

Staffing Related Questions

- 1. The RFP states that at least 50% of the clinical staff hours must be provided by full-time professional employees of the program. What is the definition of “clinical staff hours?”**

Clinical Staff hours are those hours staffed by a licensed professional.

- 2. Would like to have 24/7 staffing provided by residential counselors and part-time clinical support provided by a social worker and medical staff. Is this acceptable (page 13 references 50% of clinical staff hours being provided by full-time professional employees)?**

Please refer to Section 10.2.3 of the RFP: Staffing for staffing requirements.

- 3. Are we allowed to use any Per Diem staff?**

Yes

- 4. Section 10.2.2 requires a comprehensive assessment of physical, medical, emotional, behavioral, social, residential, recreational and, when appropriate, vocational and nutritional needs. Wouldn't they have a HH CC and wouldn't this be the CC's job?**

OMH anticipates that a comprehensive assessment be completed in coordination with the individual's current treatment providers; this could include a health home care manager if the person is associated with a health home.

- 5. For 'staffing'- is an RN the minimum title that can fulfill the 'Licensed Nurse or NursePractitioner' or can this be a LPN?**

The RN is the minimum title requirement.

- 6. Are the Clinical hours required to be provided on site or can they be provided as 'oversight'?**

Clinical hours are required to be provided on-site.

- 7. At least 50% of the clinical staff hours must be provided by those licensures listed in the RFP, although what is the minimum clinical staff hours required during a specific time frame?**

The 50 % of clinical staff hours is to be calculated using a 24/7 work week. Clinical staff hours include on-call accessibility and on-call hours can be used to meet these staffing requirements.

8. Please expand on the minimum hours and time period.

The minimum hours and time period should be proposed by the applicant in the proposal narrative. OMH expects the enriched crisis and transitional housing units to be staffed 24/7 when an individual is occupying the unit.

9. Can existing Agency residential staffing be used if they aren't currently being used in a residence or does this Project require all new staffing?

Please refer to Section 10.2.3 of the RFP: Staffing. " Existing Residential Staff cannot be used to staff this pilot; a separate staffing plan must be submitted as part of this proposal."

10. Would one FT staff person from the list of professional staff be sufficient, in addition to Peer support to cover the 24/7 requirement?

Please refer to Section 10.2.3 of the RFP: Staffing for staffing requirements.

11. Can the operating funding be used to cover the initial training of Peer Staff in the practice of Intentional Peer Support and IPS crisis training?

Yes

12. Can the operating funding be used for ongoing staff training?

Yes

13. RFP states that "At least 50 percent of the clinical staff hours must be provided by full-time professional employees of the Enriched Crisis & Transitional Housing Program". Is the understanding then, for example, that if clinical staff work 80 hours total for the program, one of these staff must work full-time at 40 hours and the remaining clinical staff can work a combined 40 hours?

Yes

14. RFP states that applicants should provide 24-hour peer support. Do Peer Support Staff need to be working at site 24-hours a day or is it sufficient to have this staff be on-call for a portion of these hours?

The RFP requires 24 hour staff and peer support staff, it does not require 24 hour peer support staff. Please refer to Section 10.2.3 Staffing of the RFP.

15. Section 10.2.3 indicates that at least 50% of the clinical staff hours must be provided by full time professional staff. Please clarify what is meant by clinical staff hours. Does this mean 50% of total staff hours?

Clinical Staff hours are those hours staffed by a licensed professional.

- 16. Section 10.2.2 indicates that existing residential staff cannot be used to staff this pilot. Is it acceptable to have only one person on the overnight shift for the licensed beds and the transitional beds with respite staff used if additional support is required?**

If there is a person or people residing in the transitional bed(s), then a separate and distinct staff funded through the RFP Enriched crisis and transitional housing pilot, must be on-site working to address the needs of those served by the Pilot program.

- 17. RFP states “At least 50 percent of the clinical staff hours must be provided by full-time professional employees of the ECTH Programs”. Can you clarify? Does this mean all staffed hours, total hours in the staffing plan, or during business hours?**

This means of all staff hours per week, 50% must be covered by professional employee.

- 18. Regarding staffing. The staffing requirements call for Peer staff and 24-hour full-time awake staff, available to clients during all hours. If both the Peer and overnight awake staff are considered clinical staff a program would need to hire more than 1 FTE of professional staff for these 3 beds to maintain the 50% requirement. Is this the intent?**

50% of all staff hours per week, must be covered by a professional employee.

- 19. Regarding staffing RFP states that “peer staff must be trained in the practice of Intentional Peer Support.” Will OMH be facilitating this training or does each program have to budget for the training in the contract? Also, where is this training available.**

Each agency would be responsible for budgeting for this training. Training is available through <http://www.intentionalpeersupport.org/> 

- 20. Can hours be added to existing staff time to serve the new units?**

Yes if this meets the requirements of staffing required as described in the RFP.

- 21. Peer support is offered through a current program. Would like to have a Recovery Specialist from this program meet with each resident within the first workday following an individual’s admission. Is this acceptable as long as funds from this grant are not used to support it?**

Yes

- 22. Would like to have 24/7 staffing provided by residential counselors and part-time clinical support provided by a social worker and medical staff. Is this acceptable (page 13 references 50% of clinical staff hours being provided by full-time professional employees)?**

Please see answer to Question #18

- 23. Can CPRP (Certified Psychiatric Rehabilitation Professional) qualify as a professional since it is not licensed by NYS State Education Department**

Professional staff are considered staff who are licensed in NYS.

24. Can part time Professional Staff be considered for this project? Can these part time professional staff be hired specifically for this project rather than to be on staff currently at the agency proposing to operate these services?

Yes

25. There is a requirement for 24 hour peer supports. Is it expected that the projects employ round the clock on site peer staff in addition to the 24 hour counselor level staff? Or is it availability via a warm line or other mechanism sufficient for overnight hours?

A warm line or other mechanisms which allow for the availability of 24 hour peer staff if needed are acceptable for meeting this requirement.

26. How would staffing patterns be impacted? The concern is that the 7 bed CR would not have enough staffing allotted through the GIN to provide the required 24 hour staffing of a licensed CR. (One current 10 bed community residence moves 3 of their beds to another 11 bed community residence creating a 14 person CR on the grounds and a 7 person CR in the community with respite program on site.)

The enriched crisis and transitional housing units are not considered part of the GIN; there is separate funding/ budget for these units.

27. Can the agency keep the 10 bed CR staffing pattern at the 7 person CR to allow for adequate 24 hour coverage for the CR program even though it would now be a 7 person CR with a respite program on site?

An agency must demonstrate how they would not lose the three bed capacity by reducing the 10 bed CR program by three. Housing redesign proposals may be considered through this RFP.

28. Do the transitional housing staff need to be on-site at each location 24/7 or available 24/7? If the beds are in different locations it would be extremely difficult to budget for staffing for each location 24/7.

If a unit has an individual on-site at each location, then 24/7 staff must also be on-site with this individual(s).

29. Who is expected to employ the QMHP performing the assessment and clearance for the program outlined in the RFP?

It is expected that housing agencies will work collaboratively with an individual's current treatment providers, including health home care managers to ensure assessments are performed.

30. Who is expected to assess that there are no “complex medical” issues needing attention for these programs?

It is expected that housing agencies will work collaboratively with an individual’s current treatment providers, including health home care managers to ensure assessments are performed.

31. Given the numerous staff requirements expressed in the RFP including such items as professional and peer staff and “an additional full-time staff [that] shall be awake...during all hours”, coupled with the funding limitations, could you please recommend a staffing pattern that would fulfill the requirements of the RFP?

OMH will not be recommending a staffing pattern as the RFP asks applicants in Section 13.1.2 Provision of Enriched Crisis and Transitional Housing Services to provide this information.

32. Given the many ways that peer support can be provided, why has IPS been chosen as the model for this program?

OMH is recommending this model as it provides a trauma-informed approach of relating encourages mutually accountable relationships emphasizes learning new and different ways of approaching challenges.

33. Has OMH determined that there are sufficient trainers certified to train in the IPS model to train all programs throughout the state as outlined in the RFP?

12 awards will be made through this RFP. If agencies have difficulty locating and finding training on IPS, they should contact OMH for further guidance.

34. What specific staff lines are envisioned to support these 3 units?

OMH will not be recommending a staffing pattern as the RFP asks applicants in Section 13.1.2 Provision of Enriched Crisis and Transitional Housing Services to provide this information and explain the applicant’s vision of what specific staffing they believe would support the needs of the program.

35. What is the minimum number of staff required per shift?

There is no minimum number of staff required per shift. Crisis and transitional housing staff must be available to an individual 24/7 if they are residing in the unit. OMH will not be recommending a staffing pattern as the RFP asks applicants in Section 13.1.2 Provision of Enriched Crisis and Transitional Housing Services to provide this information.

36. Re: staffing:Page 12 - " . . . crisis and transitional services to be developed . . . include . . . 24-hour peer support . . ."

Page 13 - "At least 50 percent of the clinical staff hours must be provided by full-time professional employees of the Enriched Crisis and Transitional Housing Program."

Page 17 - " . . . units must be staffed 24 hours a day, seven days a week and provide . . . Licensed Professionals and Peer Staff . . . at least one full-time staff shall be awake and continuously available . . ."Must peer support be provided on-site 24/7, or need we only have 24-hour peer availability? Must the applicant directly employ at least 1 full-time professional exclusively for the Initiative, and must this professional provide 50-100% of clinical services offered? Could the applicant contract with a partner organization for such services? Could you provide a sample staffing plan meeting program requirements and not exceeding the \$249,000 funding maximum?

24 hour peer availability is acceptable. 50% of all staff hours per week, must be covered by a professional employee. Yes an applicant may contract with a partner organization. OMH will not be recommending a staffing pattern as the RFP asks applicants in Section 13.1.2 Provision of Enriched Crisis and Transitional Housing Services to provide this information.

37. In the provision of staffing, can a pro- rated methodology be used to staff the project? For example, could overnight staff in a CR with 14 beds (12 licensed beds/ 2 crisis beds) address the needs of all residents with wages allocated in part to the existing licensed beds, and in part to the crisis beds if extra Enriched Crisis staffing was added to the site? 78.6% and 21.4% Is this method acceptable or would it be a conflict with regards to the provision of Medicaid reimbursement services?

No, Please refer to Section 10.2.3 of the RFP: Staffing. " Existing Residential Staff cannot be used to staff this pilot; a separate staffing plan must be submitted as part of this proposal."

38. Can staff in this proposal be shared between other agency programs, such as residential (such as 50% residential, 50% this program)?

No

39. Please define what is meant by 50% of clinical staff (who must be professional level). Does that refer to the entire staffing model for the Enriched Crisis Housing, including overnight awake and weekend staff, or are clinical staff the professional level and peer staff who directly work with the individuals on the goals outlined?

This refers to the entire staffing model for the Enriched crisis and transitional housing.

40. The staffing model refers to one "full-time staff, awake". Must this overnight staff person be a single full-time employee or may the shift be composed of various staff to fulfill the equivalent of one FTE?

Either staffing model could be acceptable, Section 13.1.2 of Provision of Enriched Crisis and Transitional Housing Services RFP asks the applicant to describe and provide this information.

- 41. If the beds are split among two or three sites, is the expectation that each site will provide 24-hour supervision by the Enriched Housing staff, or is it possible for the Enriched Housing staff to be based at one location and arrange to visit and meet with individuals at the other site?**

Please refer to answer to question # 28.

- 42. In reading the RFP, it appears that the program must not utilize existing residential staff, must have 24/7 staff and must have 50% of clinical staff employed full-time as part of the enriched crisis and transitional housing program, all within the budget limit of \$83,000 per unit (\$249,000 for 3-unit award). Given the cost of hiring 24/7 staff, these staffing requirements don't seem possible within the intended budget. Is there any information you can provide to clarify what a sample staffing pattern might look like or what the staffing pattern expectations are?**

OMH will not be recommending a staffing pattern as the RFP asks applicants in Section 13.1.2 Provision of Enriched Crisis and Transitional Housing Services to provide this information.

- 43. Clarification on staffing requirements. If there is non-professional staff on site 24/7, does professional staff have to also be on site 24/7? Can some of the professional staff hours be accomplished through on-call during evenings, overnights and weekends?**

There does not need to be both a non-professional staff and professional staff on site 24/7. Some of the professional staff hours can be accomplished through on-call during evenings, overnights and weekends.

Funding Related Questions

- 44. What are specific expectations around program sustainability past the contract period?**

Applicants selected as award recipients will be reviewed following the conclusion of the pilot initiative on performance and outcome measures. In the event funding is available to support continuation of this pilot initiative, opportunities to renew the contract will be based on performance and measured outcomes at the conclusion of the initial two-year pilot initiative.

- 45. How does this funding interact with HUD funding for CR/SRO programs, for the many sites which are currently jointly funded by OMH and HUD?**

HUD funded CR /SRO programs that impose strict homelessness criteria would not be eligible to accommodate these units.

- 46. What is the cap on Administrative Overhead/Indirect costs?**

There is no cap on administrative overhead / indirect costs.

47. Is the OMH one-time capital funding in the amount of \$84,333 per unit for reconfiguration or total allowed for complete renovation of property?

The OMH one-time capital funding is \$84,333 per award. An award is considered three units.

48. How is the operating budget funded? Is it funded by Respite, or OMH units or other sources?

The operating budget is funded through Medicaid Redesign Team funds allocated to OMH who will contract with the not for profit agency to develop the enriched crisis and transitional housing units.

49. Section 13.1.6 page 20 says that On-going payments for rent, services and supports are not consistent with the paradigm shift in this RFP and therefore will not be funded. What would we spend \$83,000 per unit on if not services and supports? Or is this saying that you won't fund a scattered site model with rent as well as services and supports?

This is saying that OMH will not fund a scattered site model with rent as well as services and supports.

50. What type in in-kind was OMH anticipating?

OMH was not anticipating any in-kind, however agencies may have in-kind supports such as donations of furniture, computers, office equipment.

51. Is the one-time capital funding of \$84,333 for all 3 units or is capital funding \$252,999 for all 3 units?

\$84,333 is capital funding for all 3 units.

52. Can capital funding be used for furnishings?

Yes

53. Can the Capital renovations/expansion be supplemented with Agency funding?

Yes

54. Can capital funding be used to build an office space for staff?

Possibly, each proposal will be reviewed on an individual basis.

55. Can capital funding be used to include non-administrative program space?

Yes

56. Can Medicaid be billed for any Psych, Medical, or other services provided by out Agency Clinic (Art 31 and/or Art 28)?

Services offered on-site by the enriched housing and transitional housing unit program are not billable Medicaid services. Agencies should follow the normal protocol with regards to billing Medicaid for services provided by the clinic.

57. How long is the \$83,000 per unit in annual Operating Funding available?

The associated funding with this RFP is for a two- year pilot program.

58. How will agencies who are given an award receive the capital funding? Is it based on a voucher system as expenses are incurred? Is it given in a lump sum? Is it given at the end of the renovation process?

Agencies that are awarded will enter into a capital construction contract with the Office of Mental Health and will be reimbursed for expenses incurred for renovation.

59. How will agencies who are given an award receive the operating funding? What will be the reconciliation process of funding received to expenses incurred?

Agencies that are awarded will enter into an operating contract with the Office of Mental Health. That contract will provide quarterly advances payments. During the year the agency is required to file a budget and a claim. At the end of the year a close-out (reconciliation process) takes place, if necessary a recovery of under spending will be set up to decrease the next quarterly advance.

60. Can the operating funding be used to cover the initial training of Peer Staff in the practice of Intentional Peer Support and IPS crisis training?

Yes

61. Can the operating funding be used for ongoing staff training?

Yes

62. Besides the \$83K per unit for operating expenses, would the resident also be responsible to pay Program fees?

The resident would not be expected to pay a program fee.

63. Can start-up costs (i.e. furniture, supplies, equipment) be expended from the one-time Capital funding or is this expected to be paid from Operations?

Start-up costs can be expended from the one-time capital funding.

64. Am I understanding correctly that the \$83,000 for each unit (resident hall) is for one year only and for renovation only? That it is expected that 3 units of 12 adults each (36) be planned for that first year totaling \$249,000.

No, the OMH capital funding of \$84,333 is a one-time allocation per award. An award is considered three units. Operating funding is an annual allocation of \$249,000 for three units. The expected number of individuals served would be significantly higher than 36 as length of stay cannot exceed 30 days.

65. Can the project be for 1 unit at \$83,000 total?

No, it is expected that each applicant awarded through this RFP will develop three crisis units by adding or reconfiguring existing residential space.

66. Does the \$83,000 also include 24-hour staffing, overhead and other expenses? May an additional percentage be charged for overhead? Or is it one time Capital expenses only.

Funding through this RFP is as follows:

1 award = 3 units of enriched crisis and transitional housing units. Operating funding for the three units is \$83,000 per unit or \$249,000 annual. Capital funding one time only= \$84,333.

67. Is Medicaid reimbursement available to each adult? If not, how is reimbursement expected?

Medicaid reimbursement is not available to individuals' receiving this service. This service will not be reimbursed through Medicaid.

68. Is the maximum amount allowed for capital/reconfiguration work \$84,333?

OMH only has one time funding in the amount of \$84,333 per award available, however an applicant may choose to use other sources of funding to complete the capital/renovations valued at a higher amount.

69. If a feasibility study or other architectural services are needed (verifying code compliance, providing construction design/advice, etc.), will OMH Housing pay directly for those services or is the cost expected to be deducted from the \$84,333.00 capital amount?

It is expected that the costs for architectural services be deducted from the \$84,333 one-time capital funding.

70. Can some of the \$84K in capital funds be used to create office space used for the respite housing?

Possibly, each proposal will be reviewed on an individual basis.

71. Can ongoing rental costs for annexed space be included in the ongoing budget if there is not a need for the renovation costs up front?

No

72. There is no PDG for this project. Is there any mechanism to provide for purchasing start up items such as furnishings, computers, office supplies, etc.?

The one-time capital funding may be used to purchase furniture and equipment as needed.

73. Page 12, Section 10.2.1 describes availability of \$84,333 per award for reconfiguration of residential space. If permitted to operate the Program at a site that is not within an existing Congregate Community Residence, CR-SRO or SP/SRO, would we be able to access capital funds for minor renovations of the site as needed to implement the program?

Yes

74. If reconfiguration of an existing site to accommodate the Program is expected to cost less than \$84,333, would we be able to use the one-time capital funding for start-up costs such as office furnishings and equipment (computers), household furniture/equipment (washer/dryer, refrigerator, dishwasher, air conditioner, television, etc.), and other necessary supplies (linens, bedding, dishes, office supplies)?

Yes

75. Page 20, Section 13.1.6 states, "Ongoing payments for rent, services or supports are not consistent with the paradigm shift sought in this RFP and therefore will not be funded." Would occupancy costs for the program units, common space, and offices occupied by the program be ineligible for funding? If so, would we be able to request funding based on fair market rent for the space occupied by the program? Or, if permitted, would the occupancy costs need to be budgeted and vouchered based on a pro-rated portion of the actual occupancy costs for the entire building within which the Program is located? Does the above mean that short-term payments for rent, services or supports would be eligible expenses?

No

76. What are the costs associated with IPS Training for Peer staff (including both the 5 Day Basic Training and the IPS Crisis Training)?

Training information can be found at <http://www.intentionalpeersupport.org/>

77. If the Agency operates the ECTHP out of an existing OMH licensed Supervised CR Program, would a portion of that sites' expenses (i.e. utilities, etc.) be expected to be assumed by the ECTHP operation funding?

The portion of that site's expenses would remain as part of the OMH licensed Supervised CR Program and there would not be an expectation that the expenses would be assumed by the ECTHP operation funding.

78. Will OMH support funding through this RFP to support the ongoing rent/property costs associated with housing the 3 crisis beds?

The funding for property related costs would be expected to come from the operating funding provided for the three enriched crisis and transitional housing program.

79. Will additional property rentals be supported to maintain the bed capacity if within the overall MH Adult Community Residence funding for the agency?

Possibly, if these units are developed through a housing redesign project and the applicant is redesigning a Community Residence to accommodate these units, then the redesign proposal will be taken into consideration.

Reconfiguration of Residential Space Related Questions

80. If 3 beds from a 24-bed certified CR(non-medicaid)are converted to these crisis beds and the 3 certified CR beds are transferred to the licensed apartment treatment program - will those formerly non-medicaid beds become medicaid in the licensed apartment program?

Possibly if the applicant is proposing a housing redesign project to accommodate the new units.

81. Would OMH consider any flexibility on the site of this enriched housing program? For instance, could services be co-located/integrated with other OMH-licensed congregate care settings which are not CR/SROs or SP/SROs, including adolescent or scattered site settings?

No

82. Can units be structured as suites, e.g. 3 private bedrooms around a shared common area?

Yes

83. Background page 4 states that the applicant needs to show how the conversion will not reduce overall capacity of housing. Where would applicants get the resources to create three new beds and what type of beds would be allowed?

The resources used would be the existing resources and the crisis resources will be created through the funding available through this RFP. For example, if an agency has a 10 bed Community Residence with enough space to accommodate additional units, the agency could add three enriched crisis and transitional housing units to the Community Residence. This would not reduce the overall capacity of housing, yet would be converting the space with a community residence.

84. Would OMH allow three new TAP beds to take the place of three converted beds?

Possibly, if these units are developed through a housing redesign project and the applicant is redesigning a Community Residence to accommodate these units, then the redesign proposal will be taken into consideration.

85. Does the population being served by this Pilot (those with SMI) need to be separated from population in current residential programs, or can population be integrated?

The population does not need to be separated from the population in current residential programs.

86. What constitutes a 'Unit'?

A unit is one bed.

87. Does there need to be a full kitchen or is a kitchenette sufficient?

This would be determined based on the proposed setting for these units.

88. Does the space being renovated or expanded need to be an existing residence or can it be a residence that is not yet purchased/donated/built?

The units need to be developed in a space that can be easily renovated or expanded in an existing residence, as the expectation is upon awards, these units will be operationalized expeditiously.

89. Does the space planning on being renovated or expanded need to currently have individuals residing in the space or can it be a space that there are currently no residential programs?

The space renovated or expanded must be in a space that has current residential programs.

- 90. On page 19 under section 13.1.4, please further explain what is meant by the last sentence “Applicants must be cognoscente on the potential conflicts with regards to the provision of any Medicaid reimbursement services that may be provided on-site and how the reconfiguration of the site may affect the ability to provide such services”.**

Agencies that have 16 or less units and bill Medicaid must be aware that if they add more units that total above 16 units, they will lose their ability to bill Medicaid as they will be considered ineligible as an Institution for Mental Disease.

- 91. Do the ECTHP participants require separate quarters (i.e. kitchen, dining, den, staff offices) and separate activities (i.e. meal preparation, dining, recreation, medication monitoring, etc.) from the site's existing Supervised Program CR residents or are they able to be integrated?**

The ECTHP do not require separate quarters, however the applicant should describe how the agency will implement the Enriched Housing and Crisis Diversion Program in a manner that transforms, yet does not disrupt the current practice of the agency’s housing program.

- 92. Can the space be outside of the community residence? Or does it have to sit in the CR space?**

No, it is expected that each applicant awarded through this RFP will develop three crisis units by adding or reconfiguring existing residential space.

- 93. Can the residential beds be where the program currently operates Supportive Living apartments? As long as the apartment beds are relocated throughout the community?**

No

- 94. Can the beds be scattered across county lines outside of where the LGU funds current housing, if the applicant operates other OMH program in the county line?**

No, these units are for the county in which they are developed.

- 95. The RFP states that an agency would be awarded three beds; however, would any consideration be given to an agency that can only develop two crisis beds due to the configuration of their congregate CR?**

No, it is expected that each applicant awarded through this RFP will develop three crisis units by adding or reconfiguring existing residential space.

- 96. If an agency could only develop two beds, could they partner with another agency in their county to develop one bed?**

Yes

97. We plan to renovate one of our CR's within this year. The full renovations will probably not be complete until 2015; however, we could configure a separate crisis bedroom into the renovations thus reducing the amount of the capital money that would be needed for this project. Would OMH allow an agency to wait until the renovations are complete to add another crisis bed so that there are three beds for the award?

It needs to be a space that can be easily renovated or expanded in an existing residence, as the expectation is upon awards, these units will be operationalized expeditiously. OMH would not allow an agency to wait.

98. What are the NYS OMH space guidelines for crisis units?

The minimum square footage is 90 sq' per person (bedroom) and 55 sq' feet support space per person.

99. Can apartments be built onto property that is currently non-residential, even if the agency operates residential programs?

No

100. Do the apartments need to be 'certified'?

All apartments should be legal apartment dwellings as determined by the local city, town or government entity. These units will not be certified or licensed by OMH.

101. Do these apartments have to be built to meet life safety code (i.e.: sprinkler/fire system)? What is the required square footage per person?

The scattered site community apartments do not have to meet LSC but if they are built as a single site apt/tx owned by the agency they must be designed to meet LSC 2012. The minimum square footage is 90 sq' per person (bedroom) and 55 sq' feet support space per person.

102. Are shared suites acceptable? Are bunk beds allowed?

Shared suites are acceptable, however every individual should have his/her own bedroom, therefore bunk beds are not acceptable.

103. Is it acceptable to share a bathroom with another suite?

Yes

104. What are the requirements for windows?

All appropriate building codes must be followed.

105. Do we have to follow the code of the building we're putting it in (Congregate Care), or follow CR-SRO/SP-SRO codes?

Yes

106. How many people per unit?

One person per unit.

107. Are kitchens required for the units? Do they need kitchenettes? (Two burner stove, running water, etc)

This would depend on the site being proposed and the availability of existing amenities.

108. How much lounge space per square foot is needed per person? Can that be shared with those already living in the building?

Lounge space is considered part of the common space. Add up all the total common space (space to which residents have unrestricted access) of kitchens, lounge space, rec rooms, etc... and divide by the total number of residents in the residence and it must average 55 sq' per person without a waiver.

109. Do the individuals in the transitional housing units need to be gender-segregated by floor or can the floor be a mix of males and females?

Individuals do not need to be segregated by gender.

110. Regarding reconfiguring existing residential space. If we propose creating crisis bed capacity within one building that currently serves NY/NY I and II eligible consumers, can we re-allocate those designated beds to re-purposed space within another CR such as a HUD 202/811 building? Total agency CR capacity would remain stable and we would track those beds to ensure that only NY/NY I and II people are placed.

No, these units cannot have any additional restrictions with regards to eligibility requirements.

111. We plan to put the 3 crisis beds in a three-bedroom unit with shared common space in an existing CR. We would then relocate 3 tenants to other CRs. In one situation, we would need to add a bathroom to an existing space. Do new bathrooms in existing buildings have to meet current handicap accessibility requirements?

The short answer is yes, however there may be some exceptions and any extensive architectural plans would need to be reviewed by OMH architects prior to construction.

112. Can space other than congregate residence or CR-SRO be used? For example, other potentially suitable property that agency owns.

No, it is expected that each applicant awarded through this RFP will develop three crisis units by adding or reconfiguring existing residential space.

113. Must the units be wheelchair accessible?

It would depend on the extent of renovations being proposed. Any extensive architectural plans would need to be reviewed by OMH architects prior to construction.

114. If existing congregate beds are reconfigured, what type of bed can be created to substitute for them?

Applicants should propose through housing redesign what type of unit could be created in place of the congregate beds.

115. Can providers repurpose an ATP(Apartment Treatment Program) for this RFP?

Yes, Applicants should propose through housing redesign what type of unit could be created in place of the congregate beds.

116. Can we use a rental site for this RFP?

No, it is expected that each applicant awarded through this RFP will develop three crisis units by adding or reconfiguring existing residential space.

117. Can the space for the three guests be in a living situation where there are apartments within a larger complex?

Yes, if it is within a larger complex that houses an OMH existing residential program.

118. While the ideal location for the program would be in the community some of the larger CRs with extra space in the building are located on the congregate grounds of psychiatric centers, would such a location be less competitive than a site in the community?

For purposes of the pilot program, proposals will not be considered for on the grounds of a psychiatric center.

119. Does OMH anticipate that respite services will be fully segregated from the rest of the CR or is it expected that the respite beds will be intermingled into existing CR space (i.e. shared kitchen and bath facilities and possibly designated respite beds located amongst the licensed beds?)

Either layout described above will be considered. Applicants should clearly describe how these units will be developed within the existing program.

120. It is being considered to reduce the number of licensed beds at one location to allow for the respite program to be developed in the community and move the 3 licensed beds to another CR operated by the agency which is located on the grounds of a psych center. This would minimize the capital costs and time needed to develop the respite program, as the on ground program has sufficient extra rooms to accommodate the 3 beds. Is this acceptable?

Proposals on the grounds of psychiatric campuses will not be considered.

121. If we had space in an apartment building used for Supported Housing, could we renovate the first floor using the available capital funding and convert it to three bedrooms, a small office, a shower and add a stove (it already has a kitchen sink and bathroom) as long as we could obtain a building permit within a required period of time.

It is required these units be developed within an existing housing program such as a Community Residence, CR-SRO or SP-SRO program. Supported Housing programs located in an apartment building would not be eligible for use for this initiative.

122. If it makes programmatic sense, in terms of the physical space configuration, to relocate more than 3 beds (e.g. 6 beds) from a congregate treatment program to a Treatment apartment program, would that be allowable?

Yes

123. Page 11, Section 10.2.1 states, "It is expected that each applicant awarded through this RFP will develop three crisis units by adding or reconfiguring existing residential space within existing Congregate Community Residences, CR-SROs or SP/SROs to serve the population identified above." Should "expected" in the above context be interpreted as "required?" While we would be able to reconfigure an existing SP/SRO, we also have a separate residential building available that could offer a friendly, homelike atmosphere consistent with the Enriched Crisis and Transitional Housing Program model. Would we be permitted to operate the Program at an otherwise appropriate site that is not within and existing Congregate Community Residence, CR-SRO or SP/SRO?

It is required these units be developed within an existing program.

124. In accordance with the NYCRR Part 584, "Each living unit shall provide for the comfort and privacy of the residents and shall be limited in size to 14 residents." Please confirm that, with the addition of beds for "crisis and transitional housing services" an existing Community Residence must adhere to a limit of 14 beds total (inclusive of the crisis beds.)

These units will not be licensed under NYCRR Part 584. Regarding the addition of units for crisis and transitional housing services, agencies that have 16 or less units and bill Medicaid must be aware that if they add more units that total above 16 units, they will lose their ability to bill Medicaid as they will be considered ineligible as an Institution for Mental Disease.

125. Should each unit of crisis and transitional housing services be its own room, or can the three units be in a shared-sleeping room?

Each unit must be its own room, shared bedroom units are not allowed.

126. Is it allowable for an addition to a currently owned house (used for Supported Housing) be done with the Capitol Project Budget?

Not for Supported Housing.

127. Is this RFP primarily targeted to CRs and CR-SROs? To expand their beds for this purpose?

The RFP is to reconfigure space in existing programs, primarily CRS and CR-SROs but not to expand beds but to create distinct and separate enriched crisis and transitional housing units.

Capacity and Licensing Related Questions

128. What role will NYS OMH play if a person's discharge plan does not work? How will discharge plans be enforced if a person is not cooperative? How does a reduction in certified capacity and conversion of those beds to non-certified get reflected on the operating certificate?

OMH will not play a role in a person's discharge plan; the discharge plan must be in place at the time of admission and decided amongst health home and current providers. The reduction in licensed capacity (all beds are "certified" – they will meet 595 and LSC regs, etc...) from 16 to 15 will be reflected as, 15 beds and 1 respite/crisis bed (or whatever we need to call these beds).

129. If non-licensed beds can be accommodated in a licensed group home, without reducing licensed capacity, how would the addition of those non-licensed beds affect site selection law compliance?

An accommodation of non-licensed beds in a licensed group home that does not reduce licensed capacity will not implicate site selection law compliance. Providers should consult with their legal counsel about compliance with the site selection law in general.

130. RFP indicates that applications requesting to convert existing housing resources into an enriched crisis and transitional housing unit must clearly state how this conversion will not reduce overall capacity of housing. Is it acceptable to convert 3 Community Residence beds to 3 licensed apartment beds to that total licensed capacity remains the same?

Yes

131. Since the enriched crisis and transitional beds will not be licensed, please confirm that the provider is not required to comply with Part 595.9 (c)(d)(e)(f).

Correct, these units are not licensed under Part 595.9.

132. If the licensed capacity of a CR is decreased in order to accommodate these units, and if OMH determines that funding should be discontinued in the future, will the provider need to get municipal approval to add the licensed beds back into the CR?

No

133. Section 13.1.5 refers to Previous Agency Experience. If the provider has an OMH contract for licensed beds but a LGU contract for Supported Housing and the LGU has not performed any monitoring visits/audits, please clarify whether the provider must submit copies of the OMH licensing visits.

Applicants must attach the most recent audit conducted for their housing programs and copies of recent monitoring reports of any mental health programs operated by the agency. If no monitoring visits or audits have been conducted, please indicate such in your narrative response.

134. We have an Apartment Treatment Program (ATP) as a single site in NYC that is owned and built for the purpose of providing licensed housing. Would like to use one or more apartments in this building as enriched crisis and transitional housing under this pilot initiative. In order to not reduce the overall capacity of the ATP, could application be made to relocate several ATP beds to a Scatter site setting and continue to provide the services either under the current ATP license, or add the re-located beds to another Scatter Site Apartment Treatment program operated in the same borough?

Yes

135. Similarly, should the want be to convert CR-SRO beds for the purposes of the pilot, would it be possible to maintain the overall capacity by relocating several CR-SRO beds to a nearby apartment (scatter site setting) in the community and continue to provide services under the current license or transfer the re-located beds to a Scatter Site Apartment Treatment license in the same borough? Would a waiver from the 24 hour front desk requirement for these re-located beds be possible under this scenario?

Yes through housing redesign.

Eligibility, Referral, and Length of Stay Related Questions

136. If the referring entity (i.e. hospital, CR program) is unavailable or no longer appropriate for the resident at the end of their 30 day stay in the ECTHP, where would the resident be discharged to? Is residency/treatment in the ECTHP beyond 30 days an option?

Agencies may discharge a client to a different level of care upon a clinical determination that the individual requires a setting and services that the ECTHP program cannot provide. Agencies should identify in writing in advance what behaviors would warrant discharge in advance of the establishment of ECTHP beds in the host facility. Upon admission to a bed, clients should be made aware of the provider expectations. An occupancy or guest agreement can specify the maximum time that a client may stay in the ECTHS bed. Stays should not extend beyond 30 days.

137. In the event a resident requires a greater level of care and/or is problematic/disruptive to the ECTHP, is an agency able to pursue discharge?

Discharge to a greater level of care is appropriate upon a clinical determination that the individual requires a setting and services that the ECTHP program cannot provide. Discharge may also be precipitated by conduct that is so disruptive to the program that the resident's continued presence in the facility threatens to seriously impair the provider's ability to operate its program safely and effectively for the benefit of all residents; however, in order to facilitate discharge due to such circumstances, agencies should use an occupancy or guest agreement that clearly identifies provider's expectations about what constitutes disruptive behavior and under what circumstances and subject to what procedural safeguards, a resident's behavior may warrant discharge for other than clinical reasons. Providers may wish to consult with their counsel regarding what forms of behavior may be grounds for discharge.

138. At what point is an ECTHS client who does not return to the bed considered discharged from the program?

Agencies should identify in writing in advance what behaviors would warrant discharge in advance of the establishment of ECTHP beds in the host facility. Upon admission to a bed, clients should be made aware of the provider expectations. An occupancy or guest agreement can specify the maximum time that a client may stay in the ECTHS bed.

139. If an ECTHS client refuses to vacate the program/move on to alternative housing, what are the provider's remedies/options?

Determinations that a client is ready to be moved to their residence or to an alternative placement should be based on a clinical assessment of the client as well as the client's wishes. An occupancy or guest agreement may specify the maximum time that a client may stay in the ECTHS bed. Providers may wish to consult with their counsel regarding the specifics of an occupancy or guest agreement.

140. Will the provider be permitted to refuse admission to an ECTHS bed who is a sex offender? Has a history of fire setting?

Agencies should identify in writing in advance what behaviors would warrant admission and discharge in advance of the establishment of ECTHP beds in the host facility.

141. For clients referred from a hospital for step-down service, who is responsible for identifying a transitional (CR) or permanent housing setting?

Clients referred from a hospital for a step-down service must have a permanent housing setting established prior to the step-down service, the hospital must ensure the client has a permanent placement and the housing agency providing the step-down service should confirm this prior to accepting the client.

142. Is there an age group or age limit to the adults to be served? Can I define an Adult to be 18-24 years old?

An Adult is defined as anyone 18 years of age or older; the services offered through this RFP cannot impose age restrictions other than this.

143. What documentation will be provided to confirm a referral has completed medical and psychosocial reviews and has a residence to return to or a permanent discharge plan in place?

The agency must ensure they are provided with a complete referral and that there is a permanent discharge plan in place prior to admission through collaboration and communication with the client's health home care manager and treatment providers.

144. What is the expectation on the amount of time granted to providers to assess and accept referrals?

Immediately upon a referral an assessment and determination should be made.

145. Will the hospitals be held responsible for ensuring that an individual has a place to reside after the completion of their crisis unit stay?

The agency must ensure they are provided with a complete referral and that there is a permanent discharge plan in place prior to admission through collaboration and communication with the client's health home care manager and treatment providers.

146. The RFP will be awarded regionally. However, are the proposed consumers going to be eligible Regionally as well? E.g. Housing services have been managed by County. Will individuals from another county be able to access crisis beds? Will there be an expectation of preferential access to individuals within county?

No, the county in which the beds are developed would serve clients from within that county.

147. Regarding recipient eligibility requirements. The 2nd bullet mentions, “individuals with a serious mental illness who are being discharged from a NYS OMH Psychiatric Center, Article 28 or Article 31 hospital and are not yet ready for a full transition into the community.” Will individuals in this category be getting discharged from these settings with a more permanent residential plan and a referral for outpatient service? It would not be reasonable to expect that the crisis program would be able to arrange appropriate transitional or permanent housing within the crisis program’s length of stay limitations.

Individuals being discharged from a NYS Psychiatric Center or Article 28/31 would need to have a permanent residential plan and outpatient mental health services in place prior to admission into the enriched crisis and transitional housing unit. The agency must ensure they are provided with a complete referral and that there is a permanent discharge plan in place prior to admission through collaboration and communication with the client’s health home care manager and treatment providers.

148. Regarding recipient eligibility requirements. The 4th bullet seemed very general, “Individuals with a serious mental illness who are not a danger to self, to others, or do not suffer from co-morbid physical injuries that require nursing or hospital level of care.” This does not describe an individual who is in crisis or a transitional situation, who would this referral be?

This criterion is in addition to the criteria that a person also is in crisis or in need of a step-down program.

149. Regarding length of stay. The RFP states “OMH expects the length of stay to be no more than 30 days, with an average length of stay to be 14 days.” In NYC, if a person is housed for more than 27 days, they accrue residency rights under landlord-tenant law. Can a program set a length of stay limit at 27 days, rather than 30 days to eliminate legal issues of tenancy?

Providers may determine a maximum length of stay based on programmatic needs and legal issues. To the extent that residency rights may be conferred upon a person staying in a crisis bed due to length of time, a provider may limit the maximum length of stay in order to avoid this possibility.

150. Are there any clinical or behavioral circumstances under which an agency could decline the placement of a particular individual, i.e. serious cognitive limitations, active substance abuse?

Per criterion from Section 9 of the RFP, eligible individuals must be individuals with a serious mental illness who are not a danger to self, to others, or do not suffer from co-morbid physical injuries that require nursing or hospital level of care.

151. Is it acceptable to serve people who are released from inpatient substance abuse treatment and provide them with a “buffer” transitional housing before reconnecting them to their community (i.e. provide step down housing to minimize relapse), assuming that these are co-occurring clients.

No, these units are to serve individuals whose primary difficulty is mental health.

152. Is it acceptable to serve someone who is at increasing suicidal risk who also has a substance abuse diagnosis to reconnect to treatment and prevent hospitalization? Or someone who is decompensating in terms of mental illness (anxiety, depression)?

Yes, either are acceptable examples of individuals to be served through this pilot program.

153. Should this be operated as either a step-down or crisis diversion program exclusively, or both?

Both

154. What will be OMH’s role in working with emergency departments to facilitate referrals to units?

The agency awarded the units, not OMH, has a role in working with emergency departments to facilitate referrals to the units. This requires the agency to develop collaborate and coordinated working relationships with the potential referral sources.

155. Page 10 indicates that one award is expected to be made in our region, which encompasses 5 counties. Would a successful applicant be expected to serve the entire region, or would an application proposing to serve one or two counties within the region be viewed just as favorably?

Applicants awarded the units would be expected to serve the county in which the units are developed.

156. In referral sources, ATP and supported housing programs are listed as potential referral sources. There are times that people in congregate treatment settings also need respite or hospital diversion services due to problems with roommates, etc. Are congregate treatment programs acceptable referral sources?

Yes

157. In section 10.2.5 performance outcomes, successful outcomes include successfully transitioned back to permanent housing in 30 days. It is anticipated that some guests in this model may be either respiteing from or pending placement in licensed transitional housing programs. A placement or return to such a setting should also be considered a successful outcome. How will this be monitored and reported?

Section 10.2.5 and Section 13.1.3 of the RFP outline expectations on monitoring and reporting requirements.

158. Are individuals expected to sign an agreement upon entry which outlines their length of stay? What would happen if the individual refused to leave?

Agencies should develop appropriate agreements which outline an individual's rights and responsibilities for these units. Agencies should ensure that there is a permanent discharge plan in place prior to admission through collaboration and communication with the client's health home care manager and treatment providers.

159. Would you consider proposals that serve clients of only one gender (e.g., exclusively male or exclusively female)?

No, units must be accessible to all genders.

160. Is there an anticipated method of referrals? Who will the referrals be coming from?

It is anticipated agencies would work collaboratively with and receive referrals directly from OMH Operated Psychiatric Center (PC), local Article 28 and Article 31 hospitals, and community mental health providers, and the Health Homes established for the region where proposed housing will be developed.

161. Can referrals come from other Supported Housing providers?

Yes

162. Can referrals come from the Program agency's supported housing to divert a hospitalization?

Yes

163. Page 9 of the RFP describes population to be served. The final bullet just indicates people who are not danger to self or others and do not require nursing or hospital care. Assume this bullet is adding some parameters to the two preceding bullets?

Yes

Miscellaneous Questions

164. Will the proposals be reviewed and scored by persons outside the local program area? There had discussions with the State on this based on previous RFP's and the State Office in Albany indicated there was an effort to increase reviewer impartiality by creating arms-length review teams. Will this be the case with this RFP?

All proposals will be reviewed by a team of OMH Central Office and Field Office staff who may or may not have direct experience with the applicant.

165. Is this RFP for stand-alone beds that are a part of or separate and distinct from the RCE crisis beds identified for EPC for example?

This RFP is for beds that are separate and distinct from the RCE crisis beds.

166. Under Provision of Services, what is meant by "medication coordination, monitoring, training and advocacy?"

Medication coordination, training, and self-advocacy means: activities designed to provide information to ensure appropriate management of medication through understanding the role and effects of medication in treatment, identification of side effects of medication and discussion of potential dangers of consuming other substances while on medication. Training in self-medication skills is also an appropriate activity. Medication monitoring means activities performed by staff which relate to storage, monitoring, record keeping, and supervision associated with the use of medication. Such activities include reviewing the appropriateness of an existing regimen by staff with the prescribing physician. Prescribing medication is not an activity included under this service.

167. The anticipated Start date is 7/15/14, does construction start on this date or does the program start on this date?

The anticipated start date refers to the start date of the OMH contract.

168. Is it expected that there be 24 hour intake?

Yes

169. Please define "unit" and "crisis unit." How many beds are in a "crisis unit"? How many units/beds will there be per award?

The term "unit" and "crisis unit" are interchangeable. A unit is an available residential placement for an individual who meets the criteria set forth in the RFP for eligibility. Three (3) units/beds per award will be made.

170. Can a provider apply for more than one region? If so, does a separate proposal need to be submitted for each or can one proposal be submitted for several regions?

Yes a provider may apply for more than one region. A separate proposal should be submitted for each region, as there may be differences in how the program will be operationalized.

171. How much time is allowed for start-up and renovations?

OMH expects these units to be developed within three to six months of award.

172. The time frame between Award and start time doesn't allow for capital improvements (2 weeks) . Is the agency expected to create beds for the interim? Is there other solutions to the issue?

The anticipated start date refers to the date the agency receives an operating and capital funding contract, rather than the start of actually admitting individuals into the units.