stakeholders in an effort to prioritize programs that provide high-quality, community-responsive services, and to place less emphasis on clinical, research, and grant-writing skills. Feedback on this procurement strategy was sought from state and local stakeholders through a public listening session (advertised through BHSB's newsletter), and follow-up discussions were offered to all attendees. However, BHSB recognizes that running an effective WRC requires a high level of management skill as well as strong governance, policies, and internal controls that ensure:

- Protections for vulnerable persons served,
- Responsible management of public funding,
- Strategic planning of services,
- Leadership development among consumers and staff, and
- System-level policy engagement.

Through this RFP, BHSB seeks to balance a low-barrier approach with maximum accountability to consumers and the Baltimore City community.

C. SCOPE OF SERVICE

Services Provided

WRCs are expected to provide all of the services listed below. The primary service is peer support. Ancillary services (such as meals) should be intended to maximize engagement in peer support and should not significantly supplant the WRC's capacity to provide peer support.

Where a minimum number of services is noted, this is a performance target tied to the contract term and fiscal year. For example, "12 sessions per year" means the provider's contract would require 12 sessions to occur during the contract term 7/1/2020 – 6/30/2021.

1. Outreach and Engagement Services
    a. A low barrier, accessible, safe space consistently open (following a schedule that does not change except during emergencies) during:
        i. Most business hours (9a-5p) and
        ii. At least some non-traditional hours (i.e. early mornings, evenings, and weekends)

b. A welcoming environment that encourages people to "come as they are," free of stigmatizing language, and pre-conditions to services (e.g. expectations of sobriety or service plan adherence)
c. On-site basic services and engagement tools such as:
    i. Computer/internet access
    ii. Telephone/voicemail access
    iii. "Mail drop" or mailing address services
    iv. Snacks or meals
    v. Low-cost incentives such as hygiene kits
d. Partnerships and coordination with transportation providers to maximize the center's accessibility and consumers' access to other resources when leaving the center
e. A newsletter and/or calendar of events published at least monthly
f. A "warm line" for telephone support and referrals during normal business hours (with documentation of calls received and topics discussed)

2. One-to-One (1:1) Support Services
    a. 1:1 Peer Support sessions (50 per year) each lasting at least 15 minutes and documented using an approved form
    b. Non-clinical crisis intervention
    c. Harm reduction services (e.g. naloxone, safety planning)
    d. Partnerships with other providers and systems to facilitate access to services (ideally on-site but at minimum through referrals) such as:
        i. Medical services (e.g. STD testing, vision screening)
        ii. Benefits screening and applications, including health insurance and SSI/SSDI Outreach, Access, and Recovery (SOAR)
        iii. Housing and homelessness services
        iv. Education, job training, and job placement services
        v. Advocacy/liaison to navigating the criminal justice system[1]
        vi. School-based services
        vii. Department of Social Services
        viii. Food pantry/nutrition resources
    e. A resource library to assist consumers with issues such as entitlements, fair housing, access to employment, etc.

[1] In FY 20, BHSB provided a supplement to RCCs to pilot direct partnerships designed to facilitate peer services in criminal justice settings. In FY 21, to support the sustainability of this pilot, the review committee will select at least one WRC/RCC applicant that plans to continue these services, which include: receiving referrals for peer services from criminal justice partners, providing scheduled on-site peer services at criminal justice locations, and working with BHSB and criminal justice stakeholders to expand access to peer services for persons involved in the criminal justice system.

f. Partnerships and coordination with mobile outreach teams and services (e.g. street outreach, mobile vans)

3. Groups and Mutual Support
    a. Scheduled, facilitated peer support groups (50 per year) focused on a specific topic
    b. To fulfill requirement 3(a), the center is required to maintain peer staff who are trained/certified to lead peer groups such as WRAP, Recovery Coach Academy (CCAR), Intentional Peer Support (IPS), SMART, Mental Health First Aid, AA/NA, Al-Anon, etc.
    c. Informational presentations by outside speakers (12 per year) on health and human services topics relevant to consumers (e.g. reproductive health, psychiatric advance directives)
    d. Group events or activities involving 3 or more consumers (12 per year) designed to promote social connection and reduce isolation

4. Anti-Stigma and Community Engagement
    a. Presentations (12 per year) to clinical service providers and public/community groups about stigma and peer support, including staffed tables at health fairs and other community events
    b. Develop an annual Community Wellness and Recovery Needs assessment with extensive involvement of staff, consumers, and local community members, and in a transparent way, use this assessment to drive the center's program development, e.g. operating hours, training, education, and resource needs
    c. Maintain relationships with neighborhood associations and representation at community events
    d. Maintain relationships with nearby service providers and businesses

5. Behavioral Health System and Workforce Development
    a. Attend quarterly WRC meetings convened by BHSB (relevant to Baltimore City WRCs) and MDH (relevant to statewide WRCs)
    b. Provide representation to policymaking and planning workgroups, committees, and boards that impact the behavioral health of Baltimore City residents
    c. Participate in trainings relevant to operating a WRC, such as: nonprofit governance, program management, and financial management.
    d. Host or facilitate trainings for persons interested in becoming peer recovery specialists, and/or sponsor consumers in attending such trainings at other locations, with priority given to trainings that have been approved by the state-designated board overseeing peer certification

e. Sponsor staff and consumers (3 persons per year) to attend at least one MDH-approved conference relevant to Maryland's peer workforce

Number of Individuals Served and Hours Open

Each WRC must serve a minimum number of persons (duplicated and unduplicated) and must maintain a minimum number of operating hours that is proportionate to the funding amount requested. Applicants must estimate a target they can achieve within the ranges below and provide evidence they can meet the target (e.g. based on prior attendance or service records at their location or a comparable location).

Requested Funding Amount	Minimum Annual Target: Unduplicated Persons Served	Minimum Annual Target: Duplicated Persons Served	Minimum Annual Target: Operating Hours
Explanation:	*Number of unique persons served who provide identifiable data. A person is counted only once even if served twice.*	*Number of all persons served, including those served anonymously. A person is counted twice if served twice.*	*Number of posted, consistent hours the center is open to the public during the week, multiplied by 52 weeks.*
$0-$300,000	100 - 200	300 - 800	1,560 - 2,600
$301,000-$600,000	200 - 250	800 – 1,000	2,600 – 2,912
$601,000-$650,000	250+	1,000+	2,912+

Applicants that cannot meet targets within these ranges can still apply, but must propose a lower target they consider appropriate and must justify:

- Why their cost per person served should be higher relative to other WRCs and
- Whether/how consumers would benefit from the higher cost (e.g. higher rent in a more accessible location or more services available).

When estimating the target for operating hours, applicants do not need to factor in emergency closings due to inclement weather.

Values and Practices Essential to Service Delivery

There are four essential values/practices for WRC Services Delivery: Peer Governance, Independence from Clinical Services and other programs, Integrated Care and Holistic or "Whole Health" Approach, and Community Based.

1. **Peer Governance**

   The WRC model is participant-led and peer-led.

   At minimum, the following is required:

   a) A governing board with at least 51% representation of persons who self-identify as a person with lived experience of addiction or mental illness.

b) This could be the board of the provider organization as a whole, or a separate board designated (and empowered) to provide oversight to the WRC program.
c) Involvement of participants in setting center policies and practices, e.g. through regular participant governance meetings.
d) Thoughtful, continuous quality improvement process that incorporates client feedback (e.g. surveys, focus groups).
e) Affirmative efforts to hire and promote persons with lived experience into management positions.

Additional recommended practices include:

f) Board representation and other governance processes specifically designed to include people who are not using or distrusting of mental health or substance use treatment services, actively use drugs, people experiencing homelessness, youth, older adults, sex workers, and other populations in the WRC's community that are not well served by traditional health services.
g) Structured processes to involve of participants as volunteers and to support participants who wish to pursue peer certification.

