	BIDDERS QUESTIONS	NSMHA RESPONSE
1	Will any Expanded Community Services/Intensive Outpatient/Program for Assertive Community Treatment (ECS/IOP/PACT) clients be included as clients to be served?	This program needs to be coordinated with the Geriatric ECS Program operated by Home and Community Services (HCS) and the Area Agencies on Aging (AAA). Since it is similar to the Geriatric ECS Program, in most cases it does not make sense for people to be in both programs. These programs offer similar services so it would make sense for people to shift out of the Geriatric Transitions Program and stay with the ECS Program if they are placed in it. IOP and PACT clients should be served by their existing teams. IOP and PACT Teams are expected to provide intensive services. They can request and receive consultation from the Geriatric Specialists from this new and more specialized program. Exceptions could be made, if justified. North Sound Mental Health Administration (NSMHA) wants to avoid duplication in services.
2	What is the referral process to get clients to this program?	NSMHA would expect the successful bidder to market this program to HCS, AAA, community hospitals, Volunteers of America (VOA) Access Line, as well as, to nursing homes and adult family homes (AFH). Close collaboration with the hospitals, HCS and AAA is a mandatory requirement of this program. NSMHA wants at least two channels for referrals – one would be direct referrals to the program and the other would go through VOA Access Line. Direct referrals could be made by anyone. HCS, community hospitals, as well as, nursing homes and AFHs are expected to major referral sources.
3	Will all AFH and Skilled Nursing Facility (SNF) in the catchment areas be given the contact information for the service?	Yes, the provider needs to market the program. NSMHA will assist by sending program opening announcements and periodic follow-up announcements. Please discuss in your proposals marketing efforts because the intent is to reach as many people as possible.

4	Will they be able to access the services provided by this program as "open access"?	Yes and first priority must go to people who are in inpatient care or the emergency departments. The source of the funds for this program is from state efforts to reduce the impact of the broader Involuntary Treatment Act (ITA) Commitment Law starting in July. It will be a question of capacity of how many community, non-hospital referrals can be accepted. The funding available for this program may not meet the entire demand for this type of service.
5	Will AFH's and SNF's be able to 'self-refer' individuals to the program who are at risk of losing their placement?	Yes, depending on the available capacity of the program community direct referrals can be accepted from community providers such as AFHs, nursing homes and other community groups.
6	The expected caseloads of 10 per full-time employee (FTE) – this means only 10 clients at a given time per county – this strikes as a small service for each county assisting only a small number of clients at a time – is it expected that there will be a waiting list process for clients referred or prioritization based on need/urgency/risk?	This is intended to be an intensive, short-term service (90 days). Hence, a caseload of 10 per FTE was chosen. This means up to 200 people per year could be served by this program. This could be changed based on experience but the goal is to provide intensive, short-term counseling, consultation and training to stabilize individuals in community settings. Also, the five FTEs are to cover the whole North Sound Region. Based on population, a bidder might have two FTE's in Snohomish County, one in Whatcom County and 1.5-2 FTE's to cover the three small counties. The location of FTEs should really be driven by service requests so flexibility is important. Priority of acceptance into the program should be given first to people that are in inpatient care in a hospital or an emergency department. Second priority would be given to people who are at risk of being hospitalized. Priority should always be given based on the seriousness of risk within these two priorities.
7	Do the 10 clients per FTE only refer to the transition services element of the proposal (adults discharging from inpatient facilities to SNF's/AFH's) or does this also include adults living in SNF/AFH who need interventions to maintain their placement and prevent hospital re-admits?	The 10 clients per FTE refer to the total caseload at any given time for each geriatric mental health professional. The model that is being demonstrated needs to be a short-term intensive counseling, consultation/training with facility staff and coordination with allied systems.

