Delaware Health

And Social Services

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

DATE: February 29th 2016

HSS-16-006

ACIST –Assertive Community Integration Support Team

for

Division of Developmental Disabilities Services

Date Due: March 18th , 2016
By 11:00 am Local Time

ADDENDUM # 1 – Q&A (Initial)

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Kieran Mohammed
Kieran.mohammed@state.de.us
Procurement Administrator

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Terrence Macy
Division Contact

Questions RFP Delaware HSS-16-006
ACIST –Assertive Community Integration and Support Team

1. Under Section I Overview, paragraph 1, page 1, the RFP states "The State of Delaware Department of Developmental Disabilities Services, seeks professional services to collect client satisfaction data using the National Core Indicators survey tool." Question: Is this request to collect National Core Indicators data a requirement of the ACIST project, or perhaps an error in the overview description of requested services

Answer: DHSS inadvertently posted an earlier version of the RFP. The correct RFP was posted within 72 hours of the first posting. All references to NCI have been removed.

2. In Appendix B, Section 1.B. Project Goals, paragraph 1, page 40 states "DDDS expects the awardee to provide supports statewide in all three counties." Question: Is there a required location for the ACIST's main offices in one of the three counties or is the main office location at the discretion of the awardee?

Answer: There is no required location for the office. Dover, DE is the most central part of the state. Given the fact that the program is statewide, it may be the best location, however, if the contractor is able to meet all of the contact needs for the program from another part of the state, they are free to set up the main office wherever they like.

3. In Appendix B, Section I.C. Target Population, paragraph 1, page 41 states "The Delaware Division of Substance Abuse and Mental Health (DSAMH) will work with DDDS to identify individuals who have had multiple and complicated histories within the mental health system. Subsequently, the contractor will re-assess each individual's on-going inclusion in the target population and continued eligibility for this program as determined by DDDS." Is there a required schedule (e.g. monthly, etc.) for the contractor to re-assess each individual for on going inclusion in the target population and continued eligibility?

Answer: Initial assessment to determine appropriateness for inclusion in the ACIST team will occur prior to the individual entering the team. Reassessment is a clinical process that should occur as often as needed. Minimum requirements will be explained in the contract once executed.

4. In Appendix B, Section I.C. Target Population, under Scope of Services, paragraph 1, page 41 states "The contractor is required to manage a program model that consists of a 50 person ACIST." Does the State have a projected time frame for the program census to ramp up to the target of 50 individuals once the program is initiated?

Answer: The target is for the program to assess and accept 6-8 individuals per month until the caseload of 50 has been reached. This will include some cases that may present in crisis and need to be assessed and engaged quickly.

5. In Appendix B, Section I.D. Goals, paragraph 5, page 43 states “The team will provide trauma informed, mental health and ID/DD/AUTISM recovery oriented services in a person-centered manner, with the goal of improving quality of life, increasing support systems with full community inclusion as per Center’s for Medicare and Medicaid (CMS) with concurrent reduction in hospitalization and incarcerations.” Is funding for the ACIST services through the HCBS waiver program?

Answer: Not at this time. If the pilot is successful, continued funding past year two will be funded under the HCBS waiver program.

6. In Appendix B, Section I.B. Project Goals, paragraph 2, page 40 states “The successful bidder should also be able to provide, at a minimum, one day of clinic services to individuals who are supported by DDDS, but who may not be participating in the ACIST.” Is this a clinic for individuals to be seen by a psychiatrist? What is the projected or targeted weekly volume of individuals to be seen and is there a designated location for these clinic services?

Answer: The clinic services are psychiatric services that include medication checks with people receiving ACIST supports, ability to see individuals that are not on the ACIST team for short periods of time to assess and prescribe medication if needed until a psychiatrist has been identified to continue care. The latter will be individuals scheduled by the DDDS Case Manager assigned as the liaison to the ACIST Team.

7. In Appendix B, Section I.D. Goals, under a) Primary Goals, paragraph 1, page 42 lists primary goals for the ACIST program. For example, primary goal item 1) states “To lessen or eliminate critical health and safety issues each individual client might experience, preventing or mitigating signs, symptoms, and/or social issues that could lead to crisis situations and the need for re-hospitalization.” Are any baseline measures or data available related to these primary goals listed? How will contactor performance in meeting these goals be determined?

Answer: There will historical information available for persons already supported by DDDS. Individuals who are not supported by DDDS at the time they are being evaluated for ACIST supports will have baseline set by the team taking into consideration reported history of baseline for the individual and/or natural supports.

8. In Appendix B, Section I.D. Goals, under b) Fundamental Principles, paragraph 1, item 1, page 42 states “1) The ACIST is the primary provider of services and functions as the fixed point of responsibility for outcomes.” What are the specific services, functions and outcomes for which the contractor is responsible? For example, is the ACIST provider responsible for providing residential and/or day-employment services?

Answer: The provider is responsible for intensive case management following the ACT Model of community services. This includes linkage to support such as day programs, employment programs, etc.… and also includes linkage to behavioral health benefits available under the individual's health insurance, including Medicaid and Medicare, (the team is responsible for providing therapy to the individual and the family). The team should have the capability to meet with individuals frequently at the start of the program (daily or more often if needed) and expertise to identify other supports and activities and the appropriate introduction to or referral to these supports according to the individual's hopes, dreams and choices.

9. In Appendix B, Section I.D. Goals, under b) Fundamental Principles, paragraph 2, page 42 states "The team will provide ongoing outreach, monitoring, behavioral health treatment, medication management, case management, crisis intervention, clinic services, monitoring of medical conditions through service coordination and behavior analysis supports to 50 individuals using an intensive case management model." Does the State have initial thoughts or specific expectations regarding what types of services are to be delivered under the broad category of "behavioral health treatment"?

Answer: Behavioral health treatment includes psychiatric supports: assessment, medication oversight, decisions about hospitalization, coordination with IMD psychiatrist for successful discharge; individual and/or family therapy by a licensed clinician (also a member of the team); support groups for substance use issues (can be conducted by a member of the team or done through referral and coordination with the team); and other mental health supports that typically fall under the category of "behavioral health" (The team is responsible for providing therapy to the individual and the family). The team is also responsible for ensuring that individuals access behavioral health benefits available under his or her health insurance, including Medicaid and Medicare.

10. In Appendix B, Section I.D. Goals, under b) Fundamental Principles, paragraph 3, bulleted item 4, page 43 states "Individual strengths and goals as identified in the Life Plan." What are the specific guidelines on the format or process for development of an individual's Life Plan? Does the State use a dedicated template for Life Plan development?

Answer: Yes. A new life span plan has been developed and training about this new format will be provided.

11. Under Section III. A. Minimum Requirements, item 1, paragraph 1, page 2 states "1. Provide Delaware license(s) and/or certification(s) necessary to perform services as identified in the scope of work. Prior to the execution of an award document, the successful Vendor shall either furnish the Agency with proof of State of Delaware Business Licensure or initiate the process of application where required." What specific license Delaware license(s) and/or certifications are required to perform services as described in the Scope of Work?

Answer: Active Delaware licenses for professional staff including: Psychiatrist, RN, APRN, Master Level Clinicians and any other profession that requires a license to practice in the state of Delaware.

12. What are the licensing requirements?

Answer: Initially, the team will adhere to contract requirements. The ACIST program will need to receive training though NADD.

13. In Appendix B, Section I.B. Deliverables, paragraph 2, item 2, page 43 states "2. The team will provide ongoing outreach, monitoring, behavioral health treatment, medication management, case management, linkage to housing, crisis management, primary health and coordination for specialty health care within the context of supports made available through DDDS." Further in Appendix B, Section I.C. Programmatic Outcomes, paragraph 7, item 7, page 44 states "7. The teams will assume responsibility for providing supports required to assist the individuals in maintaining community placement in safe, affordable, stable housing, coordinating with DDDS case managers or DDDS Family Support Specialists and other DDDS staff when required." Is the ACIST provider responsible for assisting individuals in the program in maintaining housing supports or in obtaining housing supports? Is more specific clarification available?

Answer: Yes. The provider is expected to identify appropriate, stable housing and to work with the individual to choose and maintain stable housing.

14. In Appendix B, Section I.C. Programmatic Outcomes, item 13, paragraph 9, page 45 states "13.The teams will have responsibility for acute crisis services, by providing 24 hour coverage; with staff being available either by phone or in person, as appropriate, to help diffuse crisis situations and maintain community status. The contactor is not permitted to use automated phone trees as its answering service. The goal of 24 hour coverage is to intervene during acute crisis situations to reduce or eliminate the need for hospitalization." If it is appropriate to respond to an acute crisis in person, is there a mandated response time that takes into account the 4 person ACIST staff model and statewide coverage?

Answer: The provider can present the model that they believe will work best and include how communication will occur between the team and other professionals during crisis particularly during off hours.

15. In Appendix B, Section I.C. Programmatic Outcomes, item 9, paragraph 2, page 45 states "Caseloads will be maintained at a 1:10 staff to individual ratio for the ACIST." What staff positions are calculated in the 1:10 staff ratio?

Answer: The psychiatrist is the only position NOT calculated into the ratio. The psychiatrist is in addition to the 5 team members.

16. In Appendix B, Section I.C. Programmatic Outcomes, item # 23, paragraph 2, page 47 lists numerous service components (designated a. through p.) of the ACIST model. For example, item d. states "Individual counseling (by a Licensed Master or Doctorate level clinician) at least twice a month." Are individuals to receive all of the services listed or are they to receive services based on individual needs as identified by the ACIST team?

Answer: All supports and services will be based on individual need. It is expected that the team will be meeting with individuals at the onset of their participation on the team and when in crisis more frequently, however, supports and services and frequency are based on assessed need. All supports and services will be documented in the Life Plan and reflect assessment that identifies the individual's chosen direction for the plan.

17. In Appendix B, Section V. Funding and Payment Methodology, paragraph 1, page 54 states “The Provider will be paid on a service unit rate basis. This funding is intended to support all required services. The provider must bill Medicaid or other third party payers for covered and non-covered services. Any revenues received for covered services from Medicaid, and other third party payers will be reported to DDDS on a monthly expenditure/revenue report.” Is the unit of service based on a daily rate or monthly rate? How will the State set the unit rate?

Answer: The payment for the contact will initially be made as a cost-reimbursable contract up to the annual budget approved by the division. It is the division’s expectation that, with experience, we will eventually develop a unit cost rate methodology when the service is converted to a Medicaid service. To the extent that a service provided by the selected vendor under this contract can be covered by a third party insurer, the vendor will be responsible for complying with rules of each insurer in order to obtain payment from that third party. The selected vendor is also responsible for accessing and exhausting behavioral health services, as appropriate**,** (BH services are the responsibility of the team) that can be covered by other third parties in order to meet the individual needs of each client.

18. With the prescriber hours allotted to 25 hours per month are they expected to attend daily meetings, travel, and have on-call obligations?

Answer: This is a 25 hours a week model. Yes, they are expected to be available for daily meetings and have on-call obligations including home visits if needed.

19. Do you want two different budgets: 1) psych providers 2) APRN?

Answer: Yes

20. When we are crafting our budget should we assume that we can use fleet vehicles?

Answer: No

21. Clarifying question: the budget has no vehicles?

Answer: No, just no fleet vehicles.

22. Once a person is determined eligible for ACIST services will the ACIST team take over the case?

Answer: Yes, however as the person is re-integrated back to DDDS services the ACIST team will collaborate with the DDDS team.

23. What is the time frame that the ACIST team is expected to work with an individual? Specifically, what is the time frame from admission to discharge?

Answer: The program length/services will be individualized based on each person's needs. Crisis team will take over then original team will fade. ACIST team will provide services and stabilize then ACIST team will fade and original team will resume. We see this service as having a rolling caseload; however, individuals can remain on the team for longer periods of time when needed.

24. Will the ACIST team/services be required to adhere to DDDS behavior policies and have HRC and PROBIS oversight?

Answer: Yes, people in residential services go through PROBIS and HRC. However, people living with families do not have HRC and PROBIS oversight. Regardless of residential services everyone has to follow DDDS policies related to behavior; 1) BSP policy 2) behavior modifying medications and 3) the use of restraints restrictions.

25. Have the 50 individuals already been identified?

Answer: An initial list has been developed; however, the full census is still undecided.

26. Is the demographic distribution expected to be relative to the DE population?

Answer: Yes, we assume it will be relative to state demographics. We expect ACIST to be a 3 county (state wide) program.

27. Is staff expected to be in all 3 counties?

Answer: Your response can identify a single site or multiple sites. However, you will need to be responsible to all 3 counties. Expectation is that ACIST staff is available for on call - 24 hours a day. Your budget needs to reflect your program model.

28. Are other Tele-health services permittable in addition to Tele-psychiatry?

Answer: No, not at this time.

29. Does an ACIST staff person need to be present with the individual at a Tele-psych appointment?

Answer: Yes

30. In the RFP it notes a 1:10 model. If during service delivery it is identified that this model is ineffective can this be changed during the contract period?

Answer: Yes, we can do a contract amendment, if determined necessary. We will utilize quality improvement data to help determine most appropriate model

31. When is the expected program start date?

Answer: 07/01/16

32. Will the awarded bidder be afforded the opportunity to give input on forms and the electronic record?

Answer: No, forms have already been created. If you have your own unique forms you will need to scan and upload forms into the electronic record.

33. What electronic record will DDDS use?

Answer: Core CX 360

34. Will start up funds be available for staff training and furniture?

Answer: Staff training is included in startup costs.

35. As noted on page 40 of the RFP, can you define Clinic Services?

Answer: Clinic service include face to face medication follow-up appointments with individuals on the ACIST Team and emergency evaluations scheduled by DDDS. This can include onetime visits for evaluation or medication follow up until successful referral is accomplished.

36. Is the clinic to be a fixed resource or a resource to fit people in around clinic hours?

Answer: Clinic hours will be fixed. Appointments will be made during clinic hours.

37. Do you see that people may frequently need to roll in and out of ACIST services?

Answer: The goal of the team is to stabilize the individual so psychiatric crisis are reduced. Individuals leaving the team should be psychiatrically and behaviorally stable. There may be occasions where individuals may return to the team, however, the goal of the team is to interrupt the cycle of psychiatric crisis.

38. Do you have enough people to maintain a 50 person caseload?

Answer: Yes