2. Independence from Clinical Services and other Programs

Originally, most WRCs were stand-alone nonprofits to preserve the independence of the services and ensure the center would be primarily governed by participants themselves. Over time, as organizations have taken on new grants and billable services, at some sites the WRC model has shifted to become embedded in a larger organization that offers a broader continuum of services. To ensure fidelity to the peer-run model, WRCs must take measures to ensure the program is independent from clinical services.

At minimum the following is required:

a) Dedicated space: delineated by physical boundaries (e.g. walls, partitions, etc.) that is used by the WRC only, and not shared by other programs.
b) Staffing:
    i. No clinical or billable services (or administrative support for clinical or billable services) may be provided by WRC staff during time that is charged to the WRC grant.
    ii. At least 1 dedicated staff position must be allocated 100% to the WRC, and not to other programs.

iii. For any staff who split time across multiple funding sources, they must have a clear division of time and responsibilities that is documented using timesheets or a comparable tracking method.

c) Voluntary Services: WRC participants must not be required or coerced into participating into any non-WRC services.

Additional recommended practices include:

d) Incorporating the WRC as an independent nonprofit or independent affiliate

3. Integrated Care and Holistic or "Whole Health" Approach

The WRC's philosophy recognizes that behaviors such as addiction and violence are not solely the result of individual choices but are impacted by environmental stressors and trauma. When unhealthy behavior is frequently repeated, it becomes a habit, which is reinforced by brain pathways that make it hard to change habits. WRCs provide holistic support in areas often called "social determinants of health" such as social connection, nutrition, family relationship-building, etc.

WRCs are required to employ certified peers, which is a co-competent certification, and to encourage training and professional development that improves the co-competence of staff. Additionally, WRCs are required to partner and collaborate with all types of health providers (mental health, substance use, medical, and integrated).

At minimum, the following is required:

a) WRC staff understand different types and levels of care for common health needs.
b) WRCs have comprehensive knowledge of the provider network in their community and have procedures in place that support staff in making referrals for people as quickly as possible.
c) WRC staff can act as a patient advocate with clinicians of any type.
d) WRCs have specific programming that addresses substance use, mental health, and trauma.
e) WRCs target their outreach to specifically engage people with:
    i. Substance use issues only,
    ii. Mental health issues only, and
    iii. Co-occurring issues.

Additional recommended practices include:

f) WRCs "braid" multiple funding sources, meaning they leverage more than one funding source to provide an array of integrated services to

participants, while tracking spending and performance measures separately for each grant.

4. **Community-Based**

   WRCs/RCCs are responsive to the needs of the City as a whole as well as the neighborhood surrounding the program.

   In addition to the requirements listed in the "Service Provided" section, the following is required:

   a) WRCs are located in City neighborhoods where needs are highest, as measured by indicators such as: high overdoses, high incidence of violence, and high poverty.
   b) WRCs develop knowledge of health disparities in the City as a whole as well as the community they serve and involve community members in developing strategies to address them.
   c) WRCs analyze their participant data, community-level data, and city-level data to:
      i. Identify subpopulations with service needs they are not meeting, such as: transition age youth, families with children, older adults, women, veterans, and people who identify as LGBTQ, and
      ii. Take action to improve their outreach, engagement, and retention of these groups OR, when more appropriate, design and implement a strategy to link these groups to comparable, accessible services in the community.
   d) WRCs design and implement accommodations for people with special needs such as non-English speakers, persons with low literacy, and persons with disabilities.

D. FOCUS POPULATION

The focus population for the RFP as a whole is adults (18 or older) with lived experience of substance use, mental illness, and/or trauma who are least well served by the traditional system of behavioral health care.

A WRC may (but is not required to) narrow its focus to a subgroup within this population if they can demonstrate how the subgroup experiences behavioral health disparities and how their WRC would be uniquely designed to address those disparities, for example, in the design of the physical space and services offered.