8	Are the out-of-hours/emergent consultation element of the service related to the same clients on the current caseload or is this also a service open to additional clients in need?	Yes, the 24 hour consultation and supports by this team are intended for consumers on the active caseload of this team. This could involve telephone consultation or at times going to the facility to support the staff in managing the client. This is all aimed at stabilizing the individual in their community setting and preventing unnecessary emergency room and inpatient psychiatric admissions when possible.
9	What is the expected/target volume of out-of-hours emergent client consultations if this is a separate population of client and not part of the caseload of 10 clients per FTE?	This is a specialized consultation to the mental health emergency service workers and Designated Mental Health Professionals (DMHP) across the Region to strengthen that system's capabilities in serving older adults. It is not anticipated that this would be used heavily, perhaps a couple of calls per month. If this specialized consultation service starts to be heavily utilized so it is an undue burden on the system, then some other approach will have to be developed.
10	The document states average of 2 hours per week per client (page 11) – 20 hours a week – I am guessing they mean direct contract time. If this is the case, then that only leaves 20 hours/week/per worker for all travel time, administration, follow up work, writing up plans, meetings, etc. and then the out-of-hours emergent/consultation work part of the program? I am not sure that is realistic/makes sense.	The 20 hours a week is an approximate number. If all services are provided out of facility, then NSMHA would expect 14 hours of service week productivity. Since a significant portion of services are anticipated to be out of facility the average productivity of staff is likely to be around 16 hours per week. With a caseload of ten, the average hours of service would probably be 1.6 hours per person.

11	How does the Crisis line and NSMHA emergency services contract interface with this project?	The Geriatric Care Transition Team needs to be coordinated with the Crisis Line and emergency service staff. The intent is to be available to provide support to facilities and families accepting these challenging patients. HCS is setting up a rapid access system to Exceptions to Rates to get additional funding to providers so they can give additional support to people who are having difficulties. F und requests will be handled quickly and answers should be available within hours or days. Successful bidders need to propose how they can provide support so the facilities retain the people and do not send them to the hospital unless all other less restrictive (LR) options have been attempted. The Geriatric Care Transition Team is expected to be available for consultation on people they are working with 24/7. This is to assure support for the new placement and the care givers.
12	Is the project only for NSMHA enrolled clients?	No, preference should be given to people with Medicaid for the program is substantially funded by Medicaid. The project is intended for people who are difficult to place from hospitals due to their challenging behaviors. It is expected through consultation and support these individuals will be back in the community quickly. Some individuals might not qualify for Medicaid; however as stated earlier, preference should be for people with Medicaid.
13	How is “serious mental illness” defined?	Broadly. It is believed most people will meet the Access to Care Standards (ACS). The key is that these people are difficult to place from the hospital or at risk of being hospitalized due to the difficult to manage behavior. This program could accept people for its short-term services with just a dementia diagnosis.

14	What is the Integrated Regional Response Team (IRRT)?	Integrated Regional Crisis Services are the crisis line, voluntary crisis services, DMHP services and Triage Centers.
15	How much FTE is expected for each county?	That is left up to the proposing contractor. NSMHA expects this program to be available region-wide. However, there is likely to be much greater need and demand for services in the areas with more inpatient units and nursing homes/AFHs. This would need to be considered within the design on how this would be covered. Services to the more remote areas could be accomplished by a mixture of face-to-face interviews with telephone/video conferencing.
16	Where is the staff/FTE expected to be located?	It is anticipated the vast majority of services will be provided in community settings such as hospitals, AFHs, nursing homes and private homes. NSMHA's preference is that a single agency covers the whole region to create this strong team. If this is not feasible, then it could be subcontracted out. NSMHA's preference is this being a cohesive and coordinated team because of the needs for 24 hour consultation and supports. Thus, it is up to the bidding contractor to propose the most effective way to deploy staff to cover the wide geographic area and the varying demand for services to operate an effective and efficient program. It is not anticipated that teams will have to be housed in any particular county. Consideration should be given to using start-up funding to support these staff in delivering their services in community settings and staying connected with their team and agency.

17	Does NSMHA want data to be transmitted though the CIS System or can data be submitted with an Excel spreadsheet for example?	NSMHA wants to have the encounter data submitted through the Consumer Information System (CIS). While there are not currently fields in the CIS for some of the data requested, NSMHA will accept some outcome data and customer satisfaction data in Excel spreadsheets. Eventually, the State is going to require the state-wide outcomes to report through the CIS so re-programing will have to be done. NSMHA is waiting for outcome indicators from the State and NSMHA feels these will be a required to be reported through the CIS. The State Outcome Measures are supposed to be out in the next few months. Reprograming of the CIS will be necessary to accept some of these measures. Some of the measures may be able to be provided by NSMHA so NSMHA and the successful bidder will need to work together on these measures.