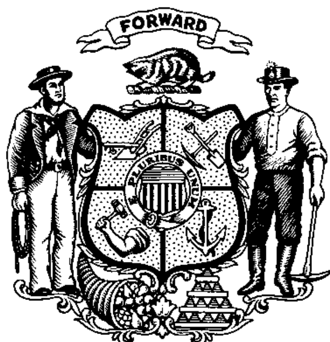
GRANT REQUEST FOR PROPOSAL

STATE OF WISCONSIN

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES



RFPG # G-0346 DMHSAS-17

COORDINATED SPECIALTY CARE FOR EARLY INTERVENTION OF FIRST EPISODE PSYCHOSIS

PROPOSALS MUST BE RECEIVED BY 3:00 PM CT 09/23/2016

LATE PROPOSALS WILL BE REJECTED

FAXED PROPOSALS WILL NOT BE ACCEPTED

THE STATE RESERVES RIGHT TO REJECT ANY AND ALL PROPOSALS

TABLES OF CONTENTS

1.0 GENERAL INFORMATION....4

1.1 SCOPE OF THE PROGRAM 4
1.2 PROCURING AND CONTRACTING AGENCY 15
1.3 DEFINITIONS 15
1.4 CLARIFICATION AND/OR REVISIONS TO THE SPECIFICATIONS AND REQUIREMENTS 17
1.5 CONTRACT QUANTITIES / NEW OR DELETED ITEMS 18
1.6 REASONABLE ACCOMMODATIONS 18
1.7 CALENDAR OF EVENTS 18
1.8 PROPOSER CONFERENCE 18
1.9 CONTRACT TERM AND AVAILABLE FUNDING 18
1.10 RETENTION OF RIGHTS 19
1.11 WHO MAY SUBMIT AN APPLICATION 19
1.12 ASSESSMENT OF COMMUNITY NEED 19

2.0 PREPARING AND SUBMITTING A PROPOSAL 20

2.1 GENERAL INSTRUCTIONS 20
2.2 PROPOSAL ORGANIZATION AND FORMAT 21
2.3 MULTIPLE PROPOSALS 22
2.4 WITHDRAWAL OF PROPOSALS 22
2.5 NOTICE OF INTENT TO APPLY 22

3.0 PROPOSAL SELECTION AND AWARD PROCESS....23

3.1 PRELIMINARY EVALUATION 23
3.2 PROPOSAL SCORING 23
3.3 PROPOSAL EVALUATION CRITERIA 23
3.4 NOTIFICATION OF INTENT TO PURSUE CONTRACT NEGOTIATIONS 23
3.5 RIGHT TO REJECT PROPOSALS AND NEGOTIATE AGREEMENT TERM 23
3.6 LETTERS OF SUPPORT (OPTIONAL) 24

4.0 MANDATORY REQUIREMENTS 24

4.1 PROPOSAL FORMAT, ELECTRONIC DATA BASE/SPREADSHEET REPORTING 24
4.2 STATUTORY REQUIREMENTS 24
4.3 ADMINISTRATIVE RULE, CERTIFICATIONS REQUIREMENTS 25
4.4 PATIENT'S/CLIENT'S RIGHTS POLICY 25
4.5 SECURITY OF ELECTRONIC DATA 25
4.6 AFFIRMATIVE ACTION PLAN AND CIVIL RIGHTS COMPLIANCE 26
4.7 TOBACCO SMOKE FREE ENVIRONMENT 26

5.0 PROPOSER INFORMATIONAL SECTION....26

5.1 GOALS, OBJECTIVES AND PERFORMANCE EXPECTATIONS 26
5.2 PROGRAM DESIGN AND METHODOLOGY 32
5.3 WORK PLAN 33
5.4 ORGANIZATIONAL EXPERIENCE AND CAPACITY 33
5.5 REPORTING, PERFORMANCE MEASUREMENT & QUALITY IMPROVEMENT 33

6.0 TECHNICAL RESPONSE SECTION 35

6.1 GOALS, OBJECTIVES AND PERFORMANCE EXPECTATIONS 35
6.2 PROGRAM DESIGN AND METHODOLOGY 36

6.3 WORK PLAN 37
6.4 ORGANIZATIONAL EXPERIENCE AND CAPACITY 37
6.5 REPORTING, PERFORMANCE MEASUREMENT & QUALITY IMPROVEMENT 38
7.0 PROJECT BUDGET 38
8.0 REQUIRED FORMS 39

1.0 GENERAL INFORMATION

Introduction and Background
The purpose of this document is to provide interested parties with information to enable them to prepare and submit an application for the development and implementation of a Coordinated Specialty Care (CSC) Program providing early intervention for First Episode Psychosis (FEP) services. The Department of Health Services (DHS) intends to use the results of this solicitation to award one or more contracts for early intervention treatment for FEP utilizing CSC model that meets Federal and State requirements.

The solicitation is organized into the following sections plus attachments:

Section I. General Information
Section II. Scope of Project
Section III. Preparing and Submitting a Proposal
Section IV. Project Proposal
Section V. Selection and Award Process
Section VI. Forms and Attachments

Please see the following resources for more details on the CSC model:

- Recovery After an Initial Schizophrenia Episode (RAISE) program's summary document for an over view of the components of the CSC model: http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf
- RAISE website via the National Institute of Mental Health: http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml
- RAISE Manuals: https://raiseetp.org/
- OnTrack USA Materials: http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx

1.1 Scope of the Program

The DHS represented by the Division of Mental Health and Substance Abuse Services (DMHSAS) invites certified Community Support Programs (CSP), counties alone or in collaboration with other counties (consortium) to submit an application for the development and implementation of an Early Intervention Treatment for First Episode Psychosis Program based on the Coordinated Specialty Care (CSC) model.[1, 2] The CSC evidence-based model is an early intervention program serving youth and young adults aged 15-25 with non-organic, non-affective psychotic disorder diagnoses. The CSC Program will utilize a coordinated team approach to provide intensive services to young adults in the early stages of FEP utilizing person-centered and recovery-oriented philosophies. Components of CSC are outreach, low-dosage medications, cognitive and behavioral skills training, Individual Placement and Support (IPS) supported employment and education, case management, and family psychoeducation. The model also emphasizes addressing each individual's unique goals, needs, and preferences through shared decision-making and collaborative treatment planning. CSC clients are enrolled in the program for a limited time (2-5 years) providing skills and treatment. This early intervention offers real hope for clinical and

[1] NASMHPD's webinar on Components of Coordinated Specialty Care for First Episode Psychosis: Guidance Related to the 5% Set-Aside in the Mental Health Block Grant http://nasmhpd.adobeconnect.com/p95pdydhky2/
[2] NASMHPD TA Coalition Webinar: Funding Strategies for Early Psychosis Intervention Models: HTTP://NASMHPD.ADOBECONNECT.COM/P62EIF236N9/

functional recovery.[3] A maximum of seven awards will be distributed via this Request for Proposals (RFP). Priority will be given to counties currently without CSC programs. Priority will also be given to service areas with a large population in need of FEP services such as Milwaukee County. Priority will also be given to areas in need of criminal justice mental health diversion resources.

The CSC program will provide low-barrier access to specialized clinical providers. Services will be provided in home, community, and clinic settings. Key elements will include:

- Early detection of psychosis;
- Team-based care;
- Shared decision-making;
- Collaborative treatment planning;
- Wellness, recovery, and resilience orientation;
- Person-centered care;
- Focus on normal developmental milestones;
- Youth friendly environment;
- Small caseloads;
- Limited treatment length; and
- Transition supports to step-down services.

Applications must detail plans, capacity, and expertise to implement a CSC Program in the proposer's service area. Applications must also detail a plan for outreach and community capacity building to better identify, refer, and recruit youth and young adults ages 15-25 experiencing FEP.

A statewide total of $738,000 is available for the first grant year, with $738,000 projected to be available for a potential renewal for three or four additional years. Renewals will be dependent on funding availability and contract deliverables. Year one of the grants will be funded from Federal Fiscal Year 2016 funding. As such, the grantee cannot carry over of funds of grant award year one into Federal Fiscal Year 2018. All funds from grant award year one must be expended no later than September 30, 2017.

Criteria that proposers need to have, or show they can develop, include the following:

- Identified expertise in providing care to youth who are experiencing psychotic illness;
- Wellness, recovery, and resilience orientation;
- Access to inpatient hospital care;
- Linkages with community resources and outreach capabilities;
- Strong psychiatric supervision and clinical leadership;
- Commitment to hiring individuals with lived experience; and
- Ability to provide data.

Proposers must incorporate a certified Community Support Program (CSP) or Comprehensive Community Services (CCS) Program to serve as a foundation for the CSC Program. If a proposer is a government entity intending to implement a FEP Team via contract the proposer must detail how the contract will be implemented and monitored. Letters of support should be attached to the application for any interagency collaboration resulting from this funding.

---

[3] Heinssen, Goldstein, and Azrin. (2014). Evidence –Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care.

CSC is designed to be a scalable program, which can be built off of an existing program. Team size should be based on the need of population of the service area of the proposer. Proposers must state the team size and level of funding necessary to support CSC services in the service area. Proposers should utilize the OnTrack USA Interactive Spreadsheet to estimate the CSC Team size, and level of funding which will be required for the service area.[4] The proposer should specify if funds will be utilized for outreach and community capacity building beyond the level identified in the model spreadsheet.

The CSC framework has similarities with the Assertive Community Treatment (ACT) model which has shared components with Wisconsin's CSPs. Shared elements include reliance on multidisciplinary treatment teams, a small client to staff ratio, and a menu of service directed at supporting adaptive functioning in the community such as case management, psychiatric treatment, housing and vocational assistance, substance abuse services, family education and support, and 24/7 accessibility.[5]

CSC builds on the ACT model and offers several enhancements and differences. CSC is specifically focused on a younger population, who do not have an established history of disability, have the capacity for out-of-office visits but do not require them as the modal practice. CSC also sets an expectation of a time-limited treatment experience of roughly three years, step-down of services, and eventual transition to other services if continued services are required.

Contract Term and Available Funding

The contract shall be effective on the date indicated in the contract and shall run until the end of the Federal Fiscal Year (September 30, 2017) with an option by mutual agreement of the Department and contractor, to renew for three or four additional one-year periods. An estimated annual amount of $738,000, for a minimum of two full CSC teams, will be made available through this RFP dependent on funding availability, for each approved contract year. Renewal of a contract for years two through four or five will be based upon the proposer's satisfactory performance, audit findings, and the availability of funds. Proposers are advised that should additional State or Federal funds become available, the DMHSAS may utilize the results of this RFP for additional awards.

The State of Wisconsin retains the right to accept or reject any or all applications if it is deemed to be in the best interest of the State of Wisconsin. If mutually agreed to by the contractor and the State, the results of this solicitation may be used by other Wisconsin agencies or other states. All applications become the property of DHS upon receipt.