E. STAFFING REQUIREMENTS

Each WRC is required to have at minimum:

1. 1.0 FTE Program Manager

2. 1.0 FTE Certified Peer Specialist
3. 1.0 FTE Registered Peer Supervisor
4. A bookkeeper, accountant or equivalent (may be an employee, consultant, services secured via contract with a fiscal sponsor, or a comparable method)

A single staff person who is a full-time program manager, certified peer, and registered peer supervisor would fulfill all staffing requirements #1-3 above. The 1.0 Program Manager does not necessarily have to be a peer or someone with lived experience.

Additionally, strong financial management is an important aspect of this project, so applicants should carefully consider the best way to meet requirement #4.

Recognizing that peer support is most effective when the "lived experience" of the peer is closely matched with the target population, applicants should consider how they will match the experience of peer staff with the target population of this RFP, and if they have proposed a priority subpopulations, how they will match their staffing pattern with the target subpopulation.

F. FUNDING AVAILABILITY

FY 21 funding levels are not yet available. The total funding amount has been relatively stable for the last five years, in the sense that cuts have been rare and have not significantly changed the total funding amount.

FY 20 funding for this service is currently $1,709,498, which is split among five organizations that operate six facilities. There is no minimum or maximum number of organizations or facilities that must receive funding, but the goal is to maintain a similar or expanded capacity to serve people.

Of the FY 20 total funding amount ($1,709,498):

- $1,052,997 (62%) is from a source dedicated for addiction services (grant number AS019)
- $656,501 (38%) is from a source dedicated for mental health services (grant number MH327)

Applicants must indicate whether they are willing to accept funds from only one or both the addiction services (AS019) and the mental health (MH327) funding sources. Eligible costs on both sources are the same, following the MDH Human Services Agreements Manual. However, costs supported through AS019 must be clearly attributed to addiction-related services and costs supported through MH327 must be clearly attributed to mental health-related services.

Given that applicants are required to demonstrate how competently they will integrate mental health and substance use programming, one potential strategy is to indicate a willingness to accept funding from both sources. It is important to be aware that this strategy would increase the complexity of grant administration and billing, since the two funding sources cannot be blended. A provider requesting funding from both sources must demonstrate they have the capacity to "braid" the funding, meaning that each funding source would have a separate contract with:

- Separate budgets
    a. If any staff are split between the 2 sources, a specific percentage of their time (FTE) must be budgeted to each and actual time spent on each must be tracked using timesheets or a comparable method
    b. Expenditures on each grant must be reported separately
    c. Each grant's spending must be tracked separately
- Separate performance measures and deliverables
    a. Some measures will be unique to each grant and reported separately
    b. Some measures (e.g. attendance) may be "combined," i.e. tracked and reported for the WRC as a whole. For these measures, the same total (same number) would be submitted on two separate reports.

G. REPORTING (DELIVERABLES)

BHSB is dedicated to enhancing outcomes reporting system-wide in order to evaluate the quality of public behavioral health services in Baltimore City. Overall, individuals receiving behavioral health services are expected to improve over time, and programs should be able to demonstrate expected outcomes.

The selected applicants will be expected to submit regular program and financial reports to BHSB using an online Contract Management System during the entirety of the approved contract term. BHSB requires regular program reporting on key indicators, as outlined below:

There are approximately 30 unique performance measures that MDH requires WRCs to track. These are subject to change. When MDH changes the performance measures, BHSB works closely with providers to update data collection tools and implement changes over a reasonable period of time.

Selected WRCs will be required to track performance measures using an Excel-based Data Tracker that was developed by BHSB or an equivalent BHSB-approved tool. If providers would prefer to use their own database or other tool, BHSB would need to review and approve that it meets the reporting requirements.

A partial list of data deliverables, given here as an example, includes:

- Unduplicated persons served (i.e. if the same person is served twice, they are counted as 1 person), and within this group:
    a. Demographics
    b. Number referred/placed in mental health services
    c. Number referred/placed in addiction services
    d. Number referred/placed in housing programs
    e. Number referred/placed in employment services
- Duplicated persons served (i.e. if the same person is served twice, they are counted as 2 persons)
- Hours open
- 1:1 Peer Encounters
- Number of peer-led groups facilitated
- Number of educational sessions held

H. CONTRACT MONITORING AND VERIFICATION

Applicants selected through this RFP process will enter into a contractual agreement with BHSB. The contract will outline all requirements, including the scope of service, insurance requirements, final approved budget, financial requirements (including required audit reports), reporting requirements (programmatic and financial), etc. Selected applicants will receive a Letter of Award that outlines the steps needed to execute the contract.

BHSB will engage in monitoring activities throughout the contract term. Some of these activities include: a) Review of program reports to evaluate progress on deliverables and outcomes, b) Review of financial reports to evaluate financial outcomes, and c) Review of general administrative compliance documents. BHSB may also conduct an audit to verify service delivery either during or after the contract year. The selected applicant will be required to participate in all relevant monitoring, evaluation, and verification activities.

If, during monitoring activities, it is discovered that the sub-vendor is not fulfilling the obligations stated in the contract resulting from this RFP, a Program Improvement Plan may be required, with additional follow-up monitoring and verification to ensure requirements are being met.

II. Overview of RFP

A. PURPOSE OF RFP

The purpose of this RFP is to select qualified organizations to implement one or more peer-run Wellness and Recovery Centers (WRCs) in Baltimore City.

B. APPLICANT ELIGIBILITY

Applicants must meet all of the criteria outlined below to be considered eligible to be selected through this RFP process:

Applicants must have at least one year of recent (within last three years) experience operating a walk-in resource center in a space that they continuously leased or owned throughout that time.

The proposed WRC does not need to be in the same space (that has been continuously leased/owned for one year) but must be in a space that is currently owned or leased by the applicant (as of the time of the applicant's submission).

If applying for more than one WRC, a separate application should be submitted for each one.

C. PROPOSAL TIMEFRAME AND SPECIFICATIONS

1. Timeline

Release Date:	November 13, 2019
Pre-Proposal Conference:	December 5, 2019
Proposal Due:	January 6, 2020
Anticipated Contract Start:	July 1, 2020

2. Pre-Proposal Conference

Date: December 5, 2019
Time: 10:00 AM - 11:00 AM
Location: Behavioral Health System Baltimore
100 S. Charles St., Tower II, 8th Floor
Baltimore, MD 21201

Attendance by applicants is **strongly recommended**. Applicants who will not be attending the pre-proposal conference may submit questions by email to Jennifer Glassman by the close of business on **December 4, 2019.** RSVPs are not required, and a phone line will not be provided.

Questions posed prior to or during the pre-proposal conference and BHSB's responses will be posted on BHSB's website at www.bhsbaltimore.org by **December 12, 2019**. Additionally, the questions and answers will be emailed to all individuals who either attended the pre-proposal conference or submitted questions.

Questions received after the conference will not be considered or responded to.

3. Proposal Due Date, Time, and Location

Proposals must be submitted electronically by email to Procurements@BHSBaltimore.org by attaching one or more PDF files. Because some email systems prohibit sending or receiving large files, applicants may need to split files into multiple emails. It is recommended that a separate email be sent with no attachments to request confirmation that the proposal was received.

All proposals must be received no later than **12:00 pm (noon) EST on January 6, 2020**. All submitted proposals become the property of BHSB. If you are having technical troubles related to submitting your proposal, contact BHSB before the due date/time.

Proposals submitted after the due date/time will not be considered.

4. Authorized Contact

Applicants are advised that the authorized contact person for all matters concerning this RFP is Jennifer Glassman, whose contact information is listed below.

Jennifer Glassman, Procurement Lead/ Special Projects Coordinator
Behavioral Health System Baltimore
100 South Charles Street, Tower II, 8th Floor
Baltimore, MD 21201
Email: Procurements@BHSBaltimore.org

5. Anticipated Service Term: July 1, 2020 – June 30, 2021, with options to renew annually pending availability of funding and performance. BHSB anticipates that this portfolio will continued to be procured on a regular basis.

