HBCI – IDD Questions and Answers

1. Where do referrals come from? Are providers responsible for engagement and recruitment, or does that fall elsewhere?

ANSWER – Please refer to the HBCI program guidance regarding referral sources. HBCI providers are responsible for forming and maintaining community partnerships and creating a workflow that supports referrals from all sources, including self-referrals.

2. For the two RFPs, HBCI Statewide (Traditional) and HBCI MH/IDD – the former only funds programs north of the Mid-Hudson Region. The latter (MH/IDD) funds 2 programs, one for NYC/LI and one for rest of state. Given that the RFP language appears identical, what are the difference between these two RFPs? It would seem that an organization applying for the HBCI MH/IDD funding for rest of state could submit the same proposal for the HBCI Statewide (Traditional) RFP? As a note, by clumping together NYC/LI in the MH/IDD RFP, the funding seems insufficient for the scope of work requested.

ANSWER –When reviewing each RFP individually, you will notice a difference in the target population to be served and the methods in which the team uses to engage each population. The grouping of NYC/LI refers to the area for the award; the catchment area for the proposed program is not expected to be five (5) boroughs and two (2) counties. RFP responses should be representative of each individual RFP, should a team decide to apply for both opportunities.

3. If we are applying for a downstate team only, can that team include multiple groups of 1 supervisor to 3 interventionists? If so, does the entire annual budget for all of the staff within the downstate team have to be within $518,271? Or is it $518,271 for each group of 1 supervisor to 3 interventionists (plus other staff positions such as a consulting psychiatrist/psychiatric NP, peer advocate and clerical support) within the downstate HBCI team (so that, for example, if we had 3 such groups in the downstate team, the annual budget could be $1,554,813)?

We have noted that the HBCI Program Guidance states, on page 6, "A program may not have more than 15.0 total FTE" which means we would be limited to 3 groups of 1 supervisor to 3 interventionists plus the other staff positions.

ANSWER – As noted in the RFP, the maximum funding for this award is $518,271. The RFP funding amount was modeled for an HBCI team consisting of one (1) Supervisor and three (3) Interventionists. The applicant's budget submitted as part of the RFP should outline proposed staffing and salaries, and any source(s) of funding outside of requested OMH funding.

4. Is it required to do both NYC and LI or can we specify which one?

ANSWER – The program’s catchment area should be specified in the application. Applicants should consider what a reasonable catchment area is for their proposed staffing plan.

5. Where do the referrals come from?

ANSWER – Please see #1.

6. Is this program inclusive of children stepping into the foster care system?

ANSWER – There is nothing in the program guidance that precludes serving children/youth enrolled in Foster Care. The goal of HBCI is to avert unnecessary psychiatric hospitalizations and residential treatment placements; Foster Care does not fall into either of these categories.

7. What is the responsibility of the in-patient/residential unit versus this program regarding discharge planning post-HBCI length of stay (post 6-9 weeks)?

ANSWER – As stated in the guidance, the goal of HBCI is to avert unnecessary psychiatric hospitalization. Some youth may be referred to the HBCI program after an inpatient admission or residential stay, but many referrals will also be submitted for youth who are not stepping down from a higher level of care. It is the hospital’s or residential setting’s responsibility to provide discharge planning from that setting. A hospital or residential facility may include the HBCI program as a discharge resource. HBCI programs are responsible for all discharge needs following the youth’s enrollment in HBCI, and consideration of all eligibility criteria for services needed following discharge from HBCI.

8. Is any telehealth permitted?

ANSWER – The HBCI program guidance states “...providers should prioritize in-person service delivery. An entire episode of care cannot be conducted by Telehealth Services only”. And also states “Telehealth may be used as an adjunct to in-person operations where appropriate. Telehealth may be used to supplement in-person services, to optimize engagement (e.g., for screening so that the individual can learn about choices in services), to temporarily provide care in circumstances where in-person engagement is not possible (e.g., risk of infection)”. KW

9. Is 9 weeks an absolute maximum length of service?

ANSWER – The HBCI program guidance states “Services can be extended beyond the expected length of service; this is decided on a case by case basis by the Supervisor if it is assessed that discharge is contraindicated for the child/youth and the child/youth and family are able to continue in the intensive program”. The program guidance also states “The family’s enrollment in HBCI is complete when the immediate threat of out of home placement or psychiatric hospitalization has passed, if further services are no longer needed, or if less intensive services will safely maintain the child/youth in the community”. Clinical determination of the Supervisor drives the length of stay in the program. This clinical determination should include an assessment of the stabilization of the acute crisis and knowledge of those children/youth in the catchment area in acute crisis who could benefit from HBCI and are not yet enrolled.

10. Is there a difference in funding of the upstate and downstate programs?

ANSWER – The upstate team and the downstate team will each be awarded $518,271.

11. Are there other services for this population in development, post HBCI-intervention?

ANSWER – There are OMH funded crisis services that are expected to serve those dual diagnosed with MH and I/DD (CPEP, CSC, ICSC). However, for services for individuals with I/DD, some may require the individual to be determined eligible by OPWDD. It is important that referents consider the eligibility criteria for each service.