Who May Submit an Application?

County Departments of Human Services, Departments of Community Programs, with a program certified under DHS 36 for Comprehensive Community Services (CCS) or DHS 63 for Community Support Program (CSP). In addition, existing Medicaid and Division of Quality Assurance (DQA) certified CCS Programs or CSPs may also apply. This organization will be the legal entity, which assumes the liability for the administration of the grant funds and is responsible to DHS for the performance of the project activities. All counties or proposers must be certified through DQA to provide CCS and/or CSP services. Submission of multiple applications from one proposer is not permissible.

---

[4] OnTrack USA (2015) Interactive Spreadsheet to Estimate Number and Cost of First Episode Psychosis Teams Needed in an Area and Number of Clients Served.
http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx

[5] Heinssen, Goldstein, and Azrin. (2014). Evidence –Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care.

Background

In its Federal Fiscal Year 2014 appropriation, Congress allocated additional funds to the Substance and Mental Health Services Administration (SAMHSA) to support evidence-based practices for programs to address the needs of individuals experiencing early serious mental illness. This program was further emphasized in the Consolidated Appropriations Act of 2016. States are now instructed to utilize 10 percent of the Mental Health Block Grant (MHBG) allocation for services for individuals experiencing FEP.[6]

SAMHSA has collaborated with the National Institute of Mental Health (NIMH) to research and develop Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care (CSC).[7, 8] NIMH research suggests that mental health providers across multiple disciplines can learn the principles of CSC for FEP, and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a team-based, collaborative, recovery-oriented approach involving individuals experiencing first episode psychosis, treatment team members, and when appropriate, family members as active participants. CSC components emphasize outreach, low-dosage medications, cognitive and behavioral skills training, supported employment and supported education, case management, and family psychoeducation. CSC also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals.

An estimated $738,000 (funded by the Wisconsin MHBG 2016 award) will be awarded in grant year one and year two (funded by the 2017 MHBG). Additional years of funding are estimated to be approximately $738,000, dependent on MHBG funding.

Based on estimates, a full CSC model FEP team in Wisconsin be funded at an annual amount of $369,000 to support a population area of roughly 400,000 – 525,000. The estimated $738,000 the DMHSAS plans to award would allow for the funding of two full programs. However, as the CSC model FEP program can be scaled to meet the needs of the population size, proposals for partial CSC FEP teams are also encouraged to submit a proposal. Actual cost will be impacted by incidence of FEP, the number of clients enrolled in the program, the length of treatment for each client, and variability in staff costs. Cost of treatment may be supported via public (i.e. Medicaid) and private insurance when available. Proposers must detail the size of the CSC Team which will be required to support the service area, and the estimated costs to operate that team. Several factors impact the team size necessary to provide services including population size, rates of incidence and prevalence, success of outreach efforts, and percentage of people interested in receiving CSC services. A need for additional outreach and community capacity building is an additional factor which will impact the team size and cost. For example, if the proposer's community requires additional work to conduct outreach with necessary community partners those efforts should be factored into the estimated efforts. Likewise, some communities may require additional capacity building to allow for an improved community-wide understanding of FEP, improved capacity to identify and refer young adults to the CSC program.

The above estimates were calculated using a model developed for OnTrack USA by the Center for Practice Innovations at Columbia Psychiatry, New York State Psychiatric Institute.[9] Staffing estimates assume the FEP Team is comprised of 1 Full Time Equivalent (FTE) FEP team leader, 1 FTE Individual Placement and Support (IPS) specialist, 1 FTE Recovery Case Manager, 1 FTE Peer Support Specialist, a

---

[6] Consolidated Appropriations Act (2016). https://www.congress.gov/114/bills/hr2029/BILLS-114hr2029enr.pdf

[7] National Institute on Mental Health – Recovery After an Initial Schizophrenia Episode. http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml

[8] RAISE ETP. http://www.raiseetp.org/

[9] OnTrack USA. http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx

0.3 FTE Psychiatrist, and 0.1 FTE Registered Nurse (RN). While all these roles must be components of a FEP Team, multiple roles may be filled by one individual. However, individuals must have the training, skills, and expertise necessary to fill those roles.

The FEP Team will offer CSC model component interventions including assertive case management, individual and group psychotherapy, recovery skills, suicide prevention planning, crisis management, supported employment and education services, family education and support, family therapy, low doses of select antipsychotic agents, pharmacotherapy, and coordination with primary healthcare. This program will place strong emphasis on outreach and engagement as well as specialized training relevant to team roles and components of the model. Once contracts are implemented, DMHSAS will conduct close monitoring with the vendor to ensure fidelity and outcome measures are met.

CSC Program Requirements

The Wisconsin program will focus on services to individuals aged 15-25 with a non-organic, non-affective psychotic disorder diagnosis. To be eligible for services, clients' time since symptom onset must be less than three years. Empirical evidence suggests the effectiveness of the CSC model is greatest for persons who meet these criteria. The goal is to expand early intervention treatments for FEP throughout Wisconsin; therefore, it is important to identify results and practices that can be utilized to broaden and replicate in other areas of the State.

Illustrate Community Need for FEP Program

Quality applications will include a needs analysis detailing and quantifying the proposer's community's need for and capacity to implement a CSC model FEP Program. This analysis should include an estimate of the current number of youth and young adults experiencing FEP aged 15-25 the proposer expects could be served via the FEP Program as well as expected incidence of FEP in the service area. Proposers should illustrate a population size and need adequate to support funding a full CSC model FEP Team or the portion of a team being proposed. An interactive tool to estimate costs and staffing for CSC model teams can be found on the OnTrack USA resource page.[10] If additional community capacity building and community outreach is anticipated beyond the projections the needs should be specified and detailed.

Outreach and Engagement

This program will place strong emphasis on outreach and engagement.[11] There will be dedicated staff time to these activities with a central point of referral and coordinated entry to the program. Staff will develop referral pathways, cultivate relationships, and provide community outreach. They will be responsible for client and family engagement which will include assertive outreach, rapid contact after referral, efficient enrollment, and ongoing education and support. Staff will use hopeful messages with an emphasis on the individuals' goals, how their experience with symptoms has impacted their daily life, and how services will be helpful to the individual. Admission interviews will be offered to eligible individuals in a timely manner and referral to more appropriate services will be offered to ineligible individuals.

FEP Team Roles

A model FEP Team, utilizing the CSC model, will be comprised of four to six clinicians with the appropriate expertise.[12, 13] Key roles, in addition to outreach and engagement, will include team leadership, case management, supported employment and education, psychotherapy, family education and

---

[10] http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx
[11] Community Outreach and Prevention as an Element of Early Intervention in Psychosis http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/
[12] NAVIGATE Team Members' Guide. https://raiseetp.org/StudyManuals/Team%20Guide%20Manual.pdf
[13] OnTrack NY Program Team Manual. http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx

support, pharmacotherapy and primary care coordination, and peer support. Each staff person, with the exception of the supported employment and education specialist, may provide dual roles. Supervision and consultation will be provided within the context of the recommendations for each role as well as State licensing and certification requirements. Staff will offer core model component service interventions including assertive case management, individual and group psychotherapy, recovery skills, suicide prevention planning, crisis management, supported employment and education services, family education and support, family therapy, low doses of appropriate antipsychotic agents, pharmacotherapy, and coordination with primary healthcare. Individual providers can serve multiple roles as long as they have achieved competency in each assigned function and there is not a conflict with the nature of their dual roles with the exception of the supported employment/education role which should be a dedicated staff. Providers will be licensed or certified in their area of expertise (e.g., psychologists, social workers, licensed professional counselors, rehabilitation counselors, nurses, psychiatrists, Certified Peer Specialists).

It is critical that the providers have expertise in their specialty area as well as interest, experience, and skill in providing care to youth experiencing FEP. Clinical skills and abilities important for working in early intervention include empathy, unconditional positive regard, and a non-judgmental approach. They will understand the unique challenges of an individual experiencing FEP and their families, the diversity of the youth served, recovery, and the potential for FEP youth to lead productive lives. It is important that the treatment team staff have a high level of respect for participants' independence and self-determination, are flexible in tailoring interventions, and are open to partnering with natural supports.

A full team (1.0) typically maintains a caseload of roughly 30 clients. A successful FEP Team assures adequate coverage of the key CSC roles rather than achieving a one-to-one correspondence between the number of providers and the components of CSC. A FEP Team requires strong overall team leadership and management and competent delivery of the core clinical services. Proposers should develop plans to scale the team size to meet the needs of the service area population. A detailed staffing plan must be provided.

Team Training

Each team staff member will require specialized training through background readings and discussions as well as on-line and in-person trainings. Team training includes the following areas:

1. CSC Conceptual Model
2. Early Recognition of Psychosis
3. Components of the Team
4. Functional Procedures
5. Timing of Team Activities
6. Theoretical Framework of CSC Treatment
7. Recovery Potential
8. Recovery Concepts
9. Trauma-Informed Care
10. Developmental Issues Specific to Adolescents and Young Adults
11. Shared Decision-Making
12. Person-Centered Care
13. Optimistic Therapeutic Perspective
14. Engaging Clients and Family Members

15. Vulnerabilities to Substance Use
16. Suicide/Safety Planning
17. Specialized Services Relevant for Each of the Team Member Roles.

Training will follow the recommended components of the model and proposers will need to show their training plan. Each team member will receive specialized training relevant to their role as well as team-based care training.

Collaborative training is encouraged among CSC programs in Wisconsin. CSC sites are encouraged to collaborate to obtain training opportunities and make efficient use of any training opportunities which may be made available through the State or the Federal government. Grantees will also be encouraged to invite other CSC grantees to any trainings which are made available.

Programmatic Oversight and Management
To ensure fidelity to the CSC model the proposer must illustrate the capacity to implement programmatic oversight and management to ensure fidelity to the CSC model.[14, 15] In addition to meeting program certification requirements for DHS 63 or DHS 36 and individual provider licensing requirements the FEP Team will receive supervision according to the model including administrative, clinical, and component supervision.[16] The team psychiatrist and team leader should also have access to expert consultation as early psychosis in youth is challenging and requires specialized expertise. Importantly the team must have small, manageable caseload size consisting of 30 clients or less to ensure adequate time to maintain fidelity to the model services, develop relationships, and provide outreach to the participants.

Team meetings should occur frequently. In addition to meeting the administrative rule that the program is functioning under, the team meeting will follow the concepts of the CSC model. The CSC model includes weekly team meetings to reinforce the principles and practices of CSC care through review of participants, discussion of roles, and review of progress towards treatment goals. The administration will ensure that the program is adequately staffed and each team member has protected time to fulfill their roles. This includes plans for back-up coverage for the team leader and the team psychiatrist.

There are multiple staffing issues to consider including how staff time is divided, target number of individuals to see, frequency of meetings, roles the individuals will serve, the responsibilities of each team member, and back-up coverage. The clinic administration must also ensure that CSC program elements are compatible and in compliance with existing federal, state, and agency rules, regulations, laws, processes, and procedures.

CSC Program Elements
The Wisconsin CSC Program will have several requirements. Team members will utilize a collaborative Team-based approach to care. The team will consist of the individual experiencing FEP, treatment staff members, and family (as desired by the individual) when appropriate and chosen by the participant. The FEP Team members will also utilize a Collaborative Treatment Planning approach. This planning

---

[14] Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation
http://nyebpcenter.trilogyir.com/Portals/0/RAISE/CSC-for-First-Episode-Psychosis-Manual-II-Implementation.pdf
[15] The OnTrack NY Program Team Manual
http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Team%20Manual_1%2021%2015.pdf
[16] Wisconsin Department of Health Services, Division of Quality Assurance.
http://www.dhs.wisconsin.gov/rl_dsl/bqa.htm

combines input from the individual experiencing FEP, the support system they choose, and the treating team.

Team members will practice a shared decision-making model. Shared decision-making is a collaborative approach where participants and clinicians actively work together toward mutually agreed upon goal setting and treatment decision making. Disagreements are clarified and compromise is negotiated.

The participants' life goals, aspirations, and ambitions must drive treatment planning. The treating team supports this through their clinical expertise and the use of evidence-based treatment. The mutually agreed upon goals, objectives, and tasks are then evaluated through measurable outcomes.

Proposers must develop a program for FEP treatment that creates a positive youth-oriented clinical climate and maintains fidelity to the clinical concepts and core elements of CSC. The FEP Team must assure their practice is person-centered and includes strengths-based planning focused on normal developmental milestones. The team will aid the individual in understanding of their problem and work toward solutions rather than focusing on difference or diagnosis. It is also critical that the team convey hope for recovery and belief in the individual's resilience. A recovery orientation refers to the process by which services and supports value and promote the ability of individuals to build a meaningful and satisfying life, as uniquely self-defined. Strength-based services are person-centered, offering choices and honoring each person's capability for growth in every stage of the recovery process.

Flexibility and accommodation are key components of the CSC model. As such provision of services should take into consideration the individual's preference for meeting sites and will include meetings in home, community, and clinic settings. For example, some young people may be better engaged in their home or community. The complexity of their needs will also dictate the best setting to provide services.

CSC services will be time limited and include transition of care. Wisconsin CSC services will be offered over a 2-3 year period starting within three years of psychosis onset with continuity of specialized care for up to five years. Phases of care include engagement with team and initial assessment, ongoing intervention and monitoring, and identification of future needs and services transition. During the final phase the team must actively work toward planned transition of the relationship with the participant and plan for transition to support networks and future services.

CSC services should provide the model's key service interventions through a multi-element approach.[17] A shared decision-making framework will be utilized to address medication preferences, goals, and adherence and other medical care needs.[18] [19] The team psychiatrist will be the primary member of the team focusing on pharmacotherapy. The prescriber will be skilled in working with individuals experiencing FEP. A program may choose to include a nurse as part of the staff to provide primary health care coordination.

The CSC Program must provide individual and group psychotherapy tailored to the individual's needs. [20] Psychological interventions are essential for symptomatic and functional recovery. Psychotherapy should

[17] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf
[18] NAVIGATE Psychopharmacological Treatment Manual http://www.raiseetp.org/studymanuals/Psychopharmacology%20Manual.pdf
[19] OnTrack NY Medical Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Medical%20Manual_1%2021%2015.pdf
[20] Individual Resiliency Training (IRT) http://www.raiseetp.org/studymanuals/IRT%20Complete%20Manual.pdf

be person-centered and resilience-oriented and utilize evidence-based treatment approaches effective for this population.

An Individual Placement and Support (IPS) model will be implemented to assist the participant in returning to work or school.[21, 22] A dedicated Supported Employment and Supported Education Specialist will be part of the team. Meaningful involvement in school and/or work is a critical element to recovery.

Another critical component of the CSC Program is skills training which helps individuals to manage symptoms and pursue life goals. Recovery Skills Training will be individualized for each participant's needs and goals.[23, 24] Skills provided will vary from individual-to-individual and over time for each individual. The following are examples of key areas of skills training that would be provided within the model.

- Social Skills: The participant will be assisted with creating or re-establishing social networks and integrated community activities as well as developing resources to avoid adverse social outcomes.
- Substance Use: Substance use treatment needs will be assessed ongoing and provided when indicated for all participants.
- Coping Skills: Through their areas of specialty, the team will assist the participant with recognizing illness symptoms and developing strategies for coping with symptoms in real-life situations.
- Financial: Financial management skills training will be provided to ensure financial stability and adequate income.
- Housing: Housing needs will be assessed and the participant will be connected to resources to avoid housing instability or loss.
- Community Living Skills: Each individual will have specific needs and priorities that will guide how they will best be assisted in the transition adulthood.

Additionally, the FEP Team must assist participants with problem solving, offering solutions to address practical problems, and coordinating services through Assertive Case Management.[25] The case manager will coordinate, create linkages, and follow-up with community resources such as schools; the Wisconsin Department of Workforce Development, Division of Vocational Rehabilitation; inpatient hospital care; mental health services and any substance use disorder treatment not provided by the team; and medical services. The case manager will assist the participant with managing day-to-day life issues.

Family involvement is a core function of a CSC Program. The team will encourage family involvement and provide services to the family.[26] The program will provide services to the family that will support the individual's recovery, including family therapy, family support, and psychoeducation. Important mechanisms for family support include peer-to-peer and parent peer specialists. The team will develop a collaborative relationship with the family by involving them in treatment planning, treatment decisions, and ongoing care where appropriate and chosen by the individual experiencing FEP.

---

[21] NAVIGATE Supported Employment and Education (SEE) Manual http://www.raiseetp.org/studymanuals/SEE%20Complete%20Manual.pdf
[22] OnTrack NY IPS Supported Employment and Supported Education Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/SEESManual%201%2021%2015.pdf
[23] Individual Resiliency Training (IRT) http://www.raiseetp.org/studymanuals/IRT%20Complete%20Manual.pdf
[24] OnTrack NY Recovery Coach Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Recovery%20Coach_1%2020%2015.pdf
[25] OnTrack NY Primary Clinician's Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Primary%20Clinician%20Manual%203.25.15%20Final.pdf
[26] NAVIGATE Family Education Program (FEP) http://www.raiseetp.org/studymanuals/Family%20Manual.pdf

Peer support is another important element for youth and young adults experiencing FEP. Multiple approaches to peer support are identified by youth as helpful in their recovery journey including Certified Peer Specialists, Peer Mutual Support and Mentoring. The program will have a plan for developing peer support.

Suicide Prevention
The program must provide ongoing suicide prevention planning and crisis management. Each participant and their primary clinician will develop a safety plan tailored for FEP. Safety plans will be in the individual's own words and will outline a strategy to help the participant manage difficult thoughts and feelings. Components include recognizing warning signs, using internal coping strategies, using socialization as a coping skill during crisis and to obtain support, contacting family members or friends who may offer help to resolve a crisis, contacting professionals and agencies, and reducing the potential for use of lethal means. The FEP Team must also provide ongoing assessment of suicidal behavior and must conduct universal suicide screening of program participants using a standardized assessment tool. The team will provide 24-hour telephone coverage to manage crisis situations and facilitate a higher level of care when needed. When necessary the team must provide triage to participants experiencing suicidal risk to determine the most appropriate level of care. The treatment team clinician will determine the intervention required including hospitalization, increased monitoring, or the current level of treatment. The safety plan will be utilized to assist the person through the risk period.

Community Outreach and Targeted Program Recruitment
A critical component of Wisconsin's CSC Program is engagement and outreach to persons experiencing a FEP, their families, and social networks. Multiple barriers must be addressed in order for a program to successfully identify and enroll individuals with early psychosis. Low incidence of FEP in addition to difficulty successfully diagnosing a disorder makes it challenging to identify individuals in need of CSC services at early onset of symptoms. As such building a strong system of outreach and referral is a critical component to the successful implementation of the CSC model in Wisconsin.

Initial efforts should involve the development of a comprehensive outreach and recruitment plan tailored to the community of focus, which builds relationships and community capacity to increase early detection and facilitates access to services. Outreach efforts should be done in a manner which will reach and engage the youth and young adult (age 15-25) target audience.[27] The program will have staff devoted to conducting community outreach and developing a central point of referral and coordinated entry to the program. Activities will include developing referral pathways, cultivating relationships, and providing community outreach with inpatient facilities, emergency departments, primary care, crisis intervention services, the criminal justice system, and schools. Importantly, proposers must develop agreements and referral pathways with colleges and universities in the proposer's proposed service area.

The FEP Program will also be required to create or adapt outreach tools to engage the target audience. These materials should communicate information about the program and serve as entry points for potential clients, family members, and service providers to learn about the program and contact staff. Components of the outreach efforts should be a website which can be easily navigated and engaging for youth and young adults. The program should maintain an active online presence via popular social media tools and sites, providing information, event announcements, and wellness information.

[27] http://nyebpcenter.trilogyir.com/Portals/0/RAISE/CSC-for-First-Episode-Psychosis-Manual-I-4-21-14.pdf

All outreach and engagement should be done in a youth-oriented person and family-centered manner. The program should establish a culture which will best facilitate success with a youth population and their families. The CSC should utilize assertive outreach, hopeful messages, a person-centered approach, and reaching the individual in means that fits the needs of the individual. Engagement should be done in a manner to focus on participant goals, how they experience their symptoms, and the impact on their daily life. Staff should describe CSC services which may be helpful to the individual and illustrate how the services may help the individual reach their personal goals. If services are not a match or wanted by the individual, staff should make referrals and connections to other services as appropriate.

Quality applications will also include plans for conducting outreach with the criminal justice system. The CSC model presents an avenue to divert youth and young adults experiencing FEP from the criminal justice system. Quality proposals will include a plan for rapid response to individuals who may be good candidates for CSC program involvement as an alternative to imprisonment.

Youth Friendliness
Of particular importance to the success of the CSC Program is that it be developed in a manner which ensures youth friendliness and accessibility.[28, 29] Outreach and engagement will be conducted via channels and areas of the community in which youth and young adults interact and/or touch the lives of youth and young adults. Services should be provided in a youth friendly location distinct from the larger clinic. This area should have a separate waiting area and entrance, if possible. If staff or the agency is serving other populations, steps should be taken to ensure a distinct youth friendly environment. The program receptionist should be trained and skilled in engaging with youth. The use of technology, internet, and mobile technology should be incorporated throughout all program phases. Establishing an internet presence is of particular importance. To engage, social media should be utilized. Social networking platforms such as Facebook and Twitter should be utilized for outreach, engagement, and communication. The use of text messaging should also be encouraged to engage program participants. When appropriate external mobile application resources and webpages should be incorporated to augment programmatic efforts.

Sustainability and Replication
The Wisconsin CSC Program should work toward sustainability of the program. One way this could be done is by maximizing billing via private insurance and Medicaid when coverage is available. To ensure this can be done, the proposer must be able to house the CSC Program as specialized care under a certified Community Support Program (CSP) or Comprehensive Community Services (CCS) Program. Many individuals experiencing FEP will be privately insured. It is important that staff obtain insurance credentials and authorization and have the appropriate licensure to bill. The program will have to monitor collections and pursue missed payments and consider outreach and negotiation with private insurance. Staff must also be able to assist participants with accessing private insurance or Medicaid coverage when they are uninsured. This includes aiding participants who may need assistance navigating systems and obtaining coverage.

Reimbursement and Billing of External Payers
Reimbursement from Medicaid or other insurance should be utilized when coverage is available to enhance program sustainability. However, CSC Program expenses must not be double counted. Grant funding should be utilized to fund program development, provide services for individuals without public or private insurance, and for services not covered under insurance or public assistance programs. If

[28] Transitions RTC: http://www.umassmed.edu/transitionsrtc
[29] Pathways 2 Positive Futures: http://www.pathwaysrtc.pdx.edu/

utilizing Medicaid, the clinic administration must ensure the CSC Program follows all Medicaid guidelines and nothing beyond what is reimbursable is billed to Medicaid.

1.2 Procuring and Contracting Agency

The Department of Health Services, Division of Mental Health and Substance Abuse Services issued this GRFP. DMHSAS will administer any contract resulting from this GRFP. The Contract Administrator will be:

Ryan Stachoviak
Mental Health Planner
Department of Health Services
Division of Mental Health and Substance Abuse Services
1 W. Wilson Street, Room 851
Madison, WI 53703
Ryan.Stachoviak@wisconsin.gov
608-261-9316

1.3 Definitions

Throughout the GRFP, the following terms are defined as:

1. **ACT**: Assertive Community Treatment
2. **BPTR:** Bureau of Prevention Treatment & Recovery – Located within the Division of Mental Health & Substance Abuse Services (DMHSAS) of WI Department of Health Services (DHS). The Bureau includes four Sections: Substance Abuse Services; Mental Health Services and Performance Management; Children, Youth and Families; and Integrated Services.
3. **CCS:** Comprehensive Community Services. Under Chapter DHS 36, WI Administrative Code, Comprehensive Community Services for persons with mental disorders and substance-use disorders provide a flexible array of individualized community based psycho-social rehabilitation services authorized by a mental health professional to consumers with mental health or substance use issues across their lifespan. (The entire administrative code provision is at http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/36.pdf.)
4. **Certified Peer Specialist:** A professional credential that qualifies individuals to use their personal recovery from a mental illness, or combined mental illness with substance abuse, to support others' recoveries and positively impact the human services system. (Visit www.wicps.org for more information.)
5. **Consumer:** A person who receives or uses mental health and/or substance abuse system goods and services. Consumers have options, make informed decisions in their own care and influence the way services are provided.
6. **Contract:** A written agreement between an awarding agency (i.e., DHS) and grant recipient or contractor that defines some type of transaction, service or programming, which is enforceable in a court of law. Types of contracts include grant agreements, purchase of service contracts and inter-agency agreements. (More information is available in the Definitions Addendum, located in Section II.)

7. **Contractor:** (also "Prime Contractor" or "Grantee") A vendor or provider who is awarded a DHS contract, and is responsible for the performance of all requirements and compliance with all contract terms.
8. **CSC**: Coordinated Specialty Care. A team-based, multi-element approach to treating First Episode Psychosis. Component interventions include assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents.
9. **CSP:** Community Support Program. A coordinated care and treatment program which provides a range of treatment, rehabilitation, and support services for persons with severe and persistent mental health illnesses in the community, through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation, and support services. (The entire administrative code provision is at https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/63)
10. **Department / DHS:** the Wisconsin Department of Health Services.
11. **Division / DMHSAS:** the Division of Mental Health and Substance Abuse Services that administers mental health and substance abuse policy in Wisconsin.
12. **DOA:** the Wisconsin Department of Administration.
13. **DQA**: the Wisconsin Department of Quality Assurance.
14. **HIPAA:** the Health Insurance Portability and Accountability Act of 1996.
15. **EBP:** Evidence-based Practice. Strategies which have been empirically researched and proven to have measurable positive outcomes and are put into operational practice for services and programs.
16. **FEP:** First Episode Psychosis.
17. **GRFP:** Request for Proposal. A procurement process where vendors submit proposals which are usually evaluated by a team of individuals against set evaluation criteria. The proposals with the highest total scores are awarded contracts, based on the available amount of funding.
18. **IPS:** Individual Placement and Support
19. **Medicaid:** The federal public system of paying for health services (including mental health and substance abuse) for persons who have little or no income.
20. **NIMH**: National Institute of Mental Health.
21. **Peer Support:** Persons in recovery who use their own experiences overcoming a mental health challenge to help others facing similar challenges.
22. **PPS:** Program Participation System. The system within which National Outcome Measures data is recorded on for counties. (System was previously called HSRS [Human Services Reporting System].) https://www.dhs.wisconsin.gov/pps/index.htm
23. **Proposal:** A response to a GRFP (Grant Request for Proposal), which may include a grant proposal.
24. **Proposer:** A person or organization submitting a proposal in response to A GRFP (Request for Proposal), including a request for a grant proposal.
25. **Providers:** Any of a group of individuals or organizations, public or private, which provide goods or services that DHS may contract for. Potential providers with DHS may also be referred to as "vendors," "grantees" or "contractors."

26. **Psychosis:** A treatable condition where a person may experience a loss of contact with reality, hold to false beliefs despite evidence to the contrary, or perceive things that are not there.
27. **Psychotherapy:** A meeting with a licensed counselor, therapist or psychologist for the purpose of helping an individual cope with feelings and mental health symptoms, and changing behavior patterns. (Most psychotherapy is short-term.)
28. **SAMHSA:** Substance Abuse and Mental Health Services Administration. A federal agency, located within the U.S. Department of Health & Human Services (DHHS), that offers a wide array of funding and resources. (See www.samhsa.gov.)
29. **State:** the State of Wisconsin.
30. **Subcontract:** A written agreement between the contractor and a subcontractor to provide services.
31. **Subcontractor:** A third party who contracts with the awarded contractor for the provision of services, which the contractor has contracted with the Department to perform.

1.4 Clarification and/or Revisions to the Specifications and Requirements

Any questions concerning this GRFP must be submitted to: Ryan Stachoviak, Mental Health Planner for DMHSAS at Ryan.Stachoviak@wisconsin.gov.

Written questions must be submitted before 4:00 PM CT on Monday 08/29/16. Questions should be submitted via email with the following subject line:

Subject: Question GRFP #G-0346 DMHSAS-17 Proposer Name

Telephone questions will not be accepted. Any oral responses, information, dates, and/or technical assistance received by a prospective Proposer from the Department or Department staff shall not, in any manner whatsoever whether before or after the release of this GRFP, be binding on the State of Wisconsin, unless followed-up and explicitly confirmed and stated in writing by the State.

Proposers are expected to raise any questions, exceptions, or additions they have concerning the GRFP document at this point in the GRFP process. If a Proposer discovers any significant ambiguity, error, conflict, discrepancy, omission, or other deficiency in this GRFP, the Proposer should immediately notify the Contract Administrator of such error and request modification or clarification of the GRFP.

In the event that it becomes necessary to provide additional clarifying data or information, or to revise any part of this GRFP, revisions/amendments and/or supplements will be provided to those entities that have completed the Notice of Intent to Apply procedure referenced in section 2.5.

Contact with State employees and/or members of the review committee concerning this GRFP is prohibited except as authorized by the Contract Administrator during the period from date of release of the GRFP until the notice of intent to award is released.

1.5 Contract Quantities / New or Deleted Items

The procuring and contracting agency does not guarantee to purchase any specific quantity of services. Proposals that state that the purchasing agency must guarantee a specific quantity or dollar amount may be disqualified.

The contractor shall not have exclusive rights to provide all services covered under this contract during the term of the contract or any extension of the contract.

1.6 Reasonable Accommodations

DHS will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities upon request. If you think you need accommodations at any time during the GRFP process, contact Ryan Stachoviak, Mental Health Planner, at 608-261-9316 or Ryan.Stachoviak@wisconsin.gov.

1.7 Calendar of Events

The table below lists specific and estimated dates and times of actions related to this GRFP. The actions with specific dates must be completed as indicated unless otherwise changed by the State. In the event that the State finds it necessary to change any of the specific dates and times in the calendar of events listed below, it will do so by issuing a notice to those entities who have submitted a Notice of Intent to Apply as detailed in section 2.5. There may or may not be a formal notification issued for changes in the estimated dates and times.

DATE	DESCRIPTION
08/08/2016	GRFP Posted to DHS Website
08/22/2016	Proposers Conference (Reference Section 1.8)
08/26/2016	Notice of Intent to Apply Due
08/29/2016	Deadline for Proposer Questions
09/02/2016	All Questions and Answers Posted to DHS Website
09/23/2016	Proposals Due – 3:00 PM CT
10/07/2016	Notification of Intent to Pursue Contract Negotiations
10/31/2016	Contract Execution Date
11/01/2016	Contract Start Date

1.8 Proposer Conference

DMHSAS will hold a conference call to answer questions regarding the RFP on Monday, August 22, 2016, from 9:00 a.m. to 10:30 a.m. To access this meeting, call 1-877-820-7831 and use participant code 142792.

1.9 Contract Term and Available Funding

An estimated annual amount of $738,000, for a minimum of two full CSC teams, will be made available through this RFP dependent on funding availability, for each approved contract year. The contract shall be effective on the date indicated in the contract and shall run for one year from that date with an option by mutual agreement of the Department and contractor, to renew for three or four additional one year periods. Year one of the grants will be funded from Federal

Fiscal Year 2016 funding. As such, the grantee cannot carry over of funds of grant award year one into Federal Fiscal Year 2018. All funds from grant award year one must be expended no later than September 30, 2017.

Renewal of the contract for years two through four or five will be based upon the Proposer's satisfactory performance, audit findings and the availability of funds. Following the fourth year of funding, the expectation is the project will be self-sustaining through the development of systems infrastructure, enhanced revenues and cost efficiencies stemming from the project. The successful proposer must demonstrate its plan for sustainability beyond the funding period. Proposers are advised that should additional State or Federal funds become available, the Division may utilize the results of this GRFP for additional awards.

1.10 Retention of Rights

The State of Wisconsin retains the right to accept or reject any or all proposals if it is deemed to be in the best interest of the State of Wisconsin.

If mutually agreed to by the contractor and the State, the results of this solicitation may be used by other Wisconsin agencies or other states.
All proposals become the property of DHS upon receipt.

1.11 Who May Submit an Application

County Departments of Human Services, Departments of Community Programs, with a program certified under DHS 36 for Comprehensive Community Services (CCS) or DHS 63 for Community Support Program (CSP). In addition, existing Medicaid and Division of Quality Assurance (DQA) certified CCS Programs or CSPs may also apply. This organization will be the legal entity, which assumes the liability for the administration of the grant funds and is responsible to DHS for the performance of the project activities. All counties or proposers must be certified through DQA to provide CCS and/or CSP services. Submission of multiple applications from one proposer is not permissible.

1.12 Assessment of Community Need

Quality proposals will include a needs analysis detailing and quantifying the proposer's community's need for and capacity to implement a CSC model FEP Program. This analysis should include an estimate of the current number of youth and young adults experiencing FEP aged 15-25 the proposer expects could be served via the FEP Program as well as expected incidence of FEP in the service area. Proposers should illustrate a population size and need adequate to support funding a full CSC model FEP Team or the portion of a team being proposed. An interactive tool to estimate costs and staffing for CSC model teams can be found on the OnTrack USA resource page.[30] Quality analyses will also utilize local data including estimated rates of FEP during the contract term. If additional community capacity building is anticipated beyond the projections in the tool the needs should be specified and detailed.

[30] http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx

2.0 PREPARING AND SUBMITTING A PROPOSAL

2.1 General Instructions

The selection of a contractor is based on the information submitted in the contractor's Proposal. Failure to respond to each of the requirements in the GRFP may be the basis for rejecting a Proposal.

Elaborate Proposals (e.g., expensive artwork), beyond what is sufficient to present a complete and effective Proposal, are not necessary or desired.

The State of Wisconsin is not liable for any cost incurred by Proposers in replying to this GRFP.

Proposers must submit Proposals in strict accordance with the requirements set forth in this section. All materials must be submitted to:

Ryan Stachoviak, Mental Health Planner
Division of Mental Health and Substance Abuse Services
Department of Health Services
1 W. Wilson Street, Room 851
Madison, WI 53703
Ryan.Stachoviak@wisconsin.gov
608-261-9316

All materials must be received in the prescribed formats by 3:00 PM CT, 9/23/2016.

Proposals must be received in the above office by the specified date and time. Receipt of a Proposal by the State mail system does not constitute receipt of a Proposal. No Proposals are allowed to be submitted by fax or email. All such Proposals will be rejected.

There are two components needed for complete submission of the Proposals: Paper (Hard Copies) and Electronic. Both components are due to the address above by the stated date and time. The following submission requirements must be followed for each of the components:

Paper (Hard Copy) Proposal Component

This component must contain the original and five paper copies of the entire Technical Proposal (see Section 2.2 Proposal Organization and Format) including any proprietary information.

Electronic Proposal Component

In addition to the paper documents described above, the entire Proposal must be submitted in non-password protected Portable Document Format (.pdf), (except for the proposed budget, which must be submitted using the required Microsoft Excel template) on a reproducible CD(s) labeled as follows:

Early Intervention for First Episode Psychosis
Name and Address of Proposer
GRFP # G-0346 DMHSAS-17

Disc X of Y

2.2 Proposal Organization and Format

Technical proposals must be organized into clearly delineated sections, as shown below. Each heading and subheading should be separated by tabs or otherwise clearly marked.

Tab 1. Cover Sheet
  a. Table of Contents
  b. Vendor Information Form DOA-3477

Tab 2. Goals, Objectives and Performance Expectations – Section 6.1

Tab 3. Program Design and Methodology – Section 6.2

Tab 4. Work Plan – Section 6.3

Tab 5. Organizational Experience and Capacity – Section 6.4

Tab 6. Reporting, Performance Measurement & Quality Improvement – Section 6.5

Tab 7. Budget – Section 7.0

Tab 8. Appendix – Letters of Support, Letters of Commitment, Memorandums of Understanding, Contracts, etc.

All materials must be received in the prescribed formats by 3:00 PM CT, 9/23/2016.

2.2.1 Transmittal Letter

A Transmittal Letter must accompany the RFP package. It must be on official business letterhead of the proposer submitting the Proposal, and must be signed in ink by an individual authorized to legally bind the vendor.

The Transmittal Letter must stipulate the following:

- The Proposer is the primary Vendor and is a corporation or other legal organization;
- Services that the Vendor intends to sub-contract to another entity;
- No attempt has been made or will be made by the Vendor to induce any other person or firm to submit or not to submit a Proposal;
- The vendor certifies they have neither directly nor indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that this Proposal has been independently arrived at without collusion with any other Vendor, competitor or potential competitor; that this proposal has not been knowingly disclosed prior to the opening of proposals to any other vendor or competitor.
- A Statement of Qualifications that the vendor is able to meet all the Mandatory Requirements and Special Terms and Conditions in Sections 4.0.
- The Proposal is valid for a minimum of 60 Days from the Proposal due date;

- The person signing this letter and all GRFP documents is authorized to make decisions on behalf of the Proposing organization and that the person has not participated, and will not participate, in any action contrary to the this statement;
- Assurance that the vendor will agree to execute and fulfill a contract according to the conditions and terms specified in this GRFP;
- That the Proposal is predicated upon the requirements, terms, and conditions of this GRFP, the posted Questions and Answers, all its attachments, and any supplements or revisions thereof; and
- That an individual authorized to bind legally the vendor has signed this Transmittal Letter.

2.3 Multiple Proposals

Submission of multiple Proposals from Proposers are not permissible.

2.4 Withdrawal of Proposals

Proposals shall be irrevocable until contract award unless the Proposal is withdrawn. Proposers may withdraw a Proposal in writing at any time up to the Proposal closing date and time or upon expiration of five (5) business days after the due date and time if received by Ryan Stachoviak. The written request must be signed by an authorized representative of the Proposer and submitted to Ryan Stachoviak at the address listed in Section 2.1 General Information. If a previously submitted Proposal is withdrawn before the Proposal due date and time, the Proposer may submit another Proposal at any time up to the Proposal closing date and time.

2.5 Notice of Intent to Apply

Prospective Proposers are requested, but not required, to submit a notice of intent to apply to the Division. The notice of intent should be submitted to the Division at the mailing address below by 3:00 PM CT on 8/26/2016. Submission of the notice of intent does not commit a prospective Proposer to submission of a Proposal.

Any supplemental written information related to this GRFP developed by the Division will be provided only to those agencies who have filed a Notice of Intent, or to agencies who request such information. Notices should be mailed, emailed, faxed, or hand delivered to:

Ryan Stachoviak, Mental Health Planner
Department of Health Services
Division of Mental Health and Substance Abuse Services
1 W. Wilson Street, Room 851
Madison, WI 53703-7851
(608) 261-9316
Fax: (608) 267-7793
Email: Ryan.Stachoviak@wisconsin.gov

3.0 PROPOSAL SELECTION AND AWARD PROCESS

3.1 Preliminary Evaluation

The purpose of the preliminary evaluation is to determine if each Proposal is sufficiently responsive to the GRFP to permit a complete evaluation. Proposals must comply with the instructions to Proposers contained in this GRFP. Failure to comply with the instructions may cause the Proposal to be rejected without further consideration. The State reserves the right to waive any minor irregularities in the Proposal.

3.2 Proposal Scoring

Proposals accepted through the preliminary evaluation process are reviewed by an evaluation committee and scored against chosen criteria. A Proposer may not contact any member of an evaluation committee except with the Contract Administrator's written approval.

3.3 Proposal Evaluation Criteria

The proposal evaluation committee will review all proposals against stated criteria. Proposals from eligible proposers will be scored according to the following competitive criterion:

Maximum Points (100 Total)

PROPOSAL EVALUATION CRITERIA	MAXIMUM POINTS
• Assessment of Community Need	5 points
• Goals, Objectives and Performance Expectations	20 points
• Program Design and Methodology	25 points
• Work Plan	15 points
• Organizational Experience and Capacity	10 points
• Reporting, Performance Measurement and Quality Improvement	15 points
• Budget	10 points
TOTAL	100 points

3.4 Notification of Intent to Pursue Contract Negotiations

All Proposers who respond to this GRFP will be notified via email of the State's intent to pursue contract negotiations as a result of this GRFP.

After notification of the intent is made and under the supervision of agency staff, copies of Proposals will be available for public inspection from 8:00 a.m. to 4:00 p.m. at One West Wilson Street, Room 850, Madison, Wisconsin. Vendors should schedule reviews with Ryan Stachoviak, at (608) 261-9316.

3.5 Right to Reject Proposals and Negotiate Agreement Term

The State reserves the right to reject any and all Proposals. The State may negotiate the terms of the contract, including the award amount, with the selected Proposers prior to entering into a

contract. If contract negotiations cannot be concluded successfully with the recommended Proposer or upon unfavorable review of the Proposer's references, the Department may terminate contract negotiations.

The Contract Administrator or designee will review each GRFP Response Package and Statement of Proposer Qualifications to verify the Proposer meets the requirements specified in this GRFP based on a pass or fail protocol. This determination is the sole responsibility of the Department.

3.6 Letters of Support

Proposers are encouraged to submit letters of support. Letters may originate from stakeholder organizations, businesses, educational institutions, and/or other health and human service provider agencies. Letters of support should address the potential for success in providing mental health and substance abuse programming in a shared services delivery system. The evaluation committee will consider letters of support in review of the proposals. If the proposer intends to contract with an organization or county letters of support must be attached to the proposal. Counties intending to form a consortium to deliver FEP services should provide letters of support with the proposal from all partnering counties. If the proposer is a consortium of counties Memorandums of Understanding (MOU) must be provided from all counties to be involved in the FEP program prior to initiation of a contract.

4.0 MANDATORY REQUIREMENTS

To be eligible for further evaluation consideration Proposers must certify their ability to meet all MANDATORY REQUIREMENTS as specified. Additional requirements may apply upon contract execution specific to the services provided.

4.1 Proposal Format, Electronic Data Base/Spreadsheet reporting

Proposers are required to submit their proposal in single-sided, single-spaced, 12-point standard font (prefer Times New Roman), with a minimum of 1-inch margins. Please limit proposals to 30 pages, not including budget, appendices, and letters of support. Budgets are to be submitted on the required Excel spreadsheet specified in Appendix A. The work plan is required to be coordinated with the budget and the performance monitoring reporting tool specified in Appendix B. For the overarching goals and objectives of this project, defined herein, data will be reported either into the PPS or on an Excel spreadsheet for those data not captured in PPS.