D. AWARD OF CONTRACT

The submission of a proposal does not, in any way, guarantee an award. BHSB is not responsible for any costs incurred related to the preparation of a proposal in response to this RFP. BHSB reserves the right to withdraw an award prior to execution of a contract with a selected applicant in BHSB's sole and absolute discretion.

BHSB will select the most qualified and responsive applicants through this RFP process. BHSB will enter into a contract with selected applicants following the notification of award. All selected applicants must comply with all terms and conditions applicable to contracts executed by BHSB.

E. RFP POSTPONEMENT/CANCELLATION

BHSB reserves the right to postpone or cancel this RFP, in whole or in part.

F. APPLICANT APPEAL RIGHTS

Applicants may file an appeal to the Procurement Lead within five days of notification of non-award. The Procurement Lead will review the appeal, examine any additional information provided by the protesting party, and respond to the protestor within ten working days of receipt of the appeal.

III. Format and Content of Proposal

A. PROPOSAL INSTRUCTIONS

Applicants should submit all required information in the format specified in these instructions by the due date. The proposal narrative should be submitted using the outline provided in the next section, and should not exceed 20 typed, single-spaced pages using Times New Roman 12-point font. The cover letter and appendices do not count toward the page limit.

The final proposal package shall include:

- A proposal cover letter signed and dated by an authorized representative of the applicant organization. If the applicant is using a fiscal agent, the legal name of that organization as well as a designated contact person with contact information should be identified.
    - The cover letter must include:
        - full legal name of the applicant organization
        - physical address
        - designated contact person
        - their contact information (email address and phone number)
- A full proposal with all appendices.

Late proposals will not be considered.

B. PROPOSAL NARRATIVE OUTLINE AND RATING CRITERIA

The proposal should be a clear, concise narrative that describes the applicant's responses to the prompts outlined below. This narrative outline will also be used as the rating criteria, and the number of points allocated to each section is also noted.

1. **Organizational Background and Capacity (25 points)**
    a. Provide an overview of your organization, including how long your organization has operated a walk-in resource center in a space that you have continuously leased or owned (required one year within the last three years). Attach a copy of the lease or deed, along with the most recent Fire Inspection Certificate and Use and Occupancy Certificate.
    b. Give the address and describe the space that you currently lease or own that would be used for the WRC. What amenities does the space offer? How is open to passersby? How would you ensure it is accessible and welcoming to the focus population, and (if you proposed to narrow your focus) to your subgroup?

c. Explain how the following are relevant to and/or emphasized in your organization's current vision, mission, values, and strategic plan: Peer Movement, Harm Reduction, and Consumer Self-Determination.
d. Describe your organization's history providing peer support and the current settings/programs in which you provide peer support.
e. If you currently employ and/or manage volunteer peers, how are they supported into decision-making and leadership roles within your organization?
f. Describe whether your organization is minority- and/or woman-owned or led.

2. Principles and Values (25 points)

a. Describe how you would maintain fidelity to a peer-run governance model and independence from clinical services, including board representation of persons with relevant lived experience; the relationship between the board and the WRC; the role of the board in governance, strategic planning, management, and quality improvement efforts. If you propose a subpopulation, describe how this governance plan is tailored to your subpopulation.
b. Describe how the WRC would support consumers to become certified peers and foster their professional development, providing examples of how your organization has done this in the recent past.
c. If your organization would provide clinical services in addition to the WRC, explain how there would be clear boundaries between clinical services and the WRC in physical space, staffing, and oversight. Describe how your WRC would ensure WRC participants do not feel coerced into participating in non-WRC services.
d. Describe your approach to providing a competent integrated, holistic "whole health" approach to addressing substance use, mental health, and medical health.
e. Describe how the proposed WRC would be responsive to the needs of the City as a whole as well as the local neighborhood surrounding the program. Discuss whether/how your WRC would be optimally located to bring services to an underserved neighborhood.

3. Service Delivery (30 points)

a. Describe what target measures you propose for duplicated persons served, unduplicated persons served, and operating hours the WRC will be open to the public. These must fall within the ranges prescribed in RFP or justification must be provided.
b. Describe your plan to provide all of the required services outlined in the "Services Provided" section of the RFP, specifically addressing

where services will be provided, who will be providing them, and if a formal or information referral partnership will be established. If you proposed a subpopulation, explain how the service would be designed to meet the needs of your chosen subpopulation.

c. Describe whether your WRC would provide or be willing to provide peer services in criminal justice settings, including (at minimum): receiving referrals from criminal justice partners, providing scheduled on-site services at criminal justice locations, and participating in planning meetings with criminal justice partners. Explain your organization's experience in providing these services.
d. Describe how your WRC would function as a low barrier "safe space" that would be welcoming, non-stigmatizing, and affirming to the target population as identified in this RFP, and if applicable, to the target subpopulation. Describe any creative strategies used to engage consumers especially any that the organization initially struggled to accommodate.
e. Describe how the proposed WRC would handle overdoses, suicide risk, and mental health crises when they occur onsite, giving examples of how your organization has managed these in the recent past.
f. Define steps your WRC would take to educate local/city/state stakeholders and policy/planning workgroups about stigma and other issues affecting WRC participants, giving examples of how your organization has engaged in policy and anti-stigma work in the recent past.

4. Staffing Plan (10 points)

a. Describe your proposed staffing model and how it will fulfill the staffing requirements of this RFP. Describe how you will fulfill the requirements for a Program Manager, CPRS, and RPS and explain how this will maximize the WRC's capacity to provide peer support. If you proposed serving a subpopulation explain how you would match your staffing model to this subpopulation.
b. Explain how you would meet the requirement to have a bookkeeper/accountant as described in the Staffing Requirements section of this RFP. Describe how your plan ensures your WRC would take a strategic approach to spending including monitoring over/under spending, maintaining protocols to verify cost eligibility, keeping documentation/receipts, and maintaining strict internal controls to prevent misuse of funds. If you indicated you are willing to accept funding from both sources, indicate how your bookkeeper/accountant will manage "braiding" the two funding sources.

5. **Effectively Serving the Focus Population (10 Points)**
    a. Describe your organization's history and expertise in serving the focus population of this RFP, including any accommodations that will be made for persons with special needs. If you are proposing to narrow your focus to a subgroup, (1) discuss the disparities that exist for this subpopulation in the City as a whole and at the location of your WRC, (2) describe how your WRC is uniquely qualified and designed to address these disparities, and (3) explain how would you accommodate someone who is not a member of your subgroup, but is a focus of this RFP?

6. **Proposed Program Budget (10 points)**
    a. Indicate whether you are willing to accept funds from both funding sources – Mental Health (MH327) and Addiction Services (AS019) or just one.
    b. Attach a line-item budget for the time period 7/1/20-6/30/21 that includes the amount of funds requested.
    c. Provide a budget justification/narrative that describes the budget in more detail. If you indicated that you are willing to accept funding from both sources, specify your plan to "braid' the two funding sources. Specify which costs are attributable to one or the other funding source and which costs would be shared.

7. **Implementation Timeline (5 points)**
    a. List or outline all of the activities that you have committed to perform in your application (if selected), but that are not yet fully operational. Show on a timeline all of the steps that would be necessary to fully operationalize them and by when each step would be completed. For the purposes of this question, your draft timeline should start on 4/1/2020, but please be aware that actual award notification may be earlier or later, depending on factors that affect the procurement process. It should be clear in your timeline that the target contract execution date is 7/1/2020, and the first disbursement of funding would typically become available between 7/1/2020 – 8/31/2020.

8. **Appendices (0 points)**
    - Copy of lease or deed
    - Fire inspection certification (within the last year)
    - Use and Occupancy Certificate
    - Line-Item Budget
    - Most recent Financial Audit and Management Letter, if applicable (or an explanation if this is not applicable)

- Most recent IRS 990 – Return of Organization Exempt from Income Taxes, if applicable (or an explanation if this is not applicable)
- Certificate of Good Standing from the Maryland Department of Assessments and Taxation
- Any relevant licenses or certifications held by individuals or the organization