Exposure Draft

Report of the Secretary of Health and Human Resources

The Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities

To The Governor and General Assembly of Virginia

November 1, 2005

Please submit comments by close of business October 27, 2005
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EXECUTIVE SUMMARY

I. INTRODUCTION

The 2005 Appropriation Act requests the Secretary of Health and Human Resources to examine the feasibility of public-private proposals for the operation and maintenance of mental health facilities. The budget language was introduced and passed by the House Appropriations and Senate Finance Committees in response to discussions that occurred during the 2005 legislative session with a Florida company, Atlantic Shores Healthcare. Atlantic Shores initiated discussions with state officials and legislators regarding the capital replacement, private operation and maintenance of Eastern State Hospital in Williamsburg, Virginia.

In response to these discussions, the General Assembly requested that the Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services study the issue of privatization, particularly in light of the restructuring legislation passed in 2002.

Item 298 C of the 2005 Appropriation Act states:

> *The Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, shall examine the feasibility of Public-Private Education Facilities and Infrastructure Act of 2002 (PPEA) proposals for the operation and maintenance of mental health facilities. In examining the feasibility of such proposals, the Secretary shall solicit comments from an established state and community consensus and planning team for any existing facility impacted by such a proposal or proposals. The feasibility study shall also examine how the proposal or proposals would address the provisions of § 37.2-316, Code of Virginia, which sets out a process for restructuring the system of mental health services involving existing state mental health hospitals including: (i) the development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs; (ii) the resolution of employment issues related to state facility employee transition planning and appropriate transitional benefits, the availability of adequate staff in the affected communities, and specific strategies for transferring qualified state facility employees to community services in the event that a PPEA proposal includes a reduction of current staff; (iii) a six-year projection comparing the cost of the current structure; (iv) a plan for community education; (v) a plan for the implementation of required community services, including state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas; and (vi) a plan for assuring the development and implementation of individualized discharge plans for persons leaving the facility. The Secretary shall report on the feasibility of the use of PPEA proposals to the Governor and General Assembly by November 1, 2005.*

II. BACKGROUND

A. Restructuring

Section 37.2-316 of the Code of Virginia was passed in 2002, as a result of legislation that was introduced initially proposing to close some state mental health facilities. DMHMRSAS, state legislators, advocacy groups and providers worked together in 2002 to redraft the introduced bill and to craft the current Code language that specifies the procedure for restructuring the services system utilizing a broadly based community consensus and planning team.

Under this legislation, for the purposes of considering the closure of a state mental health facility, or its conversion to any other use, the Commissioner is required to establish a state and community consensus and planning team consisting of Department staff and representatives of the localities served by the state hospital. The teams must be organized in the jurisdiction where the facility exists and must include local government officials, consumers, family members of consumers, advocates, state hospital employees, community services boards, behavioral health authorities, public and private service providers, licensed (private) hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested persons. In addition, local legislators may serve on the team.

The team must develop a plan that addresses the six items included in the budget language set out above. In addition, there are elements that the Commissioner must assure be included in the plan, such as a plan for community education, an implementation plan for required community services, a plan for assuring adequate staff and dealing with state employees, a plan for assuring individualized discharge plans for affected patients, and a provision for suspending the closure or conversion if state funding for facility or community services is reduced by more than 10% from the year of approval to the actual implementation.

B. Public-Private Education Facilities and Infrastructure Act (PPEA)

The Public-Private Education Facilities and Infrastructure Act of 2002, §§ 56.575.1—56-575.16 was adopted for the stated purpose of "timely acquisition, design, construction, improvement, renovation, expansion, equipping, maintenance, operation, implementation, or installation of…public infrastructure and government facilities." The *Code* states that "it is the intent of this chapter, among other things, to encourage investment in the Commonwealth by private entities and to facilitate the bond financing provisions of the Economic Growth and Tax Relief Reconciliation Act of 2001 or other similar financing mechanisms, private capital and other funding sources that support the development or operation of qualifying projects." Qualifying projects include public buildings and facilities, including certain service contracts.

The PPEA statutes and procedures provide for proposals to be solicited by a state agency or to be delivered by a private entity on an unsolicited basis. As noted above, there is a two-part submission process: each phase of this process requires submission of a monetary fee to the agency.

C. PPEA Procedures

The Commonwealth of Virginia Procedures for the *Public-Private Educational Facilities and Infrastructure Act of 2002,* issued in December 2002, contain suggested formats for conceptual state (Phase 1) and detailed stage (Phase 2) proposal submissions by private providers. Private providers should follow these guidelines in submitting proposals to DMHMRSAS. The following reviews major components of the submission process.

The organization submitting a proposal is required to submit the following information in the Phase 1 submission:

- Qualifications and experience
- Project characteristics
- Project financing
- Anticipated public support or opposition, or both
- Projected benefit and compatibility, and
- Such additional information as may seem prudent

Suggestions for the Phase 1 Submission under project benefit and compatibility include the following:

- Identify community benefits, including the economic impact the project will have on the Commonwealth and local community, i.e., tax revenue, jobs, pay and fringe benefits of such jobs, training opportunities and number and value of subcontracts generated for Virginia subcontractors.
- Explain the strategy and plan that will be carried out to involve and inform the general public, business community, local governments, and governmental agencies in areas affected by the project.
- Describe the compatibility with the local comprehensive plan, local infrastructure development plans, and any capital improvements, budget or other government-spending plan.

The more detailed Phase 2 submission should include:

- Site plans and details.
- Financing arrangements.
- List of public utilities.
- Plans for securing property.
- Listing of design and construction firms.

- Total life-cycle cost specifying methodology and assumptions of the project and proposed project start date.
- Detailed discussion of assumptions about user fees or rates and usage of the projects.
- Identification of any known government support or opposition through official communications.
- Demonstration of consistency with appropriate local comprehensive or infrastructure development plans.
- Explanation of how the proposed project would impact local development plans of each affected local jurisdiction.
- Description of an ongoing performance evaluation system or database to track key performance criteria.
- Identification of any known conflicts of interest.
- Acknowledge conformance with Ethics in Public Contracting Act.
- Additional material as reasonably requested by the public entity.

Any private entity requesting approval from or submitting a conceptual or detailed proposal to the Commonwealth must provide each affected unit of local government with a copy of those portions of the private entity's request or proposal that are not deemed confidential by the state agency. Affected local jurisdictions have 60 days to submit written comments. The Cabinet Secretary that supervises the state agency provides written approval or disapproval to proceed to a Phase 2 proposal.

Comprehensive Agreements involving any form of state-supported debt, require specific, project-level approval by the General Assembly, the Governor and the Treasury Board. A state agency must have the Governor's approval to enter into a comprehensive agreement for the project.

D. DMHMRSAS Experience with PPEA (Build Only)

Items C-137 and C-139.10 of the 2005 Virginia Acts of Assembly, Chapter 951 (the Appropriation Act) authorized the Department of Mental Health, Mental Retardation and Substance Abuse Services, with the concurrence of the Secretary of Health and Human Resources to enter into a comprehensive agreement, pursuant to the PPEA, for the ***design and construction*** of a permanent facility for the Sexually Violent Predator Program (now known as "VCBR") and a ***replacement facility*** for the existing Hancock Geriatric Treatment Center

In February 2003, the Department received an unsolicited proposal from Gilbane Properties, Inc., to finance, design and construct the Virginia Center for Behavioral Rehabilitation (VCBR) on state owned property in Nottoway County, Virginia. Similarly, in July 2004 the Department received a second unsolicited proposal from Gilbane Properties, Inc. to finance, design and construct a replacement facility for Hancock Geriatric Treatment Center at Eastern State Hospital in Williamsburg.

In both cases the Department implemented the PPEA procedures set forth by the Secretary of Administration in December 2002. The Department decided to accept and consider each proposal, posted public notice of the proposals, and solicited competing proposals. No competing proposals were received for either proposal. After initial review of the Conceptual Stage (Phase 1) proposals, and in concurrence with the Secretary of Health and Human Resources, Gilbane Properties was notified of the Department's desire to proceed to the detailed phase (Phase 2) submission. Based on the Phase 1 and 2 proposals, the vendor's oral presentations, and the Department's evaluations of the proposals and presentations, the Department recommended proceeding with negotiation of a Comprehensive Agreement with Gilbane Properties, Inc. for the construction of a new facility for VCBR, and a replacement facility for Hancock Geriatric Center. The Department is currently negotiating the comprehensive agreements for both projects.

E. Purpose of the Statutes and the Feasibility Study

The restructuring language of Title 37.2 and the PPEA language of Title 56 address different purposes, that is (i) a public process for determining whether to close a state mental health facility or to convert it to some other use, and (ii) the encouragement of private investment in state infrastructure, technology and services. However, it is clear that PPEA can and is being used for the construction of state mental health facility buildings, such as the reconstruction of the Hancock Geriatric Treatment Center at Eastern State Hospital and the construction of the Virginia Center for Behavioral Rehabilitation. **The area that has not been explored to date, and the purpose of this study is to examine the feasibility of employing the PPEA process for the *operation and continued maintenance* of a state mental health facility.**

III. METHODOLOGY OF THE FEASIBILITY STUDY

Secretary Jane H. Woods, Secretary of Health and Human Resources, directed Commissioner James S. Reinhard, M.D. to convene a staff workgroup to determine the essential policy questions and criteria that would be needed by the Administration and General Assembly to evaluate the quality of a PPEA proposal to operate and maintain a state mental health facility. The workgroup looked at privatization efforts in other states and reviewed other states' requests for proposals (RFP) for contracting facility operations and services. Department staff worked closely with facility directors, facility staff, and with the Office of the Attorney General to develop a comprehensive draft of public policy questions and evaluation criteria.

(***This Section To be Completed)***

IV. HISTORY OF THE PRIVATIZATION OF MENTAL HEALTH SERVICES

A. History of Privatization In Other States

The National Association of State Mental Health Program Directors (NASMHPD) issues The Profiles of the States, an annual report profiling trends in mental health services across the country. For a number of years, NASMHPD has questioned all states regarding components of the state mental health agencies that have been privatized. When contacted for this study, the Director of the NASMHPD Research Institute, Ted Lutterman, indicated that there are only a few states with even partially privatized systems of mental health care.

The 2002-2004 Profiles indicates that the following states had privatized all or a part of their state mental health system of care, Florida, Arkansas, Connecticut, Kentucky, Illinois, and part of a South Carolina hospital. Most "privatization" has occurred when these states have closed facilities or units and have transitioned patients into community settings where contracts were awarded in the community for services. However, state's responded to the Profiles document by including private bed purchase in the community as diversion from facilities. This is similar to Virginia's private bed purchase initiative. Florida's privatization effort is by far the most comprehensive in that an entire hospital has been privatized and is run by a private for-profit firm.

1. Florida. Florida is the only state that contracts with a for-profit organization (Atlantic Shores Healthcare) to run a state mental health facility. In 1997-98, Florida operated four state psychiatric facilities, which are under the state's Department of Children and Families (DCF). One facility, South Florida State Hospital (SFSH) had a number of very old buildings over a 37-acre campus. The hospital had never achieved accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). SFSH typically had 12-13 elopements per month; poor reporting of seclusion and restraint (S/R) episodes; and a high number of patient injuries. During 1998, the problems increased. Communities were unable to get admissions for patients and patients were not being discharged. In addition, a number of patient deaths occurred. Clinically, the care was custodial, quality assurance was poor, some medical staff conducted private practice during work hours, and an excessive number of employees existed on payroll. The facility was staffed heavily with managers, especially fiscal and nursing; and both psychologists and physicians on long-term care units had very low caseloads.

After much negative media coverage, Florida's legislature directed the DCF to develop a RFP and privatize the entire facility. The RFP called for very strong oversight. Target goals were set in various domains (e.g., construction completion, JCAHO accreditation, reduction in elopements and S/R use), including significant financial penalties for not meeting the targets. Out of fifteen groups initially interested, only Atlantic Shores Healthcare and Liberty responded to the RFP.

Under the management of Atlantic Shores Healthcare, SFSH met almost all of the target goals. The only exception was the completion date for construction of the new building. Staffing and equipment were two immediate sources of cost savings. Out of approximately 700 staff, 400 were hired. All staff had the option of transferring to another state job. Consolidating services into one building reduced both support service staff (e.g., housekeeping, building and grounds), eliminated duplication of equipment across multiple buildings, and eliminated the need for golf carts and cars to get around the campus. The staff employed by private management were given a reduced benefits package, but received significantly higher salaries, for example, direct service associates went from approximately $17,000 per year to $24,000.

A key element of success for the Florida contract was that the RFP was comprehensive and "tight", with clear expectations and penalties. In addition, the Florida DCF remained a partner with the SFSH and Atlantic Shores Healthcare administration over time. Other critical elements of success and outcomes of the privatized facility are set out in the following list.

- The DCF participates in hiring the facility management team. The Atlantic Shores Healthcare management team merged modern business principles with mental health values.
- DCF oversight, i.e., two staff are assigned to the campus for daily quality assurance monitoring.
- DCF holds the Mental Health Planning Committees (comparable to CSBs) accountable for failure to meet statutory requirements for discharge planning and for follow-up post-discharge.
- Ongoing communication.
- The state hired a nursing home consultant on retainer to find community placements for elderly patients needing skilled nursing care.
- The state analyzed characteristics and community factors related to recidivism, which was at 16% within 30 days.
- The state created career ladder positions for direct service associates. A Case Manager Discharge Team monitored up to 20 discharged patients at risk of re-admission for a month. They made 2 phone calls per week with the patient and at least 2 face-face meetings to ensure compliance with medication and mental health center appointments.
- Atlantic Shores Healthcare had significant resources that enabled up-front monies for special treatment initiatives.
- The management team hired a consultant to help draw down Medicaid/Medicare monies.
- The new management did not make any profit during the first 3 years of operation.
- Florida rates are low among the states in financing for community services.
- The private operation of SFSH "raises the bar" for performance in many clinical domains for state facilities.
- Florida has just privatized a second facility.

2. Arkansas. The Arkansas Department of Behavioral Health Service (DBHS) has limited authority over the15 Community Mental Health Centers (CMHCs), that are private, non-profits. The state has only two inpatient facilities, a 200-bed psychiatric hospital (civil and forensic) and a 350-bed long-term care psychiatric nursing home for the elderly.

In the mid-late 1990's, Arkansas had two deaths of not guilty by reason of insanity acquittees who had been discharged to community programs from the state psychiatric hospital. At that time, there were no secure residential mental health treatment programs in communities. Thus DBHS contracted with Liberty Behavioral Healthcare to operate a 42-bed "step-down" residential program for acquittees who had a dual diagnosis (mental illness and substance abuse) and who had been discharged from the state facility. They paid a flat monthly fee (per diem x 42). The CMHC was responsible for working with each patient from its services area for discharge planning.

Among the lessons learned from this contracting experience were:

- The contract significantly limited state oversight and excluded any state role in treatment planning:
- The patient length of stay (LOS) was problematic. The state expected, but did not specify contractually, a LOS of no more than 6-8 months. In actuality, a number of patients had LOS of 12-18 months, which created a backlog for the state facility and "clogged" the system.
- Although the contract required Liberty to report various quality assurance indicators (e.g., patient injuries), the state contractually had weak investigation and enforcement authority.
- The state did not have a role in hiring staff.
- The state did not set up a process or plan for the contingency of patients being non-compliant with treatment.
- DBHS set up a fee structure for 3-4 years at a time to contain costs

In recent years, Arkansas has worked with the CMHCs to develop community based secure psychiatric residential programs for acquitees that include those with and without a dual diagnosis. One CMHC in the northern part of the state created, and continues to operate, a 16-bed program through use of state Medicaid waivers. The program is in a building at the facility and was given to the CMHC.

The Liberty contract at the 42-bed program is limited currently to administrative services. A CMHC provides staff and has clinical responsibility for the program. The DBHS has contractual oversight.

3. Connecticut. Approximately 2-3 years ago as part of closing two state facilities the state transitioned patients into community-based initiatives (CBI) or supervised residential programs. The state contracted with multiple private providers to operate the CBIs. Clinical services are delivered by the Local Mental Health Authorities. Connecticut has unionized facility staff. Initial opposition by the Union to closures was

brief, because the transition included employee options of working in other facilities or state agencies or the local CBI. As attrition, transfers, and retirement occurred, the state closed positions; and no employees were laid off.

Connecticut has only two remaining state mental health facilities, but operates seven Intensive Outpatient Programs statewide.

4. Kentucky. In 1995, Kentucky transferred administrative and operational responsibilities for one state psychiatric facility, Eastern State Hospital, to the Bluegrass Regional Mental Health and Mental Retardation Board. The Bluegrass Board, which is a 501-c 3 organization, operates local community services. The region includes multiple counties. The state contracts for inpatient services with the Bluegrass Regional Board. The transfer of Eastern State Hospital occurred at the request of the Bluegrass Board in concurrence with the State. The transition process took six months, and several million dollars of transition money was allocated to assist with employee transition. State facility employees were given the option of either continuing with their job, which ended their status as a state worker, or transferring to another job in the state system. A small proportion took retirement. The major cost was to pay new retirements, pay off leave balances (sick and annual), and transfer retirement funds.

5. Illinois. In Illinois, Singer State Hospital purchases patient care for children age 12 and younger from private psychiatric hospitals. At McFarland Hospital the purchase of inpatient care for children and adolescents (C & A) allowed the closure of the state hospital C&A unit. In the Chicago metropolitan area the state purchases all C&A inpatient hospital care from private sector psychiatric hospitals. All of the mental health networks in the state purchase some inpatient care for the indigent population.

6. South Carolina. Forensic programs are being moved to a recently renovated private hospital. In addition to the physical facility, the private provider will provide security and nursing services. However, medical and program staff from the state Department of Mental Health will move with the patients and continue to design and provide patient care, as well as to make treatment and discharge decisions.

B. Earlier Privatization Efforts

In the 1980s and early 90s there were two efforts at privatization. First, Tennessee issued a Request For Proposals to privatize one of its state hospitals. No one submitted a bid the state found acceptable. Second, Montana built a new state children's mental health facility, and then sold it to a private company with an agreement the state would get a specified number of beds. The state quickly exceeded its contract number of beds, and had to spend much more than it planned for the care of children in the privatized state hospital.

C. Virginia DMHMRSAS Experience with Privatization of Forensic Services

In 1997, the U.S. Department of Justice (DOJ) initiated an investigation of Central State Hospital (CSH) for violations of the Civil Rights of Institutionalized Persons Act (CRIPA). The major findings of DOJ pertaining to forensic services at that time were:

- Lack of adequate and appropriate rehabilitative and treatment services;
- Significant patient over-crowding in the maximum security unit; and
- Inadequate space for essential treatment programming.

Demand for forensic services was increasing and the forensic unit at CSH regularly operated above its operational census. This situation jeopardized the unit's ability to provide appropriate treatment and to protect patients and staff from harm. Major renovations were needed in Building 39 (the maximum security forensic unit) to provide appropriate space for treatment programming and to enhance on-unit and building security. Patient units had to be vacated and an alternative site had to be found so that the renovations could proceed in a manner that ensured patient safety as well as security standards.

DMHMRSAS issued a Request for Proposals (RFP) to out-source services for forensic patients referred by community jails for evaluation and treatment. Liberty Healthcare was the only provider that responded to the RFP. Subsequently, DMHMRSAS entered into contracts with Liberty Healthcare (November 20, 1997) and the Riverside Regional Jail in Hopewell (October 15, 1997) for healthcare management services and leased treatment space and support cost, respectively. The construction and renovation of the Building 39 project began on October 29, 1997 and was completed on April 20, 2001.

Liberty was required by contract to comply with clinical standards, including accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the DOJ CRIPA plan of improvement, and licensing by DMHMRSAS. The contract required that CSH provide all necessary ancillary and support services, including medical, laboratory and pharmacy services performed at the Hiram Davis Medical Center on the Southside DMHMRSAS campus. CSH was also responsible financially for any specialized medical and surgical care deemed necessary and appropriate for the jail inmates during their treatment stays. The contracts were continued through late 2001, when the state entered into a final settlement agreement with DOJ.

During the contract period, contract costs for the Liberty Healthcare services and for the leased regional jail space increased significantly. In addition, Riverside Jail was experiencing overcrowding in other units and needed additional bed space for inmates. At this time, DMHMRSAS evaluated the cost-effectiveness of services provided by Liberty and the Riverside Regional Jail and concluded that significant cost-savings and administrative efficiencies could be realized by terminating the contract and bringing these services back to CSH. By March 15, 2003, all patients at Riverside were brought back to CSH at an annual cost-savings of approximately $990,000 in administrative fees

charged by Liberty, and savings of approximately $630,000 in annual rental fees and support costs charged by Riverside Regional Jail.

V. PUBLIC POLICY ISSUES FOR VIRGINIA

As part of its charge, the workgroup engaged in a number of discussions about issues that must be addressed by the Commonwealth before deciding to contract the operation and maintenance of a state mental health facility. Many of the issues discussed require consideration and discussion by both the Executive and Legislative branches of state government. Many of the critical decisions involve the willingness of the public, and by extension its elected representatives, to entrust a traditional function of state government to the private sector. In addition, the transition of state employees to the private sector, and concern regarding compensation and benefits is a major component of the decision-making process for determining whether to contract state hospital operations. The complex nature of the mental health services system includes in many cases the involvement of local government, law enforcement, the judiciary, public and private treatment professionals, human rights advocates, the legal community and consumer and advocacy organizations. Issues of appropriate treatment may also involve issues of public safety that must be dealt with by communities and policy makers. The following public policy questions require continuing discussion and debate.

- Should the management of state mental health facilities be contracted to the private sector when the function of inpatient care is so critical to maintaining the public safety net and to providing public healthcare and related services in communities throughout the Commonwealth? How will this decision impact the role of state facilities in the complex system of mental health services and indigent care? What will be the impact of privatization on relationships with area CSBs, private providers, and providers of acute care?

- If the services system is going to be transformed to a consumer-driven system of services and supports, as articulated in the Vision Statement discussed in the following section of this report, how will the views of consumers and their families be solicited in the decision-making process regarding the potential privatization of state mental health facilities?

- What relationship will the private provider have with the State Mental Health, Mental Retardation and Substance Abuse Services Board? How will the statutory oversight responsibilities of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Office for Protection and Advocacy be carried out?

- The Regional Restructuring Partnerships initiated by DMHMRSAS over the past three years have defined the role of the private sector as an entity that the public sector works with collaboratively to accomplish the best possible care for persons with mental illness. State and local governments are accountable to the citizenry and may be required because of public need to adjust the mental health services

system according to what is in the best interests of the community and the Commonwealth. While it is clear that the private sector is a vital partner in the system of care, private providers do not hold the ultimate responsibility or liability for the public safety net of services. Contracting for services that are essential to the fundamental purpose of government requires extreme caution. The Commonwealth can delegate authority for operation and maintenance, but not its responsibility to the citizens of Virginia. Will a private corporation be willing and capable of adjusting to necessary changes as inpatient treatment is increasingly reserved for those who cannot be treated in the community and close to natural supports?

- Is the Commonwealth prepared to transition state employees who work for state mental health facilities to private service? If the compensation package is equal to or better than state benefits and there is some provision for crediting state service toward retirement then the employee perception is more likely to be positive. However, unions already are working diligently to raise concern among state hospital employees. If the compensation and benefits package is not equivalent to state salary and benefits, it will likely create an outcry from state employees. If privatization occurs, the Commonwealth must include sufficient time for a full explanation and negotiation of elements of the compensation package, with some prospect for modification on the basis of negotiation. Regardless of the final decision, discussion of privatization creates anxiety and destabilizes the workforce currently employed by DMHMRSAS at state facilities and significantly hinders recruitment and retention.

- Will privatization trigger the attention of the Department of Justice (DOJ)? Any changes (particularly reductions) in staff to patient ratios must be considered very carefully to ensure that the underlying staffing principles upon which the DOJ settlement agreements were negotiated on behalf of state hospitals are maintained.

- What are the long-term implications of privatization in view of the current services system Vision of developing a consumer-driven system of community-based services? (See the following Section). Will long-term system transformation toward a recovery-based system of services be enhanced or slowed by privatization?

- Will the Commonwealth be able to act quickly if the privatized service needs to be brought back under state management?

VI. PRIVATIZATION AND THE VISION OF A CONSUMER-DRIVEN SYSTEM OF SERVICES

The Department of Mental Health, Mental Retardation and Substance Abuse Services has been involved in a multi-year strategic planning process. Seven Regional Strategic Planning Partnerships and five statewide Special Population Workgroups have worked together in a collaborative process to examine emerging trends; assess services system

strengths, opportunities, challenges, and critical issues; explore opportunities for restructuring the current system; and develop recommendations for an Integrated Strategic Plan. This process has resulted in significant progress toward the development of new community services such as crisis stabilization programs operated by CSBs, jail services teams managed jointly by CSBs and facility staff, and the development of discharge assistance plans that are monitored jointly by the CSB and facility. These are just a few examples of the progress made in recent years to improve the partnerships among the department, facilities and the CSBs. It is essential that the partnerships be preserved to implement the goals and recommendations of the Integrated Strategic Plan. The cornerstone of the Integrated Strategic Plan and the future direction of the services system is the Vision Statement that follows. The Vision Statement is embraced by public and private organizations, consumers, families and advocates and was adopted as State Board policy in September 2005.

A. Vision Statement

Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.

B. Guiding Principles

The Vision statement is supported by 8 core principles that DMHMRSAS uses in decision-making. Briefly, these principles are:

- Self-determination, empowerment, and recovery
- Accountability
- Access
- Quality of Services
- Partnerships
- Coordination
- Funding
- Efficient Use of Resources

The Vision statement guides the mission and values of the Department, and is being incorporated into the mission and values of community programs. These guiding principles of the Vision provided the focus for determining the process and criteria required for evaluation of a PPEA proposal for operation and maintenance of a facility. The process recommended by the Secretariat and DMHMRSAS follows.

VII. MAKE OR BUY ANALYSIS

A. Decision-Making Process

Careful and deliberate consideration must be given to the decision of whether or not a private entity should operate and maintain a state mental health facility. The process that should be followed in making this decision should parallel the make or buy analysis procedures of the Public Procurement Act.

A make or buy analysis offers an opportunity for increasing the provision of government-operated services by private sector entities, and for removing government from activities that might more appropriately be provided by the private sector.

B. DMHMRSAS Recommendation and Phases

The make or buy analysis recommended by DMHMRSAS was developed by the Department of General Services with the assistance of the Department of Planning and Budget and the Department of Information Technology.

1. Phase One of the analysis is to conduct an inventory of services currently provided by the state agency or services the state agency plans to provide. The agency must consider the public acceptability of contracting with a private entity. This requires determining which services are close to the fundamental purpose of government or are essential to the government's ability to protect the health, safety and welfare of its citizens. The guidelines recommend that agencies use caution in considering services of this nature for provision by contractors. Some parts of a particular service may be suitable for contractor provision while others may not.

2. Phase Two of the analysis is a determination of the cost of providing the services in-house. This phase requires the agency to determine the number of full time equivalent employees required to provide the service along with all other costs of service provision. The total in-house cost must be compared with the net contract cost. For services provided in-house currently, the agency should determine if there is a more efficient way to provide the services. If improvements are needed to enhance efficiency, these changes can be taken into consideration in comparing the net contract cost.

3. Phase Three involves determining the feasibility of contracting out. The elements of this phase of analysis are critical for decision-making with regard to the private operation of state mental health facilities. This phase involves 7 critical evaluative steps. These are:

a. Determine the availability of private providers.
b. Determine that the agency's contract administrator successfully completed the Department of General Services/Division of Purchases and Supply training or other appropriate training and that necessary personnel and procedures are in place to effectively administer the contract and monitor contractor performance.

An administrator or project officer is critical to a successful privatization program. In addition, the agency must assess the cost to the agency of having a qualified administrator who can oversee and assure that quality services are provided and to monitor the daily operations and delivery of services.

c. Consider the impact on the agency's ability to bring the service back in-house if substantial capital equipment and human resources investment is involved and contracting out provides unsatisfactory results.
d. Consider the impact on displaced employees and what provisions could be made for their continued employment, such as being hired by the contractor or retrained for other state service.
e. Prepare and issue a formal solicitation [Invitation for Bids (IFB) or Request for Proposals (RFP)] based on the scope of services, performance standards, job analysis, etc., in accordance with the Agency Procurement and Surplus Property manual (APSPM).
f. Prepare an estimate of the State's net cost of contracting the service. This includes the projected contract price; contract administration, e.g., audit, performance evaluation, communication; and other management costs, such as salaries, fringe benefits, etc.; contractor support costs, such as any space to be provided to the contractor; and "one time" costs or savings, such as solicitation costs, staff training, savings from sale of surplus property; personnel costs or savings, such as severance pay, unemployment benefits; savings on real property for the function, etc.
g. Compare estimates of net contract cost to in-house cost. Existing or optimum in-house cost can be used for this comparison. However if optimum cost is used and becomes the basis to retain the service in-house, the necessary improvements must be promptly implemented.

4. Phase Four involves a review of the requirements, materials and deliverables specified in the **Appendix** of this report to determine whether the contractor has complied with the required specifications for the proposal, has thoroughly and satisfactorily addressed all of the questions, and has provided all of the required deliverables with the proposal. The criteria listed in the **Appendix** are the most critical elements that DMHMRSAS would evaluate if a proposal were to be reviewed in the near future. However, the department reserves the right to ask for other information or to modify the material to be provided, the questions to be answered, the deliverables, and/or the evaluation criteria as proposals are submitted and as experience with the private management and operation of state facility services provide additional data for contract negotiation, management and evaluation.

The **Appendix** outlines 6 critical areas that must be addressed by the organization submitting a proposal, including materials that will be required to be delivered with each proposal, questions to be answered by the proposing entity, and a list of specific deliverables. Some of the elements set out in the following sections may also be required to comply with PPEA procedures. It is not intended that submissions be redundant, however, the organization submitting a proposal should address each of the elements listed in the **Appendix**. The 6 critical areas are:

a. Policy/Regulatory/Legal Issues/Accountability/Oversight
b. Services and Quality
c. Support Services
d. Human Resources
e. Infrastructure Development and Maintenance
f. Fiscal (Cost, Financial Feasibility, Revenue Impact)

5. Phase Five of the make or buy analysis involves making the final cost determination of whether or not to contract the service. At this Phase the public policy issues outlined earlier in this report must be examined with guidance from the Executive and Legislative branches of government.

In this Phase 5, the decision points for ***financial consideration only*** are:

a. If the net cost of contracting is equal to or less than the in-house cost and the quality and reliability of services are at least equal, DMHMRSAS may proceed with award of the contract.
b. If the net cost of contracting is higher than the in-house cost or the quality and reliability of services are not at least equal, DMHMRSAS may provide/continue to provide the service in-house and may cancel the solicitation and reject all bids/proposals received.
c. Has the organization submitting a proposal responded to all of the information requested in the **Appendix** of this report?

6. Phase Six is to review and reevaluate. The agency and project administrator must review contracts continually to ensure that the costs stay below those estimated for in-house provision. The original estimate for in-house costs should be adjusted for inflation to properly compare them with contract costs. The agency should completely reevaluate services retained in-house every two years in conjunction with budget request preparation to determine that it is still the most cost effective means of provision.

VIII. CONCLUSION

The feasibility of PPEA proposals for the operation and maintenance of state mental health facilities is dependent on a number of key policy questions and circumstances. Over the last four years, the public partners in Virginia's system of care, state facilities, CSBs and DMHMRSAS, have worked to strengthen the joint ownership and responsibility for the delivery of services. These efforts have resulted in a shared vision for system transformation, improved continuity of care, improved utilization and resource management, enhanced consumer outcomes, and shared accountability. As decisions regarding privatization are considered, they should be made within the context of the positive direction that Virginia's public system of care is moving and with the ultimate goal of enhanced services for consumers.

Currently, Virginia is not facing the situation encountered by other states that are responding to investigations by the U.S. Department of Justice, and pressures to improve their services system. In the Commonwealth of Virginia, current state facility directors and staff, working together with their partners in each region, could realize efficiencies and savings in their operations if they were able to provide services in newly constructed state of the art buildings designed to accommodate the needs of persons from their regions with complex psychiatric, medical, and physical disabilities.

Decisions about privatizing services currently operated exclusively by state government require public debate by policy-makers and the citizens. This report has outlined the major policy questions that must be addressed in a public forum. The Appendix of the report provides a guideline for the private sector to develop public-private partnership proposals and for DMHMRSAS to conduct a thorough review and evaluation of such proposals if policy makers decide that privatization should be pursued.

APPENDIX

I. EVALUATION PROCESS AND CRITERIA

A. Policy, Regulatory, and Legal Issues and Accountability

1. Materials to be Provided with Each Proposal*:* The organization submitting a proposal shall include the following materials with the proposal.

a. Policies, procedures, and plans that address and comply with Virginia's human rights regulations, including the following components:

- Assurance of consumer rights;
- Consumer complaints, including abuse and neglect;
- Consent for treatment and substitute decision making;
- Consumer involvement in treatment planning and decision making;
- Use of seclusion, restraint, and time out; and
- Privacy and authorization to use and disclose protected health information.
- Achievement and maintenance, as applicable, accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or certification by the Centers for Medicare and Medicaid Services (CMS) and licensure by the applicable state agency.

b. The licensing and accreditation or certification history of the organization submitting the proposal, including information about all citations or negative actions taken by regulatory entities over the last six years, such as sanctions, consent agreements, CMS removal of deemed status certification, and revocation actions that the organization has experienced in any state.

c. Copies of current JCAHO, CMS, or other applicable accreditations or certifications and state licenses to operate an inpatient mental health or a mental retardation facility and the reports of the two most recent JCAHO or CMS surveys and state licensure visits.

d. Current or proposed policies and procedures that address compliance with all applicable federal and state statutes, regulations, and policies including:

- Virginia Public Procurement Act,
- PPEA
- Virginia Freedom of Information Act
- Government Data Collection and Dissemination Practices Act,
- Applicable provisions of Title 37.2 of the *Code of Virginia*
- Various federal and state anti-discrimination statutes and regulations (e.g., Titles VI and VII of the Civil Rights Act of 1964, Civil Rights Act of 1991, Equal Pay

Act of 1963, Sections 503 and 504 of the Rehabilitation Act of 1973, Vietnam Era Veterans Readjustment Act of 1974, Age Discrimination Act in Employment of 1967, Americans with Disabilities Act of 1990, and Virginians with Disabilities Act of 1991)

- Health Insurance Portability and Accountability Act of 1996 (HIPPA)
- CMS regulations,
- State Mental Health, Mental Retardation and Substance Abuse Services Board Policies, and
- Departmental Instructions

e. Annual statistics by type of service or unit for the organization submitting a proposal for the past six years that describe its operations, including:

- Number of individuals served,
- Numbers of admissions and discharges,
- Average length of stay,
- Number, type, and outcome of complaints for allegations of abuse and neglect,
- Number, type and outcome of all other consumer complaints,
- Number of suicides,
- Number of medication errors,
- Numbers related to use of seclusion or restraint, and
- Number of injuries and deaths during use of seclusion or restraint
- Number of Sentinel Events requiring reporting to JCAHO

f. Policies, procedures, and plans to integrate into its operations a consumer-focused services system that promotes consumer recovery, self-determination, and resilience into its operations.

2. Questions to be Answered by the Organization Submitting a Proposal

a. How will your organization implement the state's human rights regulations, including affiliation with a local human rights committee, participation in investigations, and resolution of complaints?

b. How will your organization protect the people served by the program from abuse and neglect?

c. What actions will your organization take to integrate the system's vision statement for a consumer-focused services system that promotes consumer recovery, self-determination, and resilience into its policies, procedures, and operations?

d. How will your organization address, integrate, or participate in the state's risk management and quality improvement activities?

e. How will your organization provide necessary information about consumers and services to the Department and to the community services boards that it would be serving?

f. How will your organization handle reporting requirements to the Virginia Office for Protection and Advocacy (VOPA), the state's Protection and Advocacy for the Mentally Ill (PAMI) agency?

g. How will your organization relate to the Virginia Office of the Attorney General regarding legal representation and defense issues?

h. How will your organization deal with being subject to inspections and visits from the Office of the Inspector General?

i. How will your organization address applicable provisions in the Central Office, State Facility, and CSB Partnership Agreement?

j. How will your organization address and provide financial accountability to the Department, the General Assembly, and the Auditor of Public Accounts?

k. How will your organization integrate its automated clinical or management information system with the Department's AVATAR (State Facility Information Patient/Billing System)?

l. How will your organization ensure compatibility with VITA requirements regarding software applications, operating systems, and security?

m. How will your organization integrate or at least coordinate its procurement activities with the state's electronic procurement system (eVA)?

n. How will your organization comply with all of the statutory requirements applicable to state hospitals, including those listed in Appendix A, Title 37.2 Facility Operations Legal Concerns and Questions?

B. Services and Quality

1. Materials to be Provided with Each Proposal: The organization submitting a proposal shall include the following materials with the proposal:

a. Admissions:

- Any current policies and procedures related to admissions or the admissions process
- A plan that addresses the special needs of clients, especially related to the admission of forensic clients and clients admitted pursuant to temporary detention orders for commitment.
- Any current policies and procedures regarding the evaluation of the medical necessity for admission and the quality monitoring of the admissions process.

b. Assessments:

- Policies and procedures related to all assessments including medical, nursing, psychology, psychiatry, social work, occupational/recreational/physical/speech therapies, nutrition and risk. Include a schedule of times for re-assessments**.**

- Current policies related to quality monitoring of the assessment process and the quality of the assessments.

c. Treatment:

- Current policies and procedures regarding individualized treatment planning
- Policies and procedures for development of patient behavioral plans
- Current or proposed elements of the psychosocial rehabilitation program
- Quality monitoring process for treatment teams and programming
- Policies and procedures regarding poly-pharmacy and prescribing practices and documentation
- Quality monitoring policies regarding pharmacy, medication management and prescribing practices
- Policies and procedures related to medical care and evaluation including a plan for providing inpatient medical services for the individuals served when indicated
- Discharge planning policies and plan for implementing discharge protocols of DMHMRSAS
- Plan for assessing quality and completeness of discharge planning
- Parameters for review of individual cases with extensive use of S/R. Include recent documentation of utilization rates of seclusion and restraint at facilities currently operated by the organization
- Policies and proposed training programs for employees related to aggression management of persons served
- Evidence of experience serving persons with dual diagnoses such as mental health/ mental retardation or mental health/substance abuse
- Policies and procedures regarding utilization management and recent examples of utilization data

d. Organization of Health Care Service Delivery

- Documentation of the organizational chart and relationship to health system if applicable
- Policies and procedures related to the organization's management of professional practice including, privileges and credentialing, methods of clinical pertinence, and standards of documentation of professional practice in medical records
- Policies and procedures related to the organization's method of considering and assuring review of bioethical issues.
- Policies and procedures for the use of clinical information in organizational performance.

e. Quality Improvement, Risk Management and External Reviews:

- Policies and procedures related to the quality improvement program
- Risk management policies and procedures including process for review of critical incidents
- Current risk management statistics and examples of corrective actions taken
- Documentation of cooperation with patient advocacy groups, state oversight offices and any other oversight organizations

f. Utilization Management

- Policies and procedures in place related to: evaluating medical necessity for admission; evaluating the cost and quality of services; detecting over and under utilization of services; assuring appropriate access to services.

2. Questions to be Answered by the Organization Submitting Proposal:

a. How will your organization provide the necessary assessments, evaluations and treatment to the diverse population served including the forensic population and the dually diagnosed population?

b. How will your organization coordinate discharge and aftercare with the appropriate community services board and/ or private providers?

c. How will your organization coordinate internal risk management plans with the DMHMRSAS and state risk reporting requirements?

d. How will your organization ensure compliance with requirements of the criminal justice system as it relates to forensic review, evaluation and treatment of people served currently by state facilities?

e. How will your organization assess the effectiveness of the psychosocial programming and assure that the people served are receiving services related to their reasons for admission?

f. How will your organization integrate the principles of recovery and self-determination into all aspects of programming?

g. How has your organization handled any regulatory or oversight sanctions in facilities that you currently own or operate?

h. How will your organization submit data to the Department concerning utilization management?

C. Support Services

1. Materials to be Provided with Each Proposal: The organization submitting a proposal shall include the following materials with the proposal:

a. Policies and procedures concerning food service provision and delivery and plan for assuring compliance with all regulatory agencies
b. Quality monitors to assure safety and regulatory compliance
c. Policies and procedures concerning laundry services or Memorandum of Agreement (MOA) with laundry service to show services provided and plan for compliance with regulatory agencies.
d. Policies and procedures for personal laundry of the people served
e. Policies and procedures for building and grounds maintenance or MOA with contracted sources showing services provided
f. Policies and procedures for security provision or MOA showing security services provided and a plan for internal security for forensic units and/or clients
g. Policies and procedures for transportation of people served to medical appointments, court hearings, hospital etc. including security measures for forensic clients
h. Policies and procedures related to housekeeping services

2. Questions to be Answered by the Organization Submitting Proposal:

a. How will the organization assure compliance with all regulatory requirements regarding food service?
b. How will the organization show compliance of the MOA partners regarding regulatory requirements?
c. How will the organization evaluate security needs and effectiveness?
d. How will the organization assure adequate infection control measures for the facility?

D. Human Resources

1. Materials to be Provided with Each Proposal. The organization submitting a proposal shall include the following materials with the proposal.

a. A copy of the proposed organizational structure and staffing by shift for the new facility or facilities at the time of acquisition. This should be done in detail by discipline; for example, the number of RNs, LPNs and direct service workers to provide nursing services; the number of psychologists with Bachelors, Masters and Doctoral degrees to provide psychological services; the number of physicians designated by specialty; the number of rehabilitation staff such as occupational therapists, certified occupational therapy assistants (COTAs), physical therapists, recreational therapists, speech therapists, music therapists and any other therapists; the number of social workers with Bachelors and Masters degrees and the number of licensed clinical social workers. In addition, the organization shall

submit a plan for compliance with the Commonwealth of Virginia Office of Professional Licensure Standards.

b. The organization shall document the staffing plan by ward and by shift, including the total number of employees proposed for employment from existing state facilities at the time of acquisition. The organization shall identify how many employees will be full-time, part-time, and/or contractual at the time of acquisition and after one year.

c. Loss claims statistical information from the organization's insurance carrier for workers compensation for the past 3 years for any mental health, mental retardation facilities currently owned or operated. If none are currently owned or operated, the organization shall provide this information for any health care facility, or other type of facility currently owned or operated.

d. Turnover data by job type for the past 3 years for any mental health or mental retardation facilities currently owned or operated. Turnover is defined as the number of separations divided by the average number of filled positions over one year.

e. A copy of the organization's dispute resolution policies/practices. The organization shall provide dispute resolution/mediation/arbitration statistics and trend data for past 3 years for any mental health or mental retardation facilities that are currently owned or operated by the organization. The number of employee disputes resolved in favor of employees or management shall be provided and the number modified (those partial for employee and management); percentage or number resolved by management, and percentage/number resolved through court or other external ruling.

f. The number of EEO claims filed by employees out of the total number of employees; the number of cases found in favor of complainants, and the number found in favor of management.

g. The most recent "Employee Satisfaction Survey(s)" from the mental health/mental retardation facilities that the organization operates or has acquired.

h. A copy of the organization's Human Resources and Workforce Development Policies.

i. A copy of the organization's salary plan, including any non-base pay supplements. The Plan should show salary ranges/bands, and classifications of employees allocated to each of the ranges/bands and fringe benefits.

j. A copy of the job descriptions for direct care and support positions including qualification requirements.

k. Descriptions of all fringe benefits provided to employees. This shall include premium costs, co-payments, deductibles and restrictions on access to the benefits.

l. A description of the employee assistance program available to employees.

m. A copy of the paid time off program for employees. This shall include holidays, annual leave and sick leave / disability leave and any other forms of leave, such as educational or civil leave for jury duty or to respond to a summons.

n. A description of the organization's employee recognition program.

o. A description of the employee suggestion program.

p. A description of the performance management program and any associated forms.

q. A copy of the flexible benefits programs available to employees.

r. A copy of the overtime policy for mandatory and/or voluntary overtime.

s. A copy of the inclement weather policy.

t. The anticipated number of jobs created by the proposed project, approximate wage rates that will be paid, and projected length of employment of the newly created jobs.

u. The approximate number of job training opportunities created by the project, particularly in apprenticeship programs registered with the U.S. Department of Labor or State Apprenticeship Council.

v. Worker safety programs, including substance abuse programs, safety training, and incident avoidance programs.

w. Plans proposed to ensure that jobs created by the project will be filled by trained, qualified personnel.

x. The extent to which identified job opportunities will be made available and/or filled by residents of the Commonwealth.

y. The extent to which the project will utilize contractors and subcontractors who will generate tax revenue for the Commonwealth.

z. Plans for an Employee Health Program, including ergonomic assessments.

2. Questions to be Answered by the Organization Submitting a Proposal

a. At the time of transition, what will become of the existing staff members? Please see note below.

b. Will employees who are retained in their same capacity be paid the same salary as they were paid before the transition? If for a specified period of time, what is the time period?

c. What assistance will your organization provide to any employees who are not retained or who are laid off at a later time? What severance benefits will you provide? What Outplacement services will you provide for the employees?

d. How will you manage the transition of responsibilities?

e. What training will your employees be offered and which employees will receive it?

f. How will your organization assure adequate staffing levels , particularly for registered nurses and other professional staff?

g. How will you handle staffing during weather emergencies?

h. How will you survey the satisfaction of your employees?

i. What is your policy on alcohol and drug use by employees?

j. What is your policy for violence in the workplace?

k. What is your policy on sexual harassment?

Note: When the Medical College of Virginia Hospital converted to an Authority, employees were given 180 days notice that their positions would be transferred. If they elected to not go to the Authority, they were eligible for the State's severance benefits. If they elected to remain as employees of the Authority they were able to remain as members of the Virginia Retirement System or to move their retirement accumulations to the Authority's retirement plan. They were able to retain coverage in the State's healthcare plan or to take the Authority's. The Authority was required to develop a grievance procedure that was reviewed by the House Appropriations and Senate Finance Committees of the Virginia General Assembly.

State employees who are involuntarily separated from state service will be entitled to the State's Severance Payments, which run from 4 to 36 weeks of pay, depending on the length of service, paying the agency cost of health and life

insurance for one year and Unemployment Insurance for up to 12 to 26 weeks. The Acquiring company will be responsible for reimbursing DMHMRSAS for these costs.

E. Infrastructure Development and Maintenance

DMHMRSAS shall provide the organization submitting a proposal with an inventory of the buildings, equipment and services provided by the affected facility, including spaces leased to outside entities.

1. Materials to be Provided with Each Proposal: The organization submitting a proposal shall include the following materials with the proposal:

a. Environment of Care (JCAHO) management plans and programs for the referenced facility or for a comparable facility now operated by the offerer, to include the following:

- Safety Management Plan
- Patient Safety Program
- Security Management Plan
- Hazardous Materials Management Plan
- Emergency Management Plan
- Fire Prevention Management Plan
- Medical Equipment Management Plan
- Utility Management Plan
- Risk Management Plan

b. Facilities management service program plans to include the following:

- Operating, maintenance and repair objectives;
- Building maintenance and repair management plan;
- Emergency/disaster operating plan;
- Safety program;
- Quality control programs for support services;
- Grounds maintenance operating plan;
- Inclement weather operating plan;
- Monthly report formats for support services, with sample reports;
- Utility and energy management programs;
- Plan for adherence to the Virginia Uniform Statewide Building Code, the Life Safety Code, and any other applicable codes and regulations; and
- Management or disposition of vacant buildings.

c. Quality assurance/quality improvement programs for all support services that will exist in the referenced facility. Include samples of standard tools and results for the measurement of satisfaction of clients, families and staff.

d. Plan for compliance with the Governor's Executive Order 29 regarding procurement regulations governing Small, Women-owned and Minority-owned (SWAM) businesses, including participation goals and methods of increasing participation by SWAM businesses and for any other requirement included in the Governor's Performance Management Standards.

e. Building, infrastructure, and equipment repair, replacement and improvement plans and policies.

f. Plan for the proposed facility's participation in local or regional government disaster preparedness and support operations.

g. A description of the support services management and organizational structure, including the following information:

- Qualifications for on-site support services management personnel;
- Off-site management staff and support provided; and
- How training, annual re-training, and maintenance of staff certifications and competency are managed.

h. Identify which support services are planned for provision by in-house and which are planned for provision by contract.

- For in-house services: provide staffing by trades and licensure, and training plan and policies
- For contractual services provide plan and goals for utilization of local businesses and personnel, including impact on local economy.

i. Provide description of current or proposed technology solutions to meet the needs of business and clinical processes. (For instance, automated medical records, financial systems, etc.)

j. Provide description of actual or proposed technical infrastructure.

k. Describe the system architecture; servers, hubs, switches, work stations and access nodes within each facility on a separate diagram. Then supply DMHMRSAS with a system architecture required by your company for IT continuity across all points. Illustrate licensure requirements at their most economical points of access, ie Enterprise, server, individual user levels and recommended procurement / deployment strategy proposed to maintain data access and security.

l. Provide a copy of the transition plan to be implemented should you be awarded this contract.

m. For a comparable facility, provide copies of your most current inspections by regulatory and oversight agencies and organizations, and the resultant plans of correction. Inspection reports shall include, but are not limited to, the following:

- Department of Health
- Center for Medicare/Medicaid Services
- EPA
- Fire Marshal and Building Code Inspections
- OSHA
- JCAHO

2. Questions to be Answered by the Organization Submitting a Proposal

a. Support of other facilities, agencies and political subdivisions includes consumer transfer arrangements' internships, disaster support, property leases and maintenance, and shared programs. How do you propose to develop and maintain these relationships?
b. If awarded a contract, how do you propose handling the transfer of functions and responsibilities, including existing contractual relationships?

c. How will you manage building and equipment maintenance? Provide examples of software, logs, plans and documentation of strategy for assuring continual fitness for duty across these categories of assets.

d. How would you address renewal and replacement of buildings, improvements and equipment? Do you have a re-commissioning strategy for buildings, utility systems and other support assets, if so, share samples.

e. How do you handle environmental or hazardous material exposure or spill events.

f. How do you handle safety related incidents?

g. What actions will your organization take to help with integration into the community?

h. What is your organization's philosophy on security
- Within the facility;
- Access to the facility; and
- The facility perimeter.

i. What is your plan and philosophy for handling community relations surrounding both positive and negative events requiring interface with citizens, the community, businesses, families, media and government?

j. What methods do you use to assure that systems and data are secure, including HIPAA compliance?

k. How do you promote effective communication and responsiveness between support services and the people served?

l. How do you respond to an issue that poses a safety or high risk to the clients, staff or operations?

m. How do you pro-actively identify conditions that may present a safety or high risk to clients, staff or operations?

n. What are your contingency plans for the loss of major systems or an operational outage?

o. What tools and processes would you use to maintain the on-going quality and viability of any public-private partnership that results from this proposal?

p. How would you provide data to DMHMRSAS to meet the agency's data requirements? Would you intend to become licensed users of existing DMHMRSAS applications?

q. How do you envision your staff and operations will require support from DMHMRSAS in regard to IT infrastructure?

F. Fiscal (Cost, Financial Feasibility, and Revenue Impact)

As noted earlier in this report, the Commonwealth of Virginia Procedures for the *Public-Private Educational Facilities and Infrastructure Act of 2002* contains suggested formats for conceptual stage (phase 1) and detailed stage (phase 2) submissions. Conceptual stage items that are recommended in the PPEA procedures that are fiscal-related are identified below in italics. These items are reiterated here to ensure that they are submitted with any proposal directed to DMHMRSAS.

1. Materials to be Provided with Each Proposal: The organization submitting a proposal shall include the following materials with the proposal:

a. Audited Annual Financial Report (*current or most recently audited financial statement of the firm or firms and each partner with an equity interest of twenty percent or greater).*
b. Credit rating and stock prices (last 5 years).
c. History of fraud and litigation (last 5 years).
d. Corporate structure and ownership including date formed.
e. *Identify the legal structure of the firm or consortium of firms making the proposal).*
f. *Identify the organizational structure for the project, the management approach and how each partner and major subcontractor ($1 million or more) in the structure fits into the overall team.*
g. Summary of similar projects related to the operation and maintenance of mental health facilities (include reference information). *Describe the experience of the firm or consortium of firms making the proposal and the key principals involved in the proposed project including experience with projects of comparable size and complexity. Describe the length of time in business, business experience, public sector experience and other engagements of the firm or consortium of firms. Describe the past safety performance record and current safety capabilities of the firm or consortium of firms. Describe the*

past technical performance history on recent projects of comparable size and complexity, including disclosure of any legal claims. Include the identity of any firms that will provide design, construction and completion guarantees and warranties and a description of such guarantees and warranties.

h. *For each firm or major subcontractor ($1 million or more) that will be utilized in the project, provide a statement listing all of the firm's prior projects and clients for the past three years and contact information for same (names/addresses/telephone numbers/e-mail addresses). If a firm has worked on more than ten projects during this period, it may limit its prior project list to ten, but shall first include all projects similar in scope and size to the proposed project and, second, it shall include as many of its most recent projects as possible. Each firm or major subcontractor shall be required to submit all performance evaluation reports or other documents, which are in its possession evaluating the firm's performance during the preceding three years in terms of cost, quality, schedule, maintenance, safety and other matters relevant to the successful project development, operation, and completion.*

i. *Identify any persons known to the organization presenting a proposal who would be obligated to disqualify himself from participation in any transaction arising from or in connection to the project pursuant to The Virginia State and Local Government Conflicts of Interest Act, Chapter 31 (§ 2.2-3100 et. seq.) of Title 2.2 of the Code of Virginia.*

j. *Provide information on the level of commitment by the firm or consortium of firms to use Department of Minority Business Enterprise firms in developing and implementing the project.*

k. A list of competitors who have similar capability.

l. Financing organization (s)

m. The proposal shall include the following information on project financing:

- *A preliminary estimate and estimating methodology of the cost of the work by phase, segment, or both.*
- *A plan for the development, financing and operation of the project showing the anticipated schedule on which funds will be required. Describe the anticipated costs of and proposed sources and uses for such funds. Include any supporting due diligence studies, analyses or reports.*
- *A list and discussion of assumptions underlying all major elements of the plan.*
- *Risk factors and methods for dealing with these factors.*

n. Identify any local, state or federal resources that the organization submitting a proposal contemplates requesting for the project. Describe the total commitment, if any, expected from governmental sources and the timing of any anticipated commitment.

o. The proposal shall include the following cost information (separate total cost calculations for):

- Building and operating the facility
- Building only
- Financing costs for building
- Operating cost savings with a new building or buildings
- Annual maintenance costs
- Costs per day-operating and capital
- Cost implications of failure to operate/open facility on time
- Assumptions used for cost increases each year (escalations)

- Costs assumed related to state employees transitioning to the private sector

p. The proposal shall include the following revenue (funding) information:
- Third-party funding sources
- Proposed collections from third parties
- Percentage of state general funds that will be required to operate the facility
- Description of the billing and collection function

q. Proposals shall include the following information on project benefit and compatibility.
- *Identify community benefits, including the economic impact the project will have on the Commonwealth and local community in terms of amount of tax revenue to be generated for the Commonwealth and political subdivisions, the number of jobs generated for Virginia residents and level of pay and fringe benefits of such jobs, the training opportunities for apprenticeships and other training programs generated by the project and the number and value of subcontracts generated for Virginia subcontractors.*
- *Identify any anticipated public support or opposition, as well as any anticipated government support or opposition, for the project.*
- *Explain the strategy and plan that will be carried out to involve and inform the general public, business community, local governments, governmental agencies in areas affected by the project,* and stakeholders, such as patients and their families.
- *Describe the compatibility of the project with local, regional, and state economic development efforts.*
- *Describe the compatibility with the local comprehensive plan, local infrastructure development plans, and any capital improvements budget or other government spending plan.*

r. Six-year projection comparing costs of the proposed structure with the current structure of the facility.
s. Electronic files for cost and revenue projections included in the proposal.

2. Questions to be Answered by the Organization Submitting a Proposal

How can information presented in the proposal be independently verified?
If errors are found or corrections are required in your cost or revenue projections, how quickly can the organization make changes and return the proposal to the agency.
How will you limit operating cost increases?
Will your organization permit the DMHMRSAS audit organization to review your proposal documentation, supporting records, and interview your staff?

II. REQUIRED DELIVERABLES

A. Required documents specified in Evaluation Criteria..

B. Answers to the questions specified in Evaluation Criteria.

C. The proposal.

D. References from entities with which the organization submitting a proposal has had contractual agreements for providing the same type of service. (References shall include information from at least three Facility Owners with whom the organization submitting a proposal has or has had a contract to provide comparable services.) Information provided shall include name and address of the facility, name of contact person and position held, telephone number and e-mail address.

E. Names, addresses and telephone numbers of persons within the organization submitting the proposal or consortium of organizations submitting a proposal who may be contacted for further information

III. DMHMRSAS CRITERIA FOR PROPOSAL REVIEW

A. Completeness,
B. Organization of Proposal
C. Responsiveness,
D. Cost effectiveness,
E. Integration of operations with local jurisdictions and community service providers
F. Comparison of policies, procedures and practices to best practices in the field
G. Thoroughness of policies and procedures
H. Compatibility with Agency and Facility Policies and Requirements
I. Evidence of quality management monitors
J. Evidence of proposed adequate staffing meeting necessary competencies
K. Evidence that staffing, policies, and procedures demonstrate that treatment elements of assessment, planning, medications management, PSR, behavioral services, and milieu are integrated to provide safe and individualized treatment plans.
L. Sensitivity to existing employees
M. Evidence of understanding of the needs and requirements of the Commonwealth
N. Evidence of experience in forensic services, dual diagnosis and medical co-morbidity (if applicable)
O. Evidence of JCAHO accreditation and/or CMS certification or other relevant national accreditations or certifications.
P. Community involvement in the development of the proposal
Q. Consumer and family member involvement in the delivery of services under the proposal.
R. References

In addition, DMHMRSAS will conduct an on-line search about the organization and check with local and state authorities in other states where the entity operates a similar service to ask specific questions about performance and compliance.