12. What is the 5 year cost of living increases associated with the grant?

ANSWER – OMH obtains the budget authority on all contracts to account for potential cost of living advances (COLA) or other government mandated increases. However, the increases are not controlled by OMH and must be passed by the NYS Legislature in the yearly budget.

13. Is there additional start-up money?

ANSWER – The full funding amount for the award is outlined in the RFP.

14. Can the geography be limited/can the applicant carve out a smaller catchment area, or is the expectation that the applicant serve the entire upstate or downstate region?

ANSWER – The program's catchment area should be specified in the application. Applicants should consider what a reasonable catchment area is for their proposed staffing plan.

15. Can an organization partner with a hospital and use their catchment area and relationships, or develop a community network for a targeted region?

ANSWER – HBCI programs should develop relationships with all applicable community providers in their identified catchment area. These providers should include potential referral sources as well as discharge resources that may be appropriate for this identified population.

16. Is there prohibition on co-locating this service in a community school?

ANSWER – There is nothing in the program guidance that specifies the location for this primarily home --based program. HBCI staff are primarily in the field, providing primarily in person services to the enrolled children/youth and their families and other community partners, including school staff. Applicants should consider whether there are any barriers to access their proposed work space during school holidays, vacations, after hours and any potential confidentiality issues.

17. How are children identified/where do referrals come from?

ANSWER - Please see question #1.

18. Will there be a centralized referral process, or will the provider be able to do their own outreach?

ANSWER – Program referrals are made directly to the HBCI program. It is expected that each HBCI program will create and maintain community partnerships.

19. Can agencies triage/prioritize the referrals?

ANSWER – HBCI programs are expected to triage and prioritize referrals.

20. Does OMH/OPWDD have data on the need for these services/the potential number of eligible children in each region?

ANSWER – Applicants are expected to gather information related to this dually diagnosed population as a part of the RFP process.

21. Is the $518,271 in annual funding the maximum cap on the award?

ANSWER – The funding noted in the RFP is the annual amount.

22. Will there be a regional adjustment for the downstate awardee?

ANSWER – The RFP notes the amount of funding for a downstate awardee.

23. Must the service modality be in-person or is telehealth an option?

ANSWER – Please see question #8.

24. Are there specific credentials for the interventionists and supervisor?

ANSWER – Please refer to the HBCI program guidance for staffing guidelines.

25. Will additional outpatient services be developed to provide longer term supports for the target population with multiple needs across OMH and OPWDD?

ANSWER – OMH and OPWDD continue to collaborate on a number of services and supports for those who have varying MH and I/DD needs. However, prior to accessing these resources, the referent should be mindful of the eligibility criteria for such services and supports.

26. What are the counties that the Upstate Team would be covering?

ANSWER - The program's catchment area should be specified in the application and is determined by the applicant. Applicants should consider what a reasonable catchment area is for their proposed staffing plan. The "upstate" region is defined in the RFP.

27. How does HBCI interact with START/CSIDD Centers? Explain how CSIDD and HBCI will triage, or work together?

ANSWER – It is expected that awarded programs will coordinate services with community partners, including NYSTART/CSIDD services. In order for individuals to access NYSTART/CSIDD services, the individual must be determined eligible for OPWDD services. HBCI programs should be knowledgeable about the eligibility criteria for the available services in their community.

28. Is it possible to make a referral to both HBCI and CSIDD Center?

ANSWER – CSIDD resource center services are site-based and not intended for children under age 21 (those aged 18 – 20 years old may only access with OPWDD specific approval). Therefore, HBCI services should be accessed and triaged as an acute crisis, as outlined in the program guidance. The goal of HBCI is to avert unnecessary psychiatric hospitalizations and residential treatment placements, including for those individuals referred to or working with a CSIDD team.

29. What will the referral process look like?

ANSWER – Please refer question #1.

30. Who can make a referral to the HBCI Center?

ANSWER – Please refer to the HBCI program guidance.

31. Can telehealth be used as the primary method of service delivery?

ANSWER – No; as stated in the HBCI program guidance, in-person service delivery should be prioritized.

32. What is the role of care coordinators in the HBCI program?

ANSWER – Care coordinators are not part of the HBCI program core team. Please refer to the HBCI program guidance.

33. It is noted that admission is required in two business days, yet caseloads are capped at 2-3 per interventionist. When the staff are full, will there be an allowable waitlist for HBCI services? Who will maintain the waitlist?

ANSWER – Please refer to the HBCI program guidance; as a crisis program HBCI programs do not maintain a waitlist.

34. What level of treatment compliance is expected of the families/caregivers? If they refuse/unable to follow treatment or are unhappy, can the client be discharged?

ANSWER – HBCI is a voluntary program. Please refer to the program guidance regarding the criteria for discharge from HBCI.

35. Are Peer Advocates paid positions?

ANSWER – The RFP funding amount was modeled for an HBCI team consisting of a Supervisor and Interventionists. The applicant's budget submitted as part of the RFP should outline proposed staffing and salaries, and any source(s) of funding outside of requested OMH funding. Please also review the education and experience criteria for Interventionists in the HBCI program guidance; it is possible for a Peer Advocate to meet the criteria for an Interventionist.

36. How will the agency bill for the service? Is reimbursement by family? Hour? Encounter? Outcome? Annual grant?

ANