

Request for Information

High Needs Adolescents



Wyoming
Department of
Family Services



Wyoming
Department
of Health



Manhattan Jehlicka
DFS Clinical Services Unit Manager
307-473-3994
Manhattan.Jehlicka@wyo.gov

August 2023

Table of Contents

Administrative Information	3
Introduction and Background	3
The Challenge	4
Purpose and Intent	6
Agency Requirements	8
Submission Requirements	8

Section 1: Administrative Information

1. INTRODUCTION AND BACKGROUND

As directed by W.S. § 14-3-215, the Department of Family Services (DFS) operates the Interagency Children’s Collaborative (ICC). As one of many revisions to the state’s child protective statutes, the ICC regularly convenes a group of state officials from all agencies who have a role in supporting Wyoming youth. Members are directed to review specific cases presented by multidisciplinary teams and to assess the statewide availability and adequacy of services required to meet identified needs.

Designated members of the ICC include:

- The Director of the Department of Family Services or designee;
- The Director of the Department of Health or designee;
- The Superintendent of Public Instruction or designee;
- The Director of the Department of Workforce Services or designee; and,
- A Governor’s appointee who shall represent families receiving services from the state agencies represented herein

Under the authority granted by W.S. § 14-3-215(b), DFS proposes the following objectives be reviewed and considered for adoption by members of the ICC. To support the ongoing work of the ICC, DFS is also proposing to schedule and facilitate meetings no less frequently than once per quarter, with an ICC subgroup designated to review urgent cases meeting no less frequently than twice per month. Those designated members of the ICC subgroup shall remain available for ad hoc meetings as necessary to address challenges with timely access to appropriate and necessary services (medical, mental health and others).

1.1. The ICC has established three operating objectives:

- 1.1.1. Assessing and developing systems of care;
- 1.1.2. Individual case management and crisis intervention; and
- 1.1.3. Interagency education and training.

1.2. Focusing on the activities related to individual case management and crisis intervention, the DFS facilitates routine ICC workgroup meetings to conduct the following activities:

- 1.2.1. Identify clinically appropriate inpatient or residential placement options and facilitate an admissions review process;
- 1.2.2. Review and approve single case agreements, enhanced rates or deviations in payment methodology require to ensure access to treatment;
- 1.2.3. Identify appropriate community-based services or foster care placements with required support services;

- 1.2.4. Identify transition or diversion services - to include services for youth who are not yet in DFS custody; and
- 1.2.5. Make recommendations for policy changes to improve outcomes and/or remove barriers.

2. THE CHALLENGE

For some high-needs adolescents, the State is unable to find the most appropriate and least restrictive environment, regardless of any negotiated rate. Worse, the State also has difficulty securing even temporary room, board, and supervision. This is also a concern for those high-needs adolescents who have been accepted into an appropriate treatment program, but remain on a waitlist until a bed becomes available.

2.1. Referral sources. At the time they are referred to the State for assistance to identify emergency residential placement and treatment, many youth and adolescents are at risk of homelessness, have been admitted to hospital Emergency Departments (EDs), or county jails and detention centers. In many cases, the adolescent was detained or admitted to the ED for their own safety or for the safety of others.

Requests for assistance in managing behavior and finding appropriate treatment come from several sources to include: parents, school districts, Department of Family Services (DFS), Department of Health (WDH), Department of Education (WDE), Psychiatric Residential Treatment Facilities (PRTFs) requesting transfers, and the Wyoming Boys or Girls School. These individuals or entities, who are often the designated primary caretaker of a high-needs youth or adolescent, seek state assistance as a last resort after other efforts to secure safe and therapeutic services have failed. At times, parents fear for their safety and/or the safety of other children in the family home. In some cases, parents may seek to temporarily transfer legal custody to DFS for a period of time when they feel there are no other options.

2.2. Demographic profile. The following characteristics are true for the majority of the cases reviewed, but should not be considered an all-inclusive list. Youth and adolescents presenting to the ICC may have a wide range of diagnoses and/or disorders leading to challenges with behavior management, supervision, stabilization and placement in an appropriate treatment program. Proposers should consider strategies for supporting high needs youth that may be younger than 12, as well as youth and adolescents who may have both a mental health diagnosis as well as a developmental, neurodevelopmental or intellectual disability.

Most high needs youth and adolescents referred to the ICC are between 12 and 17 years old, with the average age being 14.3 years. However, the ICC has staffed cases for youth as young as 10. Approximately 60% of this cohort are male.

The most common clinical diagnoses include:

- Attention-Deficit/Hyperactivity Disorder (ADHD),
- Post-traumatic Stress Disorder (PTSD),
- Disruptive Mood Dysregulation Disorder,
- Major Depressive Disorder,
- Autism Spectrum Disorder, and
- Reactive Attachment Disorder.

Most often, there are significant behavioral challenges and disruptions that lead to the referral of these youth and adolescents to the ICC. There are also basic procedural barriers to timely placement as well. The most common examples of observed placement challenges include:

- Significant aggression towards self or others,
- Oppositional defiance,
- Atypical behavior due to developmental delays,
- Self-injurious behavior,
- Medication non-compliance,
- Lack of, or outdated evaluations (psychiatric, psychological, neurodevelopmental, psychosocial, etc.),
- High-risk behaviors (fecal smearing, swallowing non-food items, etc.),
- Problematic sexual behaviors, and
- Comorbid medical conditions (encopresis, enuresis, casts for broken bones, etc.) or psychological concerns that resemble a medical concern (nonepileptic seizures).

2.3. To date, state staff from multiple agencies have worked together to blend resources, canvas both in- and out-of-state provider types and programs, and identify funding mechanisms to assist adolescents that cross multiple agencies/ systems.

This multidisciplinary approach has demonstrated some success, but in many cases it has taken months to find an appropriate treatment program, obtain clinical admission approval, arrange payment and secure transport. Many of the specialty treatment programs with whom the state has partnered also have extensive waiting lists. Ensuring the immediate safety of each adolescent during this process, as well as access to the therapeutic evaluations required to support admission reviews, educational services, and immediate medication management and crisis intervention support is difficult when youth and adolescents are at risk of homelessness, being held in EDs, detention centers, or jails.

In most cases, youth and adolescents supported by the ICC have a psychiatric evaluation recommending placement in an inpatient treatment program that is subsequently only found out of state. However, with current therapeutic evaluations, stabilization, and medication management, clinical referrals can provide a more accurate depiction of need and support timely admission reviews. Immediate and appropriate interventions and

support can also increase the probability of engagement in treatment and a successful discharge.

3. PURPOSE AND INTENT:

- 3.1. The purpose of this Request for Information (RFI) is to solicit information from proposers who can offer temporary room, board, supervision, educational services in compliance with federal law, and a stabilization solution for identified high-needs adolescents referred by the ICC. For purposes of this RFI and to inform cost projections, proposers should assume “temporary” to mean episodes of care (an admission) with a length of stay between two (2) and nine (9) months, with a length of stay shorter than two (2) months and up to twelve (12) months being the exception, but still possible. The intent is for the proposed solution to provide a therapeutic alternative to long stays in EDs, county detention centers, jails, or eventual homelessness while the ICC works to locate and secure placement in a more appropriate, least restrictive, long term treatment program.
- 3.2. Proposers should consider various strategies for housing and supervising youth and adolescents based on age and gender, and comment on the feasibility of meeting the requirements as set forth including a proposed cost for initial development as well as the cost for ongoing services.
- 3.3. For the purposes of this RFI, “Contractor” will be used to identify responders who would be interested in supplying a bid when procurement activities for this scope of work begin. Contingent upon the solution proposed and solutions ultimately chosen, the Contractor could be asked to obtain certification by DFS, WDE, and/or WDH. For purposes of this RFI and proposed solutions, compliance with current licensing and certification rules need not be demonstrated.
 - 3.3.1. Contractor shall safely provide twenty-four (24) hour room, board, and supervision for up to fifteen (15) adolescents with high needs at any given time, both male and female, between the ages of 12 and 17. Contractor should consider the following in a proposed solution;
 - 3.3.1.1. There is no requirement that all youth be served in a single geographic location;
 - 3.3.1.2. Consider the least restrictive setting available to adequately support the identified youth and adolescents; and
 - 3.3.1.3. Consider supports and services within local communities that could be leveraged to help support these youth and adolescents.
 - 3.3.2. Contractor shall have twenty-four (24) hour staff for supervision;

- 3.3.3. Contractor shall maintain a direct care staff ratio as needed to ensure the safety of all adolescents. Many of these high-needs youth and adolescents will require 1:1 or 2:1 staffing for initial admission and stabilization;
- 3.3.4. Contractor shall directly provide or facilitate access to initial therapeutic evaluations, medication management and ongoing group, individual and family therapy as determined necessary for the duration of the admission. The specific services shall be determined by the treatment team through the creation and implementation of an individual treatment plan of care;
- 3.3.5. Contractor shall accept and admit any youth or adolescent referred by the State. Through internal agency processes, referrals for admission will be triaged based on acuity and safety and, once referred, shall be accepted by the Contractor for temporary placement and support;
- 3.3.6. Contractor shall actively engage with the agencies, treatment teams, and families to identify appropriate long term treatment programs provided in the least restrictive environment;
- 3.3.7. Contractor shall actively work to obtain any psychiatric or psychological assessment deemed necessary to identify appropriate long term placement and treatment options;
- 3.3.8. Contractor shall complete comprehensive medication reviews, as appropriate, and adjust medication administration as recommended and approved;
- 3.3.9. Upon placement, the Contractor shall engage with the referring entity to develop an immediate safety and crisis response plan, as well as a behavior support plan;
- 3.3.10. Contractor shall provide room, board and all meals;
- 3.3.11. Contractor shall provide sufficient space for each adolescent to ensure safety. Males and females shall not be commingled and youth and adolescents shall be separated by age, when necessary, to ensure the safety of all youth and adolescents. Commingling may be appropriate in common areas based on individual youth and adolescent circumstances;
- 3.3.12. Contractor must ensure access to a free and appropriate education, to include any individualized education program (IEP) services deemed necessary and will engage with local school districts to ensure continuity of education where possible and to leverage existing funding;

3.3.13. Contractor shall adhere to all state policies and procedures, to the extent applicable under the Contract; and

3.3.14. Contractor shall provide case management services, including assigning a case manager to serve as a single point of contact with the ICC.

3.4. Timeliness. Unless capacity limits are reached, the Contractor must begin caring for referred youth and adolescents within five (5) business days of the initial referral by the State.

4. AGENCY REQUIREMENTS:

4.1. Agency staff will work with the Contractor on the transition. Agencies agree to:

4.1.1. Consult with and advise the Contractor, as necessary, about the requirements of the Contract and provide technical assistance, when requested.

4.1.2. Pay Contractor in accordance with the Contract.

4.1.3. Monitor and evaluate the Contractor's compliance with the conditions set forth in the Contract.

4.1.4. Assign a case manager to act as a single point of contact for the ICC and relevant referring agency.

4.1.5. Complete a pre-admission packet, and provide a copy to the Contractor, that will include the following:

4.1.5.1. The adolescents's name, social security number, Medicaid number, WISER ID (A WISER ID is a single, non-duplicated number that is permanently assigned to a student throughout their education), and date of birth;

4.1.5.2. Any pertinent information about current behaviors, medical and educational needs; and

4.1.5.3. Signed Consent for Release of Medical Information for any previous psychiatric history.

Section 2: Submission Requirements

In order to facilitate a timely and comprehensive evaluation of all submitted responses, Contractors should limit the answers to the following questions to twenty-five (25) pages. All

responses must be submitted complete and in writing to **Manhattan Jehlicka (Manhattan.Jehlicka@wyo.gov)** by **5:00 pm on Monday, October 9, 2023 via email.**

All requests for information in all sections of this document must be answered as concisely as possible while providing all information necessary to understand the outsourcing process proposed. Any deviations from requirements, or requirements that cannot be satisfied by the Contractor, must be clearly identified.

Responses must include a statement that indicates that the Contractor understands the requirements of the RFI and accepts the terms and conditions under which the RFI was issued to the vendor. The response, including all supplementary information, must be forwarded to the point of contact identified herein.

Any information of a confidential or proprietary nature contained in a vendor response should be clearly marked 'PROPRIETARY' or 'CONFIDENTIAL' by item or at the top of each page. Reasonable precautions will be taken to safeguard any part of the response identified by a vendor as being confidential or proprietary.

Please provide the following information, in the requested sequence:

- Based on the information provided, would your firm bid on a Request for Proposal (RFP) for all listed services? If "yes", provide the following information.
- Provide the name, title, address, telephone and e-mail for the primary contact for receiving an RFP.
- Provide some general business background information.
- Describe similar services provided.
- Potential for value-added services.

As part of the cost breakdown, please include cost estimates for each of the following service lines:

- Initial startup costs;
- Facility/program operation fixed costs, per year, regardless of occupancy;
- Direct care staffing costs, per client served per month, assuming minimum of 5 and maximum of 15 clients;
- Educational costs, per client served per month, again assuming a client load between 5 and 15 clients any given month; and
- Any additional facility/program costs not otherwise included in the lines above.

Additionally, please indicate which of the following service packages they are capable of providing, at the costs indicated above:

- All-inclusive: facility/room and board, direct care staff, stabilization and education; or

- Direct care staff, stabilization and education only. State provides the facility/room and board; or
- Direct care staff and stabilization only. State provides the facility/room and board and educational services.