4.2 Statutory requirements

As part of the 2016 Federal Budget passed by Congress and the President, ten percent of the Community Mental Health Services Block Grant received by each state must be devoted to early interventions for mental health disorders. One promising model developed by SAMHSA in collaboration with the NIMH that seeks to address serious mental illness at an early stage is called Coordinated Services Care for First Episode Psychosis (FEP). SAMHSA recommends the implementation of this model to serve individuals experiencing FEP.

4.3 Administrative rule, certifications requirements

Proposers incorporating the CSC model for FEP into an existing CSP or CCS must be certified by the Wisconsin Division of Quality Assurance (DQA) according to all State law and rule.

Under Chapter DHS 36 Wisconsin Administrative Code, Comprehensive Community Services (CCS) for Persons with Mental Disorders and Substance Use Disorders provides a flexible array of individualized community based psychosocial rehabilitation services to youth and adults. Psychosocial rehabilitation includes medical and remedial services and supportive activities provided to or arranged for an individual by a comprehensive community services program authorized by a mental health professional to assist individuals with mental disorders and/or substance use disorders to achieve the individual's highest possible level of independent functioning, stability and independence and to facilitate recovery.[31]

Under Chapter DHS 63 Wisconsin Administrative Code Community Support Program or CSP is a coordinated care and treatment program which provides a range of treatment, rehabilitation, and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation, and support services.[32]

4.4 Patient's/Client's Rights Policy

Each Proposer shall have a written policy stating that the service will comply with client's rights requirements as specified in DHS 94, Wisconsin Administrative Code.

4.5 Security of Electronic Data

Specify the procedures that will be implemented to ensure privacy and confidentiality, including by whom and how data will be collected, procedures for administration of data collection instruments, where data will be stored, who will/will not have access to information, and how the identity of participants will be safeguarded (e.g., through the use of a coding system on data records; limiting access to records; storing identifiers separately from data).

Grant recipients must maintain the confidentiality of alcohol and other drug abuse client records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2), Health Insurance Portability and Accountability Act (HIPAA) 45 CFR Parts 160 and 164, Wis. Stat. 51.30, and DHS 92.

Record Retention
Grantees must store and safeguard all CSC records against loss, destruction, or unauthorized use consistent with s. 51.30, Wis. Stats., which deals with confidentiality of treatment records. All CSC records must be kept for at least a seven-year period. In the event that the contract is not renewed, records must continue to be retained in accordance with above regulations.

Grantees must purchase and maintain encryption software using at least 256 bit encryption software for all electronic information on any storage device that contains personally identifiable information related to a person served through CSC. Additionally, grantees must use encryption

[31] http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/36.pdf
[32] https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/63

software to send any electronic information containing personally identifiable information related to a person served through CSC.

4.6 Affirmative Action Plan and Civil Rights Compliance

4.6.1 Affirmative Action Plan

Grant recipients who are awarded contracts of fifty thousand dollars ($50,000) or more shall have included in their contracts the following clause: "A written affirmative action plan is required as a condition for the successful performance of the contract. Excluded from this requirement are grant recipients whose annual workforce amounts to less than fifty (50) employees. The affirmative action plan shall be submitted to the Contract Administrator within fifteen (15) working days following the award of the contract."

4.6.2 Civil Rights Plan

Grant recipients who are awarded contracts of fifty thousand dollars ($50,000) or more with an annual work force of twenty-five (25) employees or more shall complete and keep on file a Civil Rights compliance plan compliant with the most recent DHS Civil Rights Compliance Requirement publication. All Grantees must submit a Civil Rights Compliance Letter of Assurance to the Office of Affirmative Action and Civil Rights Compliance within fifteen (15) working days of the award date.

4.7 Tobacco Smoke Free Environment

Public Law 103-227, also known as the Pro-Children Act of 2001, prohibits tobacco smoke in any portion of a facility owned, leased, or contracted for by an entity that receives Federal funds, either directly or through the State, for the purpose of providing services to children under the age of 18. A copy of the proposer's tobacco policy should be included with the electronic copy of the grant application.

5.0 PROPOSER INFORMATIONAL SECTION

Section 5.0 contains information for Proposers regarding the responsibilities, deliverables and outcomes the contractor is responsible for providing as part of this project.

The following requirements are the minimum specifications and responsibilities. If no Proposers are able to comply with any given specification, condition of proposal or provide a specific item, the State reserves the right to delete that specification, condition of proposal or item.

5.1 Goals, Objectives and Performance Expectations

The Proposer should have clear, achievable goals and objectives for this project. The Proposer's goals and objectives should be consistent with DMHSAS' goals for this grant stated in Section 1.1.

Identify each goal, objective, related activities, timelines, measures and performance and person(s) responsible for the objectives. Goals should be agreed-upon, concrete, observable measures to know what was accomplished.

5.1.1 **Goal 1:** Conduct CSC model community outreach and targeted program recruitment for persons aged 15-25 experiencing FEP.

Objective 1: *Develop and train the FEP team in a plan of outreach and recruitment, as measured by successful implementation of the outreach and recruitment plan as specified by the CSC model.*

a. Model CSC programs identify and train one or more team members who will oversee the outreach and referral process for the program.

b. Utilizing a central point of referral and coordinated entry to the program, client and family engagement will include assertive outreach, rapid contact after referral, efficient enrollment, and ongoing education and support.

c. Staff will develop referral pathways, cultivate relationships, and provide community outreach. Outreach and collaboration with local universities and colleges should be a key component of these activities as well as a rapid response to diverting individuals from the criminal justice system. Expanded outreach and community capacity building should be incorporated into the proposal for those communities in need of outreach beyond the standard CSC protocols.

d. Utilize and/or develop CSC model FEP health communication and outreach tools.

Objective 2: *Establish and maintain a CSC model referral network and program entry.*

a. Quality program outreach efforts will utilize multiple communication strategies to build a network connecting institutions which play a role in the life of youth. These institutions include schools, colleges, healthcare systems and providers, shelters, the criminal justice system, child and youth mental health programs, and employers.[33] Quality proposals will include efforts to utilize the CSC program as an avenue for diversion from the criminal justice system.

b. Expand outreach efforts to the larger community, increasing awareness, reducing stigma, and facilitating understanding. Various methods can be used to communicate information about FEP and the program. Presentations and newsletters can be utilized to provide education about FEP and the importance of early intervention. Reaching out to larger institutions may provide linkages to the FEP program site.

c. Establish a central point of referral and entry in accordance with the CSC model ensuring people referred to the program are contacted within 24 hours and admission interviews occur within seven days.

d. Conduct client and family centered engagement and outreach.

---

[33] The National Institute of Mental Health, Recovery After an Initial Schizophrenia Episode Manual I: Outreach and Recruitment: http://nyebpcenter.trilogyir.com/Portals/0/RAISE/CSC-for-First-Episode-Psychosis-Manual-I-4-21-14.pdf

5.1.2 Goal 2: Assure adequate coverage of key roles by qualified providers. [34, 35, 36] Proposers will describe how they will provide adequate coverage of key roles by qualified providers

Objective 1: *Four to six clinicians will provide the following key roles as measured by a staffing roster that includes job descriptions: Team Leader, Recovery Case Manager, Supported Employment and Education IPS Specialist, Psychotherapist, Family Therapist, Recovery Coach, Psychiatrist, Nurse, Peer Support Specialist, Outreach and Enrollment Specialist*

a. Individual providers can serve multiple roles as long as they have achieved competency in each assigned function and there is not a conflict with the nature of their dual roles.

b. Individual providers can provide services outside the FEP Team as long as they have dedicated time to the FEP Program, there is not a conflict with the nature of their dual roles, and they are skilled in working with individuals experiencing FEP. The exception of the dual roles is the supported employment/education role which should be a dedicated staff.

Objective 2: *Provide the core treatment focus areas of CSC through a multi-element approach.*

---

[34] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

[35] Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation http://nyebpcenter.trilogyir.com/Portals/0/RAISE/CSC-for-First-Episode-Psychosis-Manual-II-Implementation.pdf

[36] The OnTrackNY Program Team Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Team%20Manual_1%2021%2015.pdf

a. Where appropriate the program should utilize fidelity measures to ensure services are provided using evidence-based treatment approaches.
b. The team psychiatrist will be the primary member of the team focusing on Pharmacotherapy.[37, 38] Evidence-based pharmacologic approaches along with a shared decision-making framework will be utilized to address medication preferences, goals, and adherence.[39, 40] The prescriber will be skilled in working with individuals experiencing FEP.
c. Medical care needs will be addressed through coordination with primary care. A program may choose to include a nurse as part of the staff to provide primary healthcare coordination.
d. An Individual Placement and Support (IPS) model will be implemented to assist the participant in returning to work or school. A dedicated Supported Employment and Supported Education Specialist will be part of the team. Meaningful involvement in school and/or work is a critical element to recovery.[41, 42, 43]
e. Provide Recovery Skills development and training services individualized to each consumer's needs and goals.[44, 45] Skills training assists individuals to manage symptoms and pursue life goals. Skills provided will vary from individual to individual and over time for each individual. The following are examples of key areas of skills training that would be provided within the model.
    1. Social Skills: The participant will be assisted with creating or re-establishing social networks and integrated community activities as well as developing resources to avoid adverse social outcomes.
    2. Substance Use: Substance use and treatment needs will be assessed and addressed ongoing for all participants.
    3. Coping Skills: Through their areas of specialty the team will assist the consumer with recognizing illness symptoms and developing strategies for coping with symptoms in real-life situations.
    4. Financial: Financial management skills training will be provided to ensure financial stability and ensure adequate income.
    5. Housing: Housing needs will be assessed and the participant will be connected to resources to avoid housing instability or loss.
    6. Community Living Skills: Each individual will have specific needs and priorities that will guide how they will best be assisted in the transition to adulthood.

---

[37] NAVIGATE Psychopharmacological Treatment Manual
http://www.raiseetp.org/studymanuals/Psychopharmacology%20Manual.pdf
[38] OnTrack NY Medical Manual
http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Medical%20Manual_1%2021%2015.pdf
[39] Shared Decision Making and Medication Management in the Recovery Process
http://ps.psychiatryonline.org/article.aspx?articleid=97273
[40] Pharmacological Treatments for First-Episode Schizophrenia
http://schizophreniabulletin.oxfordjournals.org/content/31/3/705.abstract
[41] NAVIGATE Supported Employment and Education (SEE) Manual
http://www.raiseetp.org/studymanuals/SEE%20Complete%20Manual.pdf
[42] OnTrack NY IPS Supported Employment and Supported Education Manual
http://nyebpcenter.trilogyir.com/Portals/0/RAISE/SEESManual%201%2021%2015.pdf
[43] Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual
http://bjp.rcpsych.org/content/193/2/114.short
[44] Individual Resiliency Training (IRT) http://www.raiseetp.org/studymanuals/IRT%20Complete%20Manual.pdf
[45] OnTrack NY Recovery Coach Manual
http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Recovery%20Coach_1%2020%2015.pdf

f. Assist consumers with problem solving, offering solutions to address practical problems, and coordinating services through Assertive Case Management.[46] The case manager will coordinate, create linkages, and follow-up with community resources such as schools; Wisconsin Department of Workforce Development, Division of Vocational Rehabilitation; inpatient hospital care; mental health services not provided by the team; and medical services. The case manager will assist the consumer with managing day to day life issues.
g. Provide individual and group psychotherapy tailored to the individual's needs.[47] Psychological interventions are essential for symptomatic and functional recovery. Psychotherapy should be person-centered and resilience oriented and utilize evidence-based treatment approaches effective for this population.[48]
h. The team will encourage family involvement and provide services to the family.[49] Services to the family that will support the individual's recovery, including family therapy, family support, and psychoeducation. Important mechanisms for family support include peer-to-peer and parent peer specialists. The team will develop a collaborative relationship with the family by involving them in treatment planning, treatment decisions, and ongoing care where appropriate and chosen by the individual experiencing FEP.[50]
i. Provide peer support to individuals experiencing FEP. Peer support can be provided through Certified Peer Specialists, peer mutual support, and mentoring.
j. Provide ongoing suicide prevention planning and crisis management as evidenced by documentation of a completed safety plan and ongoing assessment of suicidal behavior for each participant. The program will show in their policies and procedures and staffing that they are providing 24-hour telephone coverage, mobile outreach, and triage when safety is assessed to be at risk. [51, 52]

5.1.3 Goal 3: Provide programmatic oversight and management to ensure fidelity to the CSC model. [53, 54]

Objective 1: *Each team member will have access to supervision.*

a. Meet Division of Quality Assurance (DQA) program certification requirements and individual provider licensing/certification requirements.

---

[46] OnTrack NY Primary Clinician's Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Primary%20Clinician%20Manual%203.25.15%20Final.pdf
[47] Individual Resiliency Training (IRT) http://www.raiseetp.org/studymanuals/IRT%20Complete%20Manual.pdf
[48] Group Cognitive Behavior Therapy or Social Skills Training for Individuals With a Recent Onset of Psychosis?: Results of a Randomized Controlled Trial http://journals.lww.com/jonmd/Abstract/2008/12000/Group_Cognitive_Behavior_Therapy_or_Social_Skills.2.aspx
[49] NAVIGATE Family Education Program (FEP) http://www.raiseetp.org/studymanuals/Family%20Manual.pdf
[50] Drug and Family Therapy in the Aftercare of Acute Schizophrenics http://archpsyc.jamanetwork.com/article.aspx?articleid=491987
[51] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf
[52] The OnTrack NY Program Team Manual: http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Team%20Manual_1%2021%2015.pdf
[53] Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation http://nyebpcenter.trilogyir.com/Portals/0/RAISE/CSC-for-First-Episode-Psychosis-Manual-II-Implementation.pdf
[54] The OnTrack NY Program Team Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Team%20Manual_1%2021%2015.pdf

b. CSC team will receive supervision according to the model including administrative, clinical, and component supervision.

c. The team psychiatrist and team leader will have access to expert consultation as needed as the recognition of early psychosis in youth is challenging and requires specialized expertise. [55]

Objective 2: Implement and ensure successful use of the CSC model

a. Each team staff member will receive specialized training as measured by a listing of required background readings and on-line resources for staff and a plan for staff discussions and in-person trainings in accordance with the CSC model.

b. Ensure that the program maintains small caseloads and is adequately staffed as measured by team caseload of 25-30 (scaled to fit team size), each team member having protected time to fulfill their roles, and plans for back-up coverage for the Team Leader and the Team Psychiatrist.

c. Team meetings will follow the concepts of the CSC model.

d. Services will be time limited (2-3 years) and include transition of care tailored to meet the needs of the individual client in accordance with the CSC model.

e. Services will start within three years of psychosis onset.

f. The clinic administration must ensure that FEP program elements are compatible and in compliance with existing Federal, State, and agency rules, regulations, laws, processes and procedures as measured by maintaining DQA certification.

5.1.4 Goal 4: Develop a program for FEP treatment that creates a positive clinical climate and maintains fidelity to the clinical concepts and core elements of CSC. [56,57, 58]

Objective 1: Team members will utilize a collaborative Team-based approach to care as measured by fidelity to a Shared Decision Making model and documentation of a Collaborative Treatment Planning approach. [59]

a. The team will consist of the individual experiencing FEP, treatment staff members, and family as defined by the participant when appropriate and chosen by the participant.

---

[55] Patient.co.uk Psychosis – Diagnosis and Management http://www.patient.co.uk/doctor/psychosis-diagnosis-and-management

[56] Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation http://nyebpcenter.trilogyir.com/Portals/0/RAISE/CSC-for-First-Episode-Psychosis-Manual-II-Implementation.pdf

[57] The OnTrack NY Program Team Manual http://nyebpcenter.trilogyir.com/Portals/0/RAISE/Team%20Manual_1%2021%2015.pdf

[58] NAVIGATE Director Manual http://www.raiseetp.org/studymanuals/Director%20Manual.pdf

[59] Shared Decision-Making and Evidence-Based Practice http://link.springer.com/article/10.1007/s10597-005-9005-8#

b. Treatment planning utilizes shared decision making, input from the individual experiencing FEP including the consumer's life goals, aspirations and ambitions, the support system they choose, and the treating team.

c. The mutually agreed upon goals, objectives, and tasks are evaluated through measurable outcomes.

d. Operate the program with a Wellness, Recovery, and Resilience orientation that assures person-centered, strengths-based planning focused on normal developmental milestones as measured by results of an approved consumer survey tool. [60]

Objective 2: *Ensure youth friendliness and accessibility within the program.* [61, 62]

a. Provision of services will take into consideration the individual's preference for meeting sites and will include meetings in home, community, and clinic settings.

b. Outreach and engagement will be conducted via channels and areas of the community in which youth and young adults interact and/or touch the lives of youth and young adults.

c. Services should be provided in a youth friendly location distinct from the larger clinic. This area should have a separate waiting area, and entrance if possible. The program receptionist should be trained and skilled in engaging with youth.

d. The use of technology, internet, and mobile technology should be incorporated throughout all program phases. Establishing an internet presence is of particular importance.

5.2 Program Design and Methodology

DMHSAS is soliciting a Proposal that demonstrates a high quality, innovative and cost effective approach for the provision of Early Intervention for First Episode Psychosis services that meet the requirements identified in section 1.1, scope, and the goals and objectives specified in section 5.1. In order to provide the highest quality care, the proposer is expected to utilize and monitor fidelity with evidence-based treatment approaches and seek on-going participant input in modifying the approaches. Proposers will design specialty services that meet fidelity to the CSC model within their certified DHS 63 CSP or DHS 36 CCS program to meet the unique needs of individuals experiencing FEP. Services identified in 5.1.2 are expected to utilize evidence-based treatments shown to be effective for this population. Proposers are encouraged to follow the established CSC model. It is recommended that proposers utilize as examples the NIMH RAISE Project resources[63] and the Center for Practice Innovations' OnTrack USA resources[64] to develop a CSC program which meets the needs of their service area and meet the minimum requirements detailed in this GRFP. Proposers will specify their timeline for program implementation.

[60] Scientific and Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts, and Implications http://schizophreniabulletin.oxfordjournals.org/content/32/3/432.abstract
[61] Transitions RTC: http://labs.umassmed.edu/transitionsRTC/#sthash.Dg8pETwR.E4yG7nzA.dpbs
[62] Pathways to Positive Future: http://www.pathwaysrtc.pdx.edu/
[63] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml
[64] http://nyebpcenter.trilogyir.com/OnTrackUSA/tabid/253/Default.aspx

5.3 Work Plan

A work plan is an organizational tool that identifies significant goals, objectives, activities, measures, timelines, and responsible parties for a project. Each Proposer, through their work plan and budget detail, should provide sufficient justification for proposed staffing and other resources funded through the project.

DHS is looking for a Proposer that has the capacity to implement the expectations of the GRFP and the Proposer's objectives and work plan. The Proposer is expected to have a thoughtful plan for assuring adequate staff or contractor resources are in place in a timely way to complete objectives according to the proposed work plan.

5.4 Organizational Experience and Capacity

Criteria that proposers need to have, or show they can develop, include the following:

5.4.1 Identified expertise in providing care to youth who are experiencing psychotic illness.

5.4.2 A wellness, recovery, and resilience orientation.

5.4.3 Access to inpatient hospital care.

5.4.4 Linkages with community resources and outreach capabilities.

5.4.5 Strong psychiatric supervision and clinical leadership.

5.4.6 Identified expertise in rapid response for people in need of behavioral health services and diversion from the criminal justice system.

5.4.7 Commitment to hiring individuals with lived experience.

5.4.8 The ability to provide quality data.

5.4.9 A certified Community Support Program (CSP) or Comprehensive Community Services (CCS) Program.

5.4.10 If contracting with an organization or county, the capacity and experience collaborating and maintaining a strong contractor/contractee relationship. Letters of support should also be provided.

5.4.11 Capacity to hire and train qualified behavioral health providers.

5.4.12 Monitor fidelity to the CSC model.

5.5 Reporting, Performance Measurement & Quality Improvement

5.5.1 Contractual Accountability:

Project contractors will be responsible for maintaining communication with the State Contract Administrator, Ryan Stachoviak, providing periodic updates, briefing on challenges or barriers, trying to identify resources, etc. Contractors are required to submit

biannual reports to the Contract administrator on the progress being made on the project and are subject to periodic site visits.

5.5.2 Project Evaluation:

Projects will be evaluated against the criteria laid out in the Goals and Objectives of this GRFP. Contractors are required to conduct accurate data reporting via the Mental Health Program Participation System (PPS). Contractors must report consumers as participating in the FEP program through PPS in addition to the consumers' service utilization and consumer status outcome indicators.

5.5.3 Project Performance Measures

Performance measurement in association with project evaluation and quality improvement activities allows project stakeholders to evaluate, control, budget, learn, improve, motivate, promote and celebrate. When you can measure what you are doing and express it with numbers, it validates your work. You cannot manage what you have not measured. Proposers shall identify and track project progress against stated and approved SMART objectives. Proposers may want to consult the following Performance Measures and SMART Objectives document, Guide to Performance Measurement or any other generally accepted performance measurement resource: http://www.dhs.wisconsin.gov/publications/P0/P00620.pdf.

Proposers' objectives may evolve through the course of the contract as objectives are met or amended but reporting on the current GRFP Goals and Objectives will remain throughout the project. Any amendments to contractor objectives must be discussed with and approved by the State Contract Administrator.

5.5.4 Data Quality Reporting Standards

Data collected and used to evaluate the project and measure performance must be objective, valid and reliable and conform to applicable data reporting requirements.[65] Proposers will be expected to have a clear, efficient, valid and reliable method for collecting, storing, retrieving, analyzing and reporting data. In addition, Proposers shall report and update data required by the Mental Health PPS data system on at least a monthly basis. Additional electronic reporting on unique project objectives not measured by PPS will be required in an approved format.

5.5.5 Implementing a Quality Improvement Process

High quality services evolve over time as a result of experience and the application of formal quality improvement activities. Proactive processes that recognize and solve problems before they occur ensure that systems of care are reliable and predictable. A culture of improvement frequently develops in an organization that is committed to quality, because problems are reported and addressed. Proposers are expected to develop and utilize a formal continuous quality improvement process. Proposers may want to consult the quality improvement approach developed by the University of Wisconsin NIATx or any other recognized quality improvement resource: http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=16

[65] http://www.dhs.wisconsin.gov/pps/

6.0 TECHNICAL RESPONSE SECTION

Listed below are the technical proposal response requirements. The section(s) referenced within the response requirement provide detail concerning the required and/or desired objectives, work requirements, and standards to meet the needs of this program. This detail represents the minimum level of service requirements and objectives sought in this procurement. Many of the sections in this GRFP are interrelated and may contain overlapping information. Proposers should incorporate the goals, objectives, work requirements, and standards stated throughout this GRFP into their proposal.

Proposers must respond to each of these requirements with a descriptive narrative (appropriately labeled in accordance with the numbering scheme below) that includes methodology to the level of detail deemed appropriate by the Proposer.

6.1 Goals, Objectives and Performance Expectations

Proposers describe goals, objectives and performance expectations for each year of the grant, and fulfill the requirements described in Section 1.1 and 5.1. This response should include but is not limited to:

6.1.1 Goal 1: Conduct community outreach and targeted program recruitment for persons aged 15-25 experiencing FEP

- Objective 1: Provide a staffing plan of who will oversee the outreach and recruitment plan for the program. Describe how the FEP team will be trained and conduct external communication, outreach and referral.
- Objective 2: Detail which organizations, groups, and agencies the program will engage to develop referral pathways and how the program will work to maintain this pathway, and cultivate relationships. Describe how you will track referrals, outreach, and recruitment efforts. Describe how the program will be client and family centered and utilize CSC principles. Describe how program entry and engagement will be youth-friendly.

6.1.2 Goal 2: Proposers will describe how they will provide adequate coverage of key CSC roles by qualified providers.

- Objective 1: Provide the staffing plan and organization chart including job descriptions, ensuring that each of the key CSC roles is filled.
- Objective 2: Describe the service interventions that will be provided including the Evidence-Based or Best Practice treatments or curriculums for each. Describe what staff will provide each of the interventions. Describe what your policies, procedures, and staffing will be for providing suicide prevention planning and crisis management.

6.1.3 Goal 3: Describe how programmatic oversight and management will be provided to ensure fidelity to the CSC model.

- Objective 1: Describe the supervision plan including frequency, team members involved, modality, content, how it will be tracked, and the qualifications of the supervisor. Describe the plan for consultation.

- Objective 2: Describe how successful use of the CSC model will be ensured. Identify processes for ensuring CSC fidelity in the following areas: staff training, caseloads and staff coverage, time-limited care and transition planning, and identification of individuals experiencing first onset of psychosis. Describe how you will ensure that the FEP program elements are compatible and in compliance with existing Federal, State, and agency rules, regulations, laws, processes and procedures. Include documentation of all certifications and requirements.

6.1.4 Goal 4: Describe how the First Episode Psychosis (FEP) program will create a positive clinical climate and maintain fidelity to the clinical concepts and core elements of Coordinated Specialty Care (CSC).

- Objective 1: Describe how you will develop and maintain a collaborative Team-based approach to care. Identify how you will measure fidelity to the shared decision making approach. Describe how outcomes of the mutually agreed upon goals, objectives, and tasks will be measurable. Describe how you will ensure the program operates with a Wellness, Recovery, and Resilience orientation that assures person-centered, strengths-based planning focused on normal developmental milestones.
- Objective 2: Describe measures you will take to ensure youth friendliness and accessibility within the program. Identify specific details about the environment, resources utilized, and staff training that will be tailored to meet the needs of this population.

6.2 Program Design and Methodology

Proposers describe and define a viable CSC model for the project that addresses the specifications noted in this GRFP. Proposers should address the following information in the response to this section:

6.2.1 Describe the current certified DHS 63 CSP or DHS 36 CCS Program that will be utilized to incorporate specialty services and how the CSC model will be implemented within the certified CSP or CCS to meet the unique needs of individuals experiencing FEP.

6.2.2 Describe the CSC Team structure which will be utilized including how the team structure will be tailored to fit the organization's needs. Any modifications to the CSC Team structure should be justified and described in detail.

6.2.3 Describe in detail the evidence-based approaches you will use, why you selected them, and how you will monitor fidelity.

6.2.4 Describe how you will seek ongoing client input in modifying the approach to maximize outcomes for participants.

6.2.5 Describe eligibility criteria for participants to be considered for participation in the program and why.

6.2.6 Describe details of your program development plan including timeline for each component of staffing, training, outreach, and service delivery.

6.3 Work Plan

The work plan described in the proposal relates directly to the goals listed in Sections 1.1, 5.1, and 6.1 facilitates program accomplishments, and is sequentially reasonable. Activities in the work plan are assigned to specific personnel. The work plan is consistent with the objectives and can be accomplished in stated timeframes and proposed budget. Timeframes for tasks and activities in the work plan are appropriate to ensure that sufficient effort is planned. This response should include, but is not limited to:

- A detailed description of significant tasks, activities and strategies to be used to achieve the goals in a logical progression.
- The assignment of responsibility for work plan tasks to specific personnel and the timetable for significant tasks or activities to be started and to be completed.
- A breakdown of the number of individuals experiencing FEP the project will engage, enroll, and serve each year of the program.

6.4 Organizational Experience and Capacity

Proposers should submit a response that describes their experience, demonstrated abilities, and technical expertise to specify. This response includes but is not limited to:

6.4.1 Description of expertise and experience in providing care to youth (age 15-25) who are experiencing psychotic illness.

6.4.2 Description of proposer's experience with a wellness, recovery, and resilience orientation.

6.4.3 Evidence and description of access to hospital care.

6.4.4 Evidence of established relationships to resources in the community and ability to conduct outreach in the community or the ability to form relationships with relevant stakeholder groups or community organizations.

6.4.5 Description of proposer's expertise in rapid response for people in need of behavioral health services and diversion from the criminal justice system.

6.4.6 Description and evidence of proposer's strength and expertise in psychiatric supervision and clinical leadership.

6.4.7 Description of proposer's commitment to and/or plans to hire individuals with lived experience.

6.4.8 Evidence of proposer's ability and expertise of providing quality data and reporting.

6.4.9 Evidence of proposer operating or connection to a certified CSP or CCS Program.

6.4.10 Evidence of or description of plans to hire and train qualified behavioral health providers.

6.4.11 Evidence of experience monitoring fidelity to evidence based practices.

6.4.12 If contracting with an organization or county, the capacity and experience collaborating and maintaining a strong contractor/contractee relationship should be described. Letters of support should also be provided.

6.5 Reporting, Performance Measurement & Quality Improvement

Proposers should submit a response that describes their experience, demonstrated abilities, and technical expertise to fulfill the requirements described in Section 5.5. The Proposer has demonstrated to have an efficient system in place to assure quality and improvement for services. The Proposer clearly describes what their current quality assurance and improvement process is and what changes, if any, will be included for the project in order to fulfill the requirements described in Section 5.5. This response should include, but is not limited to:

6.5.1 A description of who will be the Proposer's lead in maintaining communication with the State Contract Administrator, providing periodic updates, briefing on challenges or barriers, and the submission of reports and the coordination of site visits.

6.5.2 A detailed description of the Proposer's current quality improvement and assurance processes that assures financial accountability, program quality, and regulatory compliance.

6.5.3 Describe how you will identify, track, and report project progress against stated and approved objectives and demonstrate that your project objectives are SMART. A description of who will be the Proposer's lead in working with DHS on the Project Evaluation, including the name of the responsible individual(s) or organization (s) that will be actively involved in the evaluation should be included.

6.5.4 Describe in detail your capacity to collect data and use it to evaluate the project and measure performance. Explain how you will ensure the data is objective, valid and reliable and conforms to applicable data reporting requirements. Include how the data will be collected, stored, retrieved, and secured. Provide a description of how you will report required data on at least a monthly basis to the Mental Health PPS data system. A discussion of who would be in charge of quality improvement and assurance for this GRFP and what role they would play, if any, in this process should be included.

6.5.5 Provide a description of your formal continuous quality improvement process. Describe how you will foster a culture of continuous improvement during the life of the project. Include a description, if applicable, of any changes to the current quality assurance, improvement, and monitoring processes that would be needed for the project.

7.0 PROJECT BUDGET

DMHSAS has developed a budget template (Appendix A) to be used for submitting the project budget. Use of this budget template is required. The budget template is an Excel spreadsheet containing three tabs. The first tab summarizes the detailed budget information entered on the second tab of the worksheet. The third and final tab contains the instructions for completing the budget worksheet. Please review the

instructions prior to completing the budget template. Please provide sufficient justification in the designated areas of the second tab to enable reviewers to understand both the level of planned expenditures and the need for the funds. Proposed budgets must provide a sufficient level of detail illustrating the proposer's ability to successfully implement a CSC model program using the level of funding and expected billing from other public and private sources. Project budgets must also include analysis of the number of clients expected to be served each year of the project and cost associated with serving those clients. The budget template and instructions are included as an appendix to this document.

The proposed budget must be on the budget template and submitted as a Microsoft Excel file. Please save your budget with a file name that identifies your agency.

All budget costs must comply with the DHS Allowable Cost Policy Manual, the Allowable Cost Policy Manual can be found on the DHS web site at: https://www.dhs.wisconsin.gov/business/allow-cost-manual.htm.

8.0 REQUIRED FORMS

The following pages contain the ancillary forms required to be submitted as part of the Proposal packet. Please reference Section 2.2 for information related to the proper order of these forms in the Proposal packet.

APPENDIX A

Budget Template Form F-01601

APPENDIX B

Performance Monitoring Report Form F-20389

APPENDIX C

Vendor Information Form DOA-3477