

**LOS ANGELES COUNTY-DEPARTMENT OF MENTAL HEALTH**

**REQUEST FOR STATEMENT OF INTEREST (RFSI) #DMH100318B1**

**NEW LOCATION FOR AUGUSTUS F. HAWKINS**

**MENTAL HEALTH CENTER**

This Request for Statement of Interest (RFSI) is used for information purposes only and does not constitute a Request for Proposal (RFP), Request for Services (RFS), or an offer of a contract. Using the responses to this RFSI, the County may do one of the following: (1) issue a formal solicitation; or (2) take no further action at this time.

**NOTHING IN THIS DOCUMENT SHALL BE CONSTRUED AS OBLIGATING THE COUNTY TO ISSUE A FORMAL SOLICITATION OR TO NEGOTIATE A CONTRACT.**

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| **PART I-AGENCY INFORMATION** |
| 1. Legal Name of Agency:
 |  |
| 1. Legal Entity (LE) # (if applicable):
 |  |
| 1. Administrative Headquarters Address:
 |  |
| 1. Service Area Served:

(see attached map) |  |
| 1. Contact Person Name and Title:
 |  |
| 1. Contact Phone # and E-mail:
 |  |

With the planned new state-of-the-art Behavioral Health Center being constructed on the campus of the new Martin Luther King Jr. Community Hospital, there is a need to identify a new location for the acute inpatient psychiatric care services offered at Augustus F. Hawkins Mental Health Center (MHC) for adults and adolescents.

Currently the program is licensed for 76 beds and 60 beds are available for client care. All beds are secure. Respondents are encouraged to submit responses for current or greater number of beds to expand the program. Respondents will find a description of the current program at Augustus F. Hawkins MHC in attachment two of this RFSI.

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| **PART II-PROGRAM EXPERIENCE** |
| ***The New Location for AUGUSTUS F. HAWKINS MENTAL HEALTH CENTER’s******Acute Inpatient Psychiatric Program which includes BOTH*** ***Adults (50 Beds) and Adolescents (10 Beds)*** |
| 1. Are you a current Los Angeles County-Department of Mental Health contract provider for acute inpatient psychiatric services? If you are **NOT** a current provider of acute inpatient psychiatric services, please proceed to question #2.

| **YES** | **NO** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| 1a. If “**Yes**” to #1., are you interested in offering a new location for the Augustus F. Hawkins MHC inpatient adult and adolescent program?

| **YES** | **NO** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| 1b. Do you currently have existing space for the Augustus F. Hawkins MHC inpatient adult and adolescent program?

| **YES** | **NO** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| 1c. If “**No**” to #1b., are you willing to build new space?

| **YES** | **NO** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| 1d. If “**Yes**” to #1a. or #1c., what is your estimated timeframe for the new location or repurposed space to be available for use?

| **OPERATIONAL** | **ESTIMATED TIMEFRAME**  |
| --- | --- |
| **NEW LOCATION** **[ ]**  |  |
| **REPURPOSED****[ ]**  |  |

 |
| 1e. Please provide an estimate on the number of beds the new location or repurposed space will support.

| **Estimated Number of Beds** | **ADULTS**  | **ADOLESCENTS**  |
| --- | --- | --- |
|  |  |

 |
| 1. If you ARE **NOT** a current Los Angeles County-Department of Mental Health contract provider for acute inpatient psychiatric services, are you interested in contracting with Los Angeles County for a replacement location for the Augustus F. Hawkins MHC Acute Inpatient Adult and Adolescent Psychiatric program?

| **YES** | **NO** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| 2a. Please describe the space you intend to use for acute inpatient adult and adolescent psychiatric program.  |
| 2b. Please indicate if the space is currently operational, requiring repurpose, or a new location.

| **OPERATIONAL** | **REPURPOSED** | **NEW** |
| --- | --- | --- |
| **[ ]**  | **[ ]**  | **[ ]**  |

 |
| 2c. Based on your response on #2a., please indicate your available bed estimate for adults and adolescents.

| **Number of Beds**  | **ADULTS**  | **ADOLESCENT**  |
| --- | --- | --- |
|  |  |

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| 1. If this is a new program(s) for your organization, explain your program start up procedures and, if applicable, an estimated timeline and cost for program licensure and operational capacity.

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| **PART III-PROGRAMS AND SERVICES** |
| 1. Briefly provide the admissions process (e.g., assessment and evaluation) and treatment and discharge for the acute inpatient psychiatric adult and adolescent patients.

 |
| 1. List all clinical disciplines involved in the care of an acute inpatient psychiatric adult and/or adolescent patient (i.e. social services, case managers, therapists, M.D., nursing, etc.).

 |
| 2a. Does your agency offer a Psychiatry Residency Program for adult and adolescent acute inpatient psychiatric care?

| **YES** | **NO** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| 2b. If “**No**” to #2a., is your agency willing to develop a Psychiatry Residency Program? |
| 1. Describe the supportive services provided to acute inpatient psychiatric adult and adolescent patients (i.e. dietary, pharmacy, laboratory, laundry and linen, etc.).

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| 1. Briefly explain your agency’s Quality Management Program for your adult and adolescent acute inpatient psychiatric program.

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| **PART IV-FACILITIES** |
| 1. Please provide additional information, including address(es), about the space that may be utilized for the new location for the Augustus F. Hawkins MHC Acute Adult and Adolescent Inpatient Psychiatric Program.

 |
| 1. Please briefly describe any necessary construction.

 |
| 1. For ***existing*** acute inpatient psychiatric contract providers, please provide a breakdown of your current unit(s) as noted below:

*Instructions: Identify the current age demographic (specifically, adolescent and adult) and indicate the number of current licensed and available licensed beds per unit.*

| **Number of Beds** | **ADULTS** | **ADOLESCENTS**  |
| --- | --- | --- |
| **LICENSED**  |  |  |
| **AVAILABLE**  |  |  |

 |
|  3a. For the last twelve months, please indicate the monthly average census (percentage % of utilization) for each adult and adolescent unit.

| **Bed Utilization** | **Monthly Percentage % ADULTS** | **Monthly Percentage %****ADOLESCENTS**  |
| --- | --- | --- |
| **September 2018**  |  |  |
| **August 2018** |  |  |
| **July 2018** |  |  |
| **June 2018** |  |  |
| **May 2018** |  |  |
| **April 2018** |  |  |
| **March 2018** |  |  |
| **February 2018** |  |  |
| **January 2018**  |  |  |
| **December 2017**  |  |  |
| **November 2017** |  |  |
| **October 2017** |  |  |

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| 3b. Please indicate the average day rate per bed.

|  |  |  |
| --- | --- | --- |
| **Average Day Rate** **per Bed**  | **ADULTS**  | **ADOLESCENTS**  |
| $ | $ |

 |
| 1. Is your agency willing to enter into a lease or rental agreement for psychiatric beds on a 365 day per year basis?

| **YES** | **NO** |
| --- | --- |
| [ ]  | [ ]  |

 |
| 1. Is your inpatient program gender separate or comingled? Please explain how you separate gender populations.

| **Separate** | **Comingled** |
| --- | --- |
| **[ ]**  | **[ ]**  |

 |
| **PART V- AUTOMATION** |
| 1. Do you utilize an electronic health record system?

| **YES** | **NO** |
| --- | --- |
| [ ]  | [ ]  |

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| 1a. If “**Yes**,” to #1., please indicate the brand name.  |

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| **PART VI-REIMBURSEMENT RATES** |
| 1. Provide your daily rate for services and briefly describe what is **included** in the daily rate.

| **DAILY RATE**  | **INCLUSIONS**  |
| --- | --- |
| $ |  |

 |
| 1. Describe what is **excluded** from the daily rate.

 |
| 1. Describe how any excluded services from the daily rate is provided and billed.

 |

***Disclaimer: Responses to this RFSI shall become the exclusive property of the County of Los Angeles. The County shall not, in any way, be liable or responsible for the disclosure of any parts thereof, if disclosure is required or permitted under the California Public Records Act or otherwise by law. A blanket statement of confidentiality or the marking of each page of the response as confidential shall not be deemed sufficient notice of exception. Respondents must specifically label only those provisions of their respective responses which are “Trade Secrets,” “Confidential,” or “Proprietary” in nature.***

***In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a response marked “Trade Secrets,” “Confidential,” or “Proprietary,” Respondent(s) agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney’s fees, incurred in connection with any action, proceedings, or liability arising in connection with the Public Records Act request.***

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| **PART VIII-SIGNATURE** |
| I hereby represent and warrant that I am authorized to make the foregoing representations on behalf of the aforementioned agency and acknowledge and certify that the foregoing responses to this RFSI are truthful and accurate. |
| 1. Name of Agency:
 |  |
| 1. Print Name and Title of Authorized Agency Representative:
 |  |
| 1. Signature of Authorized Agency Representative:
 |  |
| 1. Date:
 |  |