FY15 Chronic Inebriate Anti-Recidivism Program – Permanent Supportive Housing Program
Request for Proposals
Pre-proposal Teleconference: October 30, 2014 @ 1:00 PM-3:00 PM
Deadline for Written Inquiries: November 17, 2014
Deadline for Proposals: November 25, 2014

REMINDER: If your agency intends to respond to this RFP, please follow these instructions: Make sure you have signed into your myAlaska account associated with your agency. After selecting the 'Apply' at the bottom of the solicitation an application will be generated. A yellow bar will appear at the top of the application which states "DHSS is requesting that you indicate your intent to apply for this opportunity." Please select the 'Send Notice" button to indicate your intentions. This is not required but greatly appreciated.

GEMS Overview: GEMS stands for Grants Electronic Management System. It is a new management tool for our service providers, as well as a new tool for applicants.

Once on the GEMS portal webpage, all members of the public can view posted Request for Proposals or Request for Letters of Interest by clicking on the Solicitations tab located in the upper left corner under the State of Alaska seal. To fully utilize the site, you must have a GEMS account and a myAlaska account to authenticate your identity.

If an agency has an active grant or has had a grant with DHSS in recent years, **registration may not be necessary**. Please contact your Agency Power User, DHSS Grants Administrator, or Michael Christenson, Information System Coordinator, at (907) 465-5073 to confirm if your agency and contact information already exists in GEMS. Creating duplicate agencies or contacts may cause errors within the system.

Agency Power Users must log in to assign permissions and invite other agency users into GEMS. Once permissions have been assigned, users must login using their myAlaska account to authenticate their identity.

Please see the GEMS training section of the portal webpage to find helpful training videos regarding the system and its usage. https://gems.dhss.alaska.gov/

If you need any assistance with GEMS, please contact me directly at Amy.Burke@alaska.gov, or (907) 465-6983. You may also contact Michael Christenson, Information System Coordinator, at Michael.Christenson@alaska.gov, or (907) 465-5073.

Questions and Answers from the Pre-proposal Teleconference:

Section 1.01:

Question #1: There is a question, in the discussion about the funding that may become available in the part A, non-competitive fashion, what is the intent behind those dollars, what are they intended to support?

Answer #1: So what it says in this section is the successful Category A- Assertive Community Treatment applicants may be eligible to receive additional non-competitive operating grant awards in the amount of $2,215,000. Therefore the purpose of the funds is through those two fund sources, the total amount available for 2.5 years of program operations total $4,100,000 in grant funds. And then later on in the RFP, if you print it out it comes up to 41 pages, so in section 1.06 Program Funding, if you printed that is page 16 and 17 that covers in further detail that operating fund.

Section 1.02:

Question #2: It appears as if Category A and Category B, the agencies have similar functions; outreach, engagement assessment, housing, referrals stuff like that, in the interest of efficiency, do you see that this RFP prohibits shared services between Category A and B applicants? It's whether two agencies can use a common engagement function to prevent from a bunch of people running around the street perhaps interviewing the same people multiple times or have a combined assessment function which either does the functionality assessment or the clinical assessment which divides people up into either SUD, SMI or dually diagnosed people and triage to the appropriate service category provider? A second question under this section, under phase 2, assertive outreach and engagement, initial goal setting and assessment, and affordable housing are listed as a generic, which suggests that they can be a shared service, that it is a common function to both Category A and B target populations, so maybe there is something else? It can just wait

Answer #2: Is your question whether one agency can pursue both Categories? Ok, I will re-cover the target population for both and then when we get to the section about outreach, if we have not answered your question then, you could re-ask it or submit it in writing, under 1.03, client outreach and service delivery and 1.05, population and service area.

Question #3: A question about the advisory groups, it pretty much the same question, the advisory groups are going to have many of the same agencies on because the population would tend to more than likely overlap, SMI, SUD, dually diagnosed, and certainly the community impacts are similar to the extent the RFP follows the legislative language that talks about chronic inebriates, my question is to the extent to which there can be a combined advisory board that addresses the problem rather than the diagnosis or category of service? Or do the advisory boards need to be separate?

Answer #3: What we have laid out in this RFP is Category A forms as stakeholder group and Category B- ICM, forms a different stakeholder group.

Question #4: Would you entertain a combined stakeholder group if that was the will of the community?

Answer #4: Please submit that question in writing.

Question #5: This RFP, deals more with facilities side, most large facility projects are done through joint ventures because of their complexities, and my question is given the complexity of this and

that this RFP does not preclude it, are joint ventures allowed under this title? Seems like there are a lot of shared services, and there is certainly a need for collaboration but the funding streams are separate, so one way to enhance collaboration would be by using some joint venture having the applicants, in separate categories, as in the RFP, but have them collaborate through some sort of joint venture which spells out the responsibility of each party, really a different way of spelling out the earlier question.

Answer #5: Please put that in writing if not addressed later.

Question #6: On the evaluation, this is the program outcomes, could you please describe the extent to which the housing tenure would be a measure to successful program performance given that the grantee doesn't have the housing inventory and cannot in anyway coerce an individual to stay in one place and treatment that may enhance this is, that cannot be coerced either, maybe you can describe your logic in laying out those primary program outcomes as a direct result of program activities under this title?

Answer #6: Back on section 1.01 where Permanent supportive housing as an evidence based practice is described and is characterized recovery orientated services with safe and affordable housing, and that under the program description it describes it. Please hold that question to the end to see if we have covered it in other sections that mention the program standard as well in the evaluation section.

Question #7: Under the title of the program permanent supportive housing, how are we to be paid if we have a traditionally indigent population that is under resourced and we have a fairly limited amount of funding that was originally intended to provide services, there is a requirement of housing, how is the housing to be paid for, at least how is the state conceiving that under this?

Answer #7: That is answered in 1.06 Program funding on page 16-17, to ensure affordable housing is available for program participants, DBH will prioritize allocation of DHSS rental subsidy vouchers to individuals receiving comprehensive services through this RFP. Then it goes on to say that DHSS/AHFC "Moving Home voucher Program" will serve up to 150 individuals statewide with targeted rental assistance to individuals who are Alaska Mental Health Trust Beneficiaries and are chronically homeless. Vouchers are allocated through an application process through DBH.

Question #8: Questions about the vouchers, we saw as well, are these vouchers geographically restricted? They say statewide, so presume that they are not, they can used in other locations and how long do those vouchers last and/or what their term is also, it says 150 vouchers made available, is that specific to this program or is that for all AHFC programs related to inebriates?

Answer #8: That is saying that 150 mental health trust beneficiaries statewide will be allocated those vouchers through a process managed by DBH. This section also goes on to, under this same section, where appropriate, grantees will be expected to utilize the fund in this grant or other relevant sources (such as Medicaid, Individual Services Agreements (ISA), Section 8 Housing Choice Voucher Program, Special Needs Housing Grant, HUD Continuum

of Care subsidy and service programs, local funding, private donations, etc. to ensure that the target population has access to all necessary services and supports to ensure housing stability.

Question #9: On the committee, Category B, stakeholder group, can you talk a little about their authority? Example, will they be choosing a geographic area that we serve? Specific participants?

Answer #9: Please submit that question in writing.

Question #10: On that same section, on the program outcomes, it talks about recidivism, how will that be measured? Through follow-up surveys? Is there some measurement mechanism?

Answer #10: Under program outcomes, 1.03, there is 1.b., it describes Creation of Evaluation Plan, and that successful applicants will work with their DBH Program Manager to create and agree upon a data collection and evaluation plan within 90 days. So successful applicant is required to submit, in the scoring criteria that goes along with the evaluation plan is that applicants will submit an evaluation plan with performance measures as well as how they will be tracking those, their data collection strategies and that is 12 points and the applicant includes the logic model, with their activities applicable to the project and that is 12 points. So there is further detail around the evaluation and how applicants will be scored in that criteria.

Question #11: We will have to submit an evaluation plan but then after it's awarded we work with DBH to create an evaluation plan?

Answer #11: On page 14 it says that applicants required to submit a draft evaluation plan and a sample is included as an attachment. And then after award DBH will work with the applicants to provide resources around their plan. Later in that section is says please include in your application a logic model and first draft evaluation plan for review.

Question #12: Can you explain the logic in dividing the two programs as you did, between the ACT and the ICM, SMI, substance use, in the theory that over the past many years there has been a real strong drive across the field to eliminate such distinct barriers and to work in a way that addresses the co-occurring needs of any individual?

Answer #12: Can you please submit that question in writing?

Question #13: It suggests that all services will be provided in the Municipality of Anchorage, but the vouchers are statewide, would this program support or could vouchers be used in communities that are closer to the home residence of the target population clients? In light of the services closest to home philosophy? I recognize that services need to be provided in the Municipality of Anchorage but housing may be broader and if a person comes from another community and they need housing in that home community, can the vouchers be used to support that? My thought is that consistency would be with the philosophy of services closest to the clients home. To a certain extent it is given that inventory of housing in the Municipality is short and the individual may choose to return to their community for housing and if that is the case, and the supportive housing

demonstrates that, could the individual be housed in their community under this title? Or do they all have to be housed in Anchorage?

> **Answer #13:** Are you asking if services need to be provided in the Municipality of Anchorage? Please submit that question in writing. Services are for the Municipality of Anchorage and we have made that clear and I am not sure your question is related to the scope of this RFP in terms of the service delivery. The service requirement is that services are delivered in Anchorage and for Category A, Act- the program requirements are that 75% are provided in areas that are comfortable and convenient for participants, that is what is outlined in this RFP and if that does not answer your question, please submit it in writing.

Section 1.03

Question #14: You say FY15, which only runs to June 30th right, so this funding is for $1.86 million for 6 months or less? Is this funding for 18 months? What exactly is this funding for?

> **Answer #14:** The requirements for FY15 in terms of program development and forming evaluation groups is for the first 6 months and then by end of that period services will begin to implemented. Please look at section 1.06 program funding, pg. 16, the funding is for a 2.5 year period beginning mid-year in FY15, January 1, 2015 through June 30, 2017. That is the timeline for this RFP.

Question #15: I'm re-visiting the possibility of joint operations in the areas of assessment, outreach, engagement and housing referrals and inventory services? Yes, whether they can be a shared service?

> **Answer #15:** Is the question whether Category A and B applicants can do that together? Please submit that in writing.

Question #16: The question of the joint venture? Are they permitted, they are not prohibited, they are not mentioned under this title, typically in a facilities grant they would be mentioned one way or another. So are they prohibited?

> **Answer #16:** The applicant can only apply for one funding category and in their application they are to describe how they are following the program standards for that particular program.

Question #17: Can they affiliate with one another?

> **Answer #17:** Can you submit that in writing?

Question #18: Another question to that effect, you have all these clearly defined services under Category A and Category B separately, how do individuals find themselves identified as Category A or Category B under the proposal because at this point it is not apparent, a location, apparent for that determined to be made, so it could be that whomever is awarded Category A, for some reason everyone needs services under Category A and the risk again for those awarded under Category B

they will all be assessed for needing services under Category B, where is the bridge?

> **Answer #18:** The target population is more clearly defined under section 1.05 and under the program standards and they are different target populations, for Category A-ACT, services are limited to individuals with a severe and persistent mental illness and priority for those with a diagnosis of schizophrenia, other psychotic disorders with severe functional impairment due to mental illness and Category B- ICM, is for individuals with primary substance use disorder and have been identified as a top user of the Anchorage Safety Center, so those are the distinct populations in Category A versus Category B.

Question #19: How do you go from gathering people who are in need whether it be a the service center or the safety center or wherever you are identifying your clients, Brother Francis, Bean's Café, out in the streets where this program is intended to take place, what is the vehicle for the determination to move them into either Category A or Category B, not their diagnosis but the methodology? A Lot of these are the same folks and which category they fall into probably needs some shared or agreed upon entry, otherwise, again you falls prey to a system that feeds on its own delivery service system unless there is a standardized method for people who are coming in under this one grant program that has two awardees. We have two doors not one with the creation of this program. How do, individuals coming off the streets, what is the function that sorts them into Category A and Category B?

> **Answer #19:** Under 1.05 target population and Service Area, the target population, permanent supportive housing will be prioritized to individuals, A) who are chronically homeless, B) below 50% Area Median Income; and under D) grantees will be required to use a screening tool to prioritize based on vulnerability, and two tools are listed there which are the Level of Care Utilization Systems or the Vulnerability Index Service Prioritization Decision Assistance Tool, so I would refer you to that section.

Question #20: So let's say for example I have the grant for substance abuse and I a schizophrenic client so then I screen them and send them over to someone else? Sounds like that is what we are trying to avoid with having a Providence single point of entry?

> **Answer #20:** We are looking in the program standards that might help answer your question. The program criteria for individuals to enter either the ACT or the ICM are listed in the attached program standards as well as in the target population description in this RFP. So if there are further questions regarding that we could find the answers in the RFP for you or you could submit them in writing.

Question #21: Do they walk out of the sleep over center and decide today I am Category A or is there a place, a function that decides between A or B and if not, how do we get that built in here? So we will put that in writing.

> **Answer #21:** Under phase 2 Client Outreach & Service Delivery, pg. 11, under section 1.03, during the client outreach phase, the successful grantee will conduct active outreach to chronically homeless individuals to engage, assess, and prioritize the target population, in accordance with the program standards. In Category A they will deliver services including

outreach and engagement according to the program standards and Category B according to the program standards.

Question #22: It would seem like the two agencies or awardees would have to have daily meetings because they are going to outreach to 4th Avenue and talk to the same people that the other guy talked to last night. Is that a concern yet?

Answer #22: If we have not answered your questions on this section 1.03, can you submit them in writing and we will move on to section 1.04, program evaluations.

Section 1.04

Question #23: Many of the outcomes appear to rely on the CSR or the completion releasement data in AKAIMS, do I have that right? I am referring to the correspondence with the Dept. goals, pg. 13 and the life quality in a safe environment, especially, it appears to use the CSR and the one above it, 1.1, successfully completes treatment, is typically driven by AKAIMS, both suggest to me that someone needs to be enrolled in or admitted into a treatment program that uses that data collection but there appears to be no way of moving clients into treatment which would compromise the use of those measures or performance standards for evaluation criteria, is there something I am missing here?

Answer #23: Are you referring to the sample attachment? I am not sure what your question is, all grant programs have to align with DHSS priorities and core services and related items were included in that section and then under what the applicant has to submit, they submit a draft evaluation plan based on the contents of this RFP and a description of their program.

Question #24: If you could go back to page 13, DHSS priority 1, and Objective 1.1.3. Performance measure and it say the percent of Alaskans discharged from substance abuse treatment services that successfully completed treatment and that is a very common measure derived from AKAIMS for those people who are enrolled in treatment programs and my questions is, is it your intent to use the same measure for this program and if so, we need to enroll people in AKAIMS, which appears to be discouraged, at least not required, as participation in this grant. My question is whether or not people are required, well both in a way, if they are using AKAIMS and the CSR, it assumes that someone has taken measures from at least two points in the course of care, that is the only way you can show improvement if people are encouraged to have alternate ways of measuring this they are still related to treatment, so I am puzzling about how we both comply with the DHSS goals and make sure that people are voluntarily participating in a program that typically generates the measures that are used for those performance indicators.

Answer #24: Is your question whether applicants are asked to track the DHSS performance measures or it is question whether grantees are required to use AKAIMS and the CSR?

Question #25: At what point do they become a client when you are working with someone from off the street?

Answer #25: Please submit that in writing if the RFP does not answer that.

Question #26: I may be reading this wrong but the paragraph above the DHSS priority 1 just says the grant programs are required to align with DHSS priorities and core services detailed below. So I am not sure the quoted performance measures below are required specifically for the grantees to do, those are statewide measures that the grantee is supposed to align with. So those are what the state priorities are with the evaluation plan corresponding to it. This is more of a clarifying question/statement.

> **Answer #26**: Yes, you are reading that correctly. All grant programs are required to align with the DHSS priorities and core services. What the grantee is required to track is included in the evaluation plan component, fidelity, length of stay, behavioral/treatment outcomes and submits the first draft of the evaluation plan and logic model, the example is attached.

Section 1.05

Question #27: In some cases for people either in Category A or Category B, my understanding is while that is the entire target population, referrals will be taken from the Anchorage Safety Center for Category B or API or other referral sources for Category A, in some cases they may not meet all of the criteria specified under 1.05.A., if they don't are they still eligible, for example the definition for chronic homelessness, the immediate income, history of hospitalizations, somebody may not, meet all those criteria's but still be referred by the Safety Center, are they still eligible.

> **Answer #27:** I would refer you to the program standards and the program entry criteria for both programs and if that doesn't answer your question then please submit your question in writing.

Section 1.06

Question #28: Back to the voucher question on page 17, so we are wondering about the priority of the allocation of the program vouchers, if it is statewide, and we are understanding that only a portion of that priority is delegated to the Anchorage municipal area, the target population, we are concerned that there is not really housing for that many, so the requirement that the housing first model is used is kind of based on paper but not actually square footage, is that being taken into account?

> **Answer #28:** Can you submit that in writing?

Question #29: Looking at the housing data for Anchorage, I think it is called the point in time survey, it shows a distribution of clients that are pretty much inverse of the funding allocation that supports services for the seriously mentally ill, it's almost twice as many people who identify themselves as suffering from substance abuse disorders of some type. Is there a rationale for the funding distribution that favors SMI clients in spite of that basic data point?

> **Answer #29:** Can you submit that in writing?

Section 2: No questions

Section 3: No questions

Section 4:

This section is the criteria, explaining what we are looking for in your response and how you will be scored. You will be entering your responses to the RFP in GEMS. This is not going to be the typical process where you type a grant proposal, print five copies, and send them via mail to grant and contracts. Everything is now done in GEMS; you will respond and submit it in GEMS by November 25th before 11:59 PM. Please note, in Section 4, there are two columns on the right hand side, 'Review' and 'Points'. So for those criteria that are just a review, a technical review to make sure certain items are provided or completed, then no points are assigned. We have also set up a way for you to respond to each question, whether it be a text box where you simply enter in your response to the questions, or if we are requesting a documents, there will be a link provided where you can download the attachment or template, save it to your desktop, fill it out as necessary, then upload it to that same question. Rather than looking throughout the entire RFP for the questions to answer, we have laid it all out in this section for you. I do want to make it clear that you can only upload one document per answer. Per each question, the review/ evaluation criteria are also provided. You can see what we are looking for in a response and you are able to see how it is going to be weighted, therefore how much time you should spend on each answer.

Written Questions and Responses to the RFP:

Question #30: Regarding the requirement for a "stakeholder group/steering committee" (p. 8): what is the authority level of this group? In other words, will this committee have to approve all program design decisions of the grantee?

> **Answer #30:** The stakeholder group holds no formal authority over the successful applicant program/DHSS grantee. The RFP details the purpose and composition of the stakeholder group(s) in Sections 1.02 and 1.03. Please also see Evaluation/Review Criteria Section 4.11 "proposal clearly describes applicants plan for forming a stakeholder group" with associated point value of 8. Additional evaluation criteria in Section 4.05 include "Applicant describes in their plan how they will conduct outreach to the community and formation of stakeholder groups, to include list of partners, and how input will be incorporated into program plans" with associated point value of 6.

Question #31: "The anticipated primary outcomes … include housing stability (as measured through housing tenure [length of stay in permanent supportive housing] and housing status at discharge)" (p. 9)… Therefore, it is critical to understand the true availability of the "rental subsidy vouchers" discussed on pg. 17. Questions:

- As the "Moving Home Voucher Program" is intended for 150 individuals statewide, to what extent will vouchers be available to participants in Anchorage-specific programs supported by this RFP?

> **Answer #31:** The availability of rental subsidies to the Anchorage community will be determined through geographic appropriation of the total available statewide and

DHSS/AHFC funding available for rental subsidies. While DHSS will prioritize available subsidies to individuals served by this program, applicants are referred to RFP Section 1.06 Program Funding "grantees will be expected to utilize the funds in this grant or other relevant sources (such as Medicaid, Individual Service Agreements (ISA), Section 8 Housing Choice Voucher Program, Special Needs Housing Grant, HUD Continuum of Care subsidy and service programs, local funding, private donations, etc. to ensure that the target population has access to all necessary services and supports to ensure housing stability".

Question #32: Is there actually enough housing available in Anchorage to support 150 placements?

Answer #32: Please see Section 1.03: "successful applicants should detail how they plan to provide the following services on finding and maintaining housing", including pre-tenancy supports: "housing search, assistance with rental application and connection to rental subsidy or provide bridge rental subsidy through grant, orientation to housing and services, review of lease program policies, assistance with rental interview/facilitation of housing unit inspection".

Question #33: The RFP requires separate applications for ACT (directed at persons with severe and persistent mental illness) and ICM (directed at persons with primary diagnosis of substance abuse) services. To reiterate some of the questions asked in the teleconference:

- As the chronic inebriate population is largely saddled with both issues (reflected on the p. 6 list of "service requirements" which includes both types of services, not to mention the state's merging of ADA and MHDD years ago), would DBH entertain a joint application, representing agencies mutually committed to reaching the goals of the initiative?

Answer #33: Please refer to Section 1.01 of the RFP under Structure of this RFP, which states "DBH…is splitting funds into two categories…These two programs will serve distinct populations in order to meet the varying intensity of behavioral health needs of the chronically homeless population in the Anchorage area." Please refer to Section 1.01 "Applicants can only apply for ONE funding category".

It is the Division's intent, when funding an evidence-based practice such as ACT, to follow the model to full fidelity, including the target population this practice is shown to be effective with. Please reference the target population description in Section 1.05, as well as attached Interim Program Standards for both programs that contain further information on the target population.

Question #34: Can you provide any clarification regarding the State's intention to develop a day rate or a case rate for Medicaid to support the ACT program? This had been discussed in the past, and the long-term viability of an ACT team would seem to be improved with this in place. Is this still in the works, is there a timeframe that you can provide? A related question has to do with the eventual mix (%) of grant and Medicaid billing that is expected of the ACT Team. Can you provide guidance on this as well?

Answer #34: The Division of Behavioral Health intends to explore Medicaid financing strategies for Permanent Supportive Housing, including case rate payment mechanisms for Assertive Community Treatment. DBH is currently securing a technical assistance contract to create a 3-5 year strategic plan around supportive housing including exploration of and recommendations around financing mechanisms for support services. The eventual mix (%) of grant and Medicaid billing expected of the ACT team (post FY2017) will be determined through the calculation of case rate methodology using data pulled from service mixture utilization from the Alaskan ACT team.

The program will be funded as outlined in the RFP under Section 1.06 Program Funding and 3.05 Duration of Grant with any potential continued funding under the following conditions:

a) DHSS's judgment there is a continued need for the grant project service;
b) The grantee's satisfactory performance during the previous grant year;
c) The availability of sufficient grant program funds, and whether continuation of the financing is consistent with public health and welfare; and
d) The ability of the grantee and the DHSS to agree on any adjustments in payments or service.

Question #35: I have a clarification question for the proposal for the ACT/Intensive Case Management RFP: The funds are identified on page 4 and page 6 of the RFP (and in several other locations) as being capital funds. My question is: What operating expenses are allowable in FY15? I understand from page 4 that applicants for Category B may be eligible to receive additional operating funding for FY16-17. As ACT programs are heavily focused on service delivery; we are envisioning some personnel costs associated with FY15 startup.

Answer #35: The designation of "capital" vs. "operating" merely designates the source of the funds. For allowable costs for this solicitation, please see Section 1.06 Program Funding, specifically the section marked Proposed Budget. This section references 7 AAC 78.160 (costs). Budgets should "support program staffing and service delivery requirements stated in this RFP".

"Where realistic, DBH operating funds will be utilized before capital funds (through this appropriation) are expended". Please see below potential budget breakdown year-by-year for both categories to accomplish this. Please note that budgets should only contain totals for funds available through this solicitation ($3,760,000 capital funds).

ACT Program Funding	Capital Funds
FY 15 (6 months of operations)	$ 900,000.00
FY 16 (12 months of operations)	$ 680,000.00
FY 17 (12 months of operations)	$ 305,000.00
	$ 1,885,000.00
ICM Program Funding	Capital Funds
FY 15 (6 months of operations)	$ 375,000.00
FY 16 (12 months of operations)	$ 750,000.00

FY 17 (12 months of operations)	$ 750,000.00
	$ 1,875,000.00
Total:	$ 3,760,000.00
	(capital)

Question #36: The intent of the program is to create a coordinated system. How does the Division imagine the two grantees will coordinate the services across the two service types since no coordinating mechanism is built into the RFP?

Answer #36: Please refer to Section 1.01 of the RFP under Structure of this RFP, which states "DBH…is splitting funds into two categories…These two programs will serve distinct populations in order to meet the varying intensity of behavioral health needs of the chronically homeless population in the Anchorage area." Please also refer to the "Introduction" within Section 1.01 for additional clarification regarding the intent of this RFP, specifically "The programs funded through this solicitation will serve to re-balance the housing and services continuum toward less acute care."

Question #37: The RFP divides the service types between the diagnoses of SMI and SUD. How do bidders and providers square this with the developments of the field of the past 20 years requiring the provision of services to individuals who experience co-occurring disorders—most of the target population of this appropriation?

Answer #37: It is the Division's intent, when funding an evidence-based practice such as ACT, to follow the model to full fidelity, including the target population this practice is shown to be effective with. Please reference the target population description in Section 1.05, as well as attached Interim Program Standards for both programs that contain further information on the target population.

ACT: Admission Criteria excerpt from Interim Program Standards (pg. 10-11): "Recipients must meet the following admission criteria: 1) Severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fifth Edition, or DSM V, of the American Psychiatric Association) that seriously impair their functioning in community living. Recipients must have a primary mental health diagnosis and a major Axis I disorder. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability and because of research supporting the effectiveness of ACT for persons with these disorders. The appropriateness of ACT services for persons without these primary diagnoses is not supported by research and is of questionable appropriateness. Persons with a sole diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders are not the intended recipient group for ACT services. Persons with severe mental illnesses who have not been able to remain abstinent from drugs or alcohol will not be excluded from ACT services". Please also see ACT Interim Program Standards section on ACT Program Fidelity Monitoring (pg. 10).

ICM: Please reference attached ICM Interim Program Standards, Admission Criteria section: "A diagnosable mental, emotional, or behavioral disorder of sufficient duration to meet diagnostic criteria specified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, that has resulted in functional impairments that substantially interferes with or limits one or more major life activities. Persons who have not been able to remain abstinent from drugs or alcohol will not be excluded from ICM services". Regarding this solicitation, please refer to RFP Section 1.05 Target Population and Service Area: "ICM Services are limited to individuals with primary substance use disorder and have been identified as a top user of the Anchorage Safety Center (ASC) for public intoxication."

Please reference the Interim Program Standards for both categories to review the following sections: Admission and Discharge Criteria and Required Core Services (to include Integrated Dual Disorders Treatment).

Question #38: Can organizations make joint ventures to respond to this RFP or must proposals be separate from one another?

Answer #38: Please refer to Section 1.01 of the RFP under "Structure of this RFP" that states "Applicants can only apply for ONE funding category." Please also refer to Section 1.06 Program Funding, which states "Due to the unique nature of ACT services, and to maintain fidelity to the model, one agency must employ the entire ACT team staffing model. Multi-agency agreements for staffing are not recommended."

Question #39: How do we obtain detox services for those who need it, or is the substance use side of this proposal expected to provide detox as a part of the service?

Answer #39: Please refer to Section 1.06 Program Funding, which states (for ICM only): "although the grant award will be made to one grantee, it is expected that one agency will not be able to meet all of the needs of the target population. The successful applicant will submit a proposal that illustrates shared funding through potential subcontracts and Memorandum of Agreements (MOA's). These should clearly define the role of the ICM agency and the services being performed by the subcontractor(s) within the funding limitations. Subcontracts must be pre-approved by DBH and are subject to 7 AAC 78.180 (Subcontracts). It is up to the successful applicant to define the brokered vs. non-brokered services to create a collaborative model to comprehensively serve this high-needs population. This allows for some program flexibility as the successful applicant can creatively design a program to meet the needs of the target population."

Question #40: 1. Flexibility and efficiency of operations: The RFP emphasizes flexible and efficient operations. In some cases, this objective is compromised because of the required separation of category A and B services.

a. Can services be more efficiently provided through joint operation of:
   i. assessment,
   ii. outreach and
   iii. housing inventory management and referral services.

b. Are joint ventures permitted under this RFP? How about affiliation agreements?

Answer #40: Please refer to Section 1.01 of the RFP under Structure of this RFP, which states "DBH…is splitting funds into two categories…These two programs will serve distinct populations in order to meet the varying intensity of behavioral health needs of the chronically homeless population in the Anchorage area."

Please refer to Section 1.01 of the RFP under "Structure of this RFP" that states "Applicants can only apply for ONE funding category."

Question #41: Composition of advisory groups: The composition of advisory and steering groups for categories A and B appear to have a different composition.

i. Can there be one unified oversight/advisory body to ensure smooth coordinated operations?
ii. Why is the AMHTA on one steering/advisory committee and not on the other?

Answer #41: Please refer to section 1.02 Program Goals and Anticipated Outcomes, under "Community Stakeholders" which states "a stakeholder group will be formed for each Category to ensure responsive services are prioritized to the target population." This section also describes the different functions of each stakeholder group:

ACT: "This referral committee will serve to prioritize services to high risk individuals identified as frequent users of the emergency services system (and meet eligibility criteria for ACT services)."

ICM: "This steering committee will allow for community input into program implementation, responsiveness, and feedback on neighborhood impact of the services."

Successful applicants "will conduct outreach to appropriate entities in the in the homeless and emergency service provider network…" Please also see Section 2.04 Support/Coordination of Services "Stakeholder groups will be asked to identify and involve critical community members and entities that are not already involved". Please also see Evaluation/Review Criteria Section 4.11 "proposal clearly describes applicants plan for forming a stakeholder group". Please also see scoring/evaluation criteria under Section 4.17 "Proposal adequately addresses the applicant's efforts to involve critical community member and entities in the community planning process".

Question #42: Clinical needs assessment: The RFP distinguishes between potential clients with severe mental illnesses and those with substance abuse problems These are triaged into Category A Services (Assertive Community Treatment) and Category B Services (Intensive Case Management (Figure on p.7)

i. Who determines the client's diagnostic category? What if a client is dually diagnosed?

Answer #42: Please see Section 1.01 Introduction and Program Description: "Successful applicants will be required to perform a vulnerability assessment to determine the highest needs individuals to be served through this grant and ensure these individuals are receiving the appropriate housing model". Please see Section 1.05 Target Population and Service Area "Grantees will be required to use a screening tool to prioritize based on vulnerability (such as Level of Care Utilization System (LOCUS) or Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPAT))".

Please also reference the Interim Program Standards following sections: Admission and Discharge Criteria, Assessment and Person Centered Planning, and Required Core Services (to include Integrated Dual Disorders Treatment).

Question #43: Are grantees allowed to share initial diagnostic functions or vulnerability assessments to effectively triage people into Cat A (SMI) or Cat B (SUD)? The dually diagnosed issue resurfaces. (see p.7)

Answer #43: Please refer to Section 1.01 of the RFP under Structure of this RFP, which states "DBH…is splitting funds into two categories…These two programs will serve distinct populations in order to meet the varying intensity of behavioral health needs of the chronically homeless population in the Anchorage area."

Please also refer to Section 1.01 of the RFP under "Structure of this RFP" that states "Applicants can only apply for ONE funding category." Please refer to Section 1.06 Program Funding, which states "Due to the unique nature of ACT services, and to maintain fidelity to the model, one agency must employ the entire ACT team staffing model. Multi-agency agreements for staffing are not recommended."

Please see Section 1.03 Program Services/Activities: "For the purposes of referral and coordination of care, proper Release of Information (ROI)'s or Business Associate Agreements must be in place with appropriate entities that provide services to the target population. This will ensure collaboration and partnership between providers and non-duplicative services."

Question #44: Definition of the target population: Section 1.05 defines the target population and service area. This definition is different than the target population for Category B services.

i. The RFP (p. 14) suggests target population penetration as a measure of performance. Will the denominator (size of the population) be a number agreed upon by the proposer and the Division?

Answer #44: Statewide performance measures are tracked and monitored by DHSS; all grant programs are required to align with specific Department-wide priorities and core services. The specific Department-wide priorities and core services related to this program are included in this RFP to illustrate which priorities and core services this program aligns with. Please see evaluation/review criteria under ICM Section 4.13 "services are in alignment with DHSS's priorities and core services" (with associated point value of 4).

DHSS statewide performance measures for the Division of Behavioral Health rely on CSR and AKAIMS data. Please see Section 1.04 Program Evaluation Requirements and Reporting under subsection marked Behavioral/Treatment Outcomes: "Grantees will provide DBH with results of initial and periodically administered Client Status Review (CSR) for DBH analysis of treatment outcomes. Grantees clinical team reviews progress and data for each recipient at least weekly, and adjusts treatment as indicated. Summary data will be included in treatment plans and will be used to inform treatment plan changes. Clinical staff will develop quarterly and annual reports for DBH/DHSS clinical and management review, relying on grantee/AKAIMS reports and other on-site monitoring activities. Quarterly reports to include but not limited to the identified outcomes listed in the logic model and evaluation plan."

For grantee-required evaluation, "applicants are required to submit a draft evaluation plan based on the contents of this RFP" with attached Sample Items to Include in Draft Evaluation Plan. Please see evaluation/review criteria under ICM Section 4.13 "applicant includes an evaluation plan with stated performance measures the applicant will use to evaluate the progress of the grant project toward achieving the program goals and desired outcomes. Evaluation plan is based on the contents of this RFP (at minimum to include program fidelity, housing tenure, recidivism, and behavioral health/treatment outcomes) and includes data collection strategy" with associated point value of 12.

Question #45: Section 1.05 defines the characteristics of the population. Is the data set available? Is the number of clients in the target population defined by Anchorage Safety Center use rates?

Answer #45: Please see Section 1.03 Program Services/Activities "To target specific individuals, the applicant will need strong partnership with the Municipality of Anchorage to identify top users of the Anchorage Safety Center to be paired with housing and services".

Question #46: The characteristics of eligible clients referred by the Anchorage Safety Center to Cat B providers may not be the same as those clients described in Section 1.05. Are clients refused services?

Answer #46: For Category B: ICM under Section 1.05 "ICM services are limited to individuals with primary substance use disorder and have been identified as a top user of the Anchorage Safety Center for public intoxication". This is the target population of this category.

Section 1.03: "Proposals must include a description of proposed activities that support the goals and outcomes to be employed in the project. Proposed activities must match those summarized in the Logic Model. The applicant must also include a timeline for implementation in their proposal. Applicants agree to comply with all of the following additional program requirements and service standards, see attached Interim Program Standards".

Question #47: Responsibility for rental payments: The RFP emphasizes permanent housing for homeless people suffering from substance abuse and severe mental illnesses.

ii. The RFP (p.5.) suggests that the objective of the project is to provide supportive housing, not to support housing. Will the successful proposer be responsible for increasing the number of housing units for these populations?

Answer #47: Please refer to RFP Section 1.06 Program Funding "grantees will be expected to utilize the funds in this grant or other relevant sources (such as Medicaid, Individual Service Agreements (ISA), Section 8 Housing Choice Voucher Program, Special Needs Housing Grant, HUD Continuum of Care subsidy and service programs, local funding, private donations, etc. to ensure that the target population has access to all necessary services and supports to ensure housing stability".

Please see Section 1.03: "successful applicants should detail how they plan to provide the following services on finding and maintaining housing", including pre-tenancy supports: "housing search, assistance with rental application and connection to rental subsidy or provide bridge rental subsidy through grant, orientation to housing and services, review of lease program policies, assistance with rental interview/facilitation of housing unit inspection".

Question #48: How do clients served under this RFP pay for rent when they have little sources of income? Are all expected to be served by vouchers? Does the grantee have the financial responsibility to provide housing under this grant?

Answer #48: Please see Section 1.01 Introduction and Program Description, Permanent Supportive Housing is "characterized by availability of recovery-oriented services in integrated community settings coupled with safe and affordable housing". Please see Section 1.03 Program Services/Activities, applicants are asked to detail how they will ensure the following services are available to the target population, including "linkage to affordable housing/rental subsidies".

Please see reference to SAMHSA's Permanent Supportive Housing Evidence Based Practice under Section 1.02 Program Goals and Anticipated Outcome. Affordability is defined under this model as tenant payment of 30% of their income towards rent and the remainder of rent is subsidized.

The availability of DHSS rental subsidies to the Anchorage community will be determined through geographic appropriation of the total available statewide and DHSS/AHFC funding available for rental subsidies. While DHSS will prioritize available subsidies to individuals served by this program, applicants are referred to RFP Section 1.06 Program Funding "grantees will be expected to utilize the funds in this grant or other relevant sources (such as Medicaid, Individual Service Agreements (ISA), Section 8 Housing Choice Voucher Program, Special Needs Housing Grant, HUD Continuum of Care subsidy and service programs, local funding, private donations, etc. to ensure that the target population has access to all necessary services and supports to ensure housing stability".

Please see Section 1.03: "successful applicants should detail how they plan to provide the following services on finding and maintaining housing", including pre-tenancy supports:

"housing search, assistance with rental application and connection to rental subsidy or provide bridge rental subsidy through grant, orientation to housing and services, review of lease program policies, assistance with rental interview/facilitation of housing unit inspection".

Question #49: Will the successful proposer be responsible for the housing tenure primary outcome if it has no control over rental payments?

Answer #49: Please see Section 1.03 Program Services/Activities, applicants are asked to detail how they will ensure the following services are available to the target population, including "linkage to affordable housing/rental subsidies". Primary program outcomes include housing stability as measured through housing tenure (length of stay in permanent supportive housing). Please see evaluation/review criteria for Category B ICM in Section 4.11 "proposal describes applicants thorough understanding of Permanent Supportive Housing (i.e. affordable, choice of housing, use of housing as stable platform for recovery, voluntary and flexible services)" as well as "proposal demonstrates understanding of the goals and outcomes of the project "housing tenure, reduced recidivism".

Question #50: Are detoxification and residential treatment considered short-term housing?

Answer #50: Please see Section 1.01 Introduction and Program Description, Permanent Supportive Housing is "characterized by availability of recovery-oriented services in integrated community settings coupled with safe and affordable housing".

Please see reference to SAMHSA's Permanent Supportive Housing Evidence Based Practice under Section 1.02 Program Goals and Anticipated Outcome. "Services and housing are separated, therefore the housing unit is not owned by the service provider and engagement in services is not a requirement of tenancy".

Please see evaluation/review criteria for Category B ICM in Section 4.11 "proposal describes applicant's thorough understanding of Permanent Supportive Housing (i.e. affordable, choice of housing, use of housing as stable platform for recovery, voluntary and flexible services)" with associated point value of 6. Additional criteria in this section include: "Proposal demonstrates understanding of and willingness to follow Housing First philosophy (housing with no pre-conditions of sobriety or treatment compliance)" with associated point value of 10. In addition, "proposal demonstrates understanding of the goals and outcomes of the project "housing tenure, reduced recidivism" with associated point value of 8.

Question #51: Distribution of funds: The RFP awards more funds to the treatment of severely mentally ill clients than to clients suffering from substance abuse. The point in time homeless surveys suggest that there are more homeless people suffering from substance abuse than from mental illness. How was the funding distribution determined?

Answer #51: Please refer to Section 1.06 Program Funding: "(ACT) team can request up to a total of $1,885,000 from this capital solicitation to fund an ACT team for the 2.5 year

duration…. (ICM) team can request up to a total of $1,875,000 from this capital solicitation to fund an ICM team for 2.5 years of operations".

Please refer to the "Introduction" within Section 1.01 for additional clarification regarding the intent of this RFP: "The Department of Health and Social Services has identified several challenges including the development of quality local Psychiatric Emergency Services throughout the state and alternatives to hospitalization. Alaska Psychiatric Institute (API), the only state-owned psychiatric hospital, has only 50 acute adult beds and often operates at capacity. In addition, there is a statewide shortage of residential supportive housing that can accommodate people with behavioral health issues too severe to be managed in a standard assisted living home but who do not require hospitalization. Individuals exiting correctional facilities or involved with the Court System lack housing with support services to prevent repeated episodes of homelessness and institutionalization. In addition, those experiencing chronic homelessness often do not have access to the appropriate services and supports necessary to aid in their recovery… The programs funded through this solicitation will serve to re-balance the housing and services continuum toward less acute care."

It is the Division's intent, when funding an evidence-based practice such as ACT, to follow the model to full fidelity, including the target population and team size this practice is shown to be effective with. Please reference the attached Interim Program Standards for further information on the model and program fidelity. ACT is a well-researched practice with strong evidence for reducing hospitalizations and jail days. Costs were derived from looking at other communities that have successfully implemented ACT and using SAMHSA's ACT budget simulation model. Please also reference the Interim Program Standards for both ICM and ACT to include Integrated Dual Disorders Treatment (section heading: Required Core Services).

Question #52: Definition of community: How are communities defined? The RFP specifies that services will be provided in the Municipality of Anchorage. However, preventing people from rural communities from becoming stranded and substance abuse dependent in Anchorage may require preventive services in the clients home community. Strong outreach and supportive work with behavioral health aides and, possibly, the addition of housing stock in rural communities may better help the situation. In addition, services closer to home appeared to be consistent with the AMHTA policies.

Answer #52: It is outside of the scope of this RFP to create additional housing stock in rural communities. This RFP is limited to services in the Municipality of Anchorage. Please see Section 1.01 Introduction and Program Description.

Question #53: Evaluation: the RFP does not make it clear who is responsible for assuring compliance with DHSS priority measurements and performance measures.

Answer #53: Statewide performance measures are tracked and monitored by DHSS; all grant programs are required to align with specific Department-wide priorities and core services. The specific Department-wide priorities and core services related to this program

are included in this RFP to illustrate which priorities and core services this program aligns with. Please see evaluation/review criteria under ICM Section 4.13 “services are in alignment with DHSS’s priorities and core services” (with associated point value of 4).

Question #54: If the proposer develops the evaluation plan, are they also responsible for retaining an evaluation function? (Internal or independent evaluator)

Answer #54: For grantee-required evaluation, please refer to RFP Section 1.04 Program Evaluation Requirements and Reporting: “applicants are required to submit a draft evaluation plan based on the contents of this RFP” with attached Sample Items to Include in Draft Evaluation Plan. “Successful applicants will be expected to work with their DBH Program Manager once awarded on an evaluation plan with stated performance measures the applicant will use to evaluate the progress of the grant project toward achieving the program goals and desired outcomes….Post award, DBH will work with successful applicants to provide resources of a third-party evaluator”. DBH will hire the evaluator directly and provide as a resource to successful applicants as well as demonstrate proof of effectiveness; “this data collection is important for future expansion of Permanent Supportive Housing (PSH) services statewide”.

Please see evaluation/review criteria under ICM Section 4.13 “applicant includes an evaluation plan with stated performance measures the applicant will use to evaluate the progress of the grant project toward achieving the program goals and desired outcomes. Evaluation plan is based on the contents of this RFP (at minimum to include program fidelity, housing tenure, recidivism, and behavioral health/treatment outcomes) and includes data collection strategy” with associated point value of 12.

Please also see 4.05 Evaluation and Review Criteria “The response demonstrates understanding of the purpose of Phase 1: Program Development & Community Outreach Phase (staffing, training, formation of community stakeholder group). Applicant demonstrates willingness to work with DBH Program Manager during this phase for development of program and evaluation plan” with associated point value of 8.

Question #55: The primary outcome (p.9) is housing tenure. Does this hold if the issue is rent payment? Who judges adequacy of “finding and maintaining” housing is timely payment of rent is the main issue? This is important in accommodating the requirement of separating receipt of housing from receipt of services (including supporting housing visits).

Answer #55: For grantee-required evaluation, please see section regarding evaluation plan: “applicants are required to submit a draft evaluation plan based on the contents of this RFP” with attached Sample Items to Include in Draft Evaluation Plan. Please see evaluation/review criteria under ICM Section 4.13 “applicant includes an evaluation plan with stated performance measures the applicant will use to evaluate the progress of the grant project toward achieving the program goals and desired outcomes. Evaluation plan is based on the contents of this RFP (at minimum to include program fidelity, housing tenure, recidivism, and behavioral health/treatment outcomes) and includes data collection strategy” with associated point value of 12.

Please see Section 1.03 Program Services/Activities, applicants are asked to detail how they will ensure the following services are available to the target population, including "linkage to affordable housing/rental subsidies". Primary program outcomes include housing stability as measured through housing tenure (length of stay in permanent supportive housing). Please see evaluation/review criteria for Category B ICM in Section 4.11 "proposal describes applicants thorough understanding of Permanent Supportive Housing (i.e. affordable, choice of housing, use of housing as stable platform for recovery, voluntary and flexible services)" as well as "proposal demonstrates understanding of the goals and outcomes of the project "housing tenure, reduced recidivism".

Please see Evaluation/Review Criteria Section 4.12: "Applicant includes description of how they will provide housing stability services with the goal of assisting clients to find and maintain housing" with associated point value of 10.

Question #56: DHSS priority measurements appear to depend on use of CSR and AKAIMS. P 13 suggests an improvement in behavioral health issues. Demonstrating this change required at least 2 successful administrations of the CSR, and an ability to receive data from all providers to do the analysis. Will AKAIMS be the source of data for treatment completion? How about if a person refuses service?

Answer #56: Statewide performance measures are tracked and monitored by DHSS; all grant programs are required to align with specific Department-wide priorities and core services. The specific Department-wide priorities and core services related to this program are included in this RFP to illustrate which priorities and core services this program aligns with. Please see evaluation/review criteria under ICM Section 4.13 "services are in alignment with DHSS's priorities and core services" with associated point value of 4.

Please see Section 1.04 Program Evaluation Requirements and Reporting under subsection marked Behavioral/Treatment Outcomes: "Grantees will provide DBH with results of initial and periodically administered Client Status Review (CSR) for DBH analysis of treatment outcomes. Grantees clinical team reviews progress and data for each recipient at least weekly, and adjusts treatment as indicated. Summary data will be included in treatment plans and will be used to inform treatment plan changes. Clinical staff will develop quarterly and annual reports for DBH/DHSS clinical and management review, relying on grantee/AKAIMS reports and other on-site monitoring activities. Quarterly reports to include but not limited to the identified outcomes listed in the logic model and evaluation plan."

Please also see ACT Interim Program Standards, Introduction: "Because ACT teams often work with recipients who may passively or actively resist services, ACT teams are expected to thoughtfully carry out planned assertive engagement techniques which largely consist of rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques". Please see ICM Program Standards, Required Core ICM Services: "The ICM team will use a variety of techniques to engage recipients, including the use of collaborative

and motivational interventions to engage recipients and promote recipients' development of intrinsic motivation to receive services from the ICM team" (pg. 19).

Question #57: Who selects and retains the third party evaluator?

Answer #57: Please refer to RFP Section 1.04 Program Evaluation Requirements and Reporting: "applicants are required to submit a draft evaluation plan based on the contents of this RFP" with attached Sample Items to Include in Draft Evaluation Plan. "Successful applicants will be expected to work with their DBH Program Manager once awarded on an evaluation plan with stated performance measures the applicant will use to evaluate the progress of the grant project toward achieving the program goals and desired outcomes….Post award, DBH will work with successful applicants to provide resources of a third-party evaluator".

DBH will hire the evaluator directly and provide as a resource to successful applicants as well as to collect information for state purposes around proof of effectiveness; "this data collection is important for future expansion of Permanent Supportive Housing (PSH) services statewide".

Please also see 4.05 Evaluation and Review Criteria "The response demonstrates understanding of the purpose of Phase 1: Program Development & Community Outreach Phase (staffing, training, formation of community stakeholder group). Applicant demonstrates willingness to work with DBH Program Manager during this phase for development of program and evaluation plan" with associated point value of 8.

Reminder: The deadlines again are; all inquiries should be written and addressed to me by close of business, November 17th. The proposals are due at 11:59 pm on November 25th. Please attempt to submit them prior to close of business that day or no one will be in our office to assist you with any technical difficulties you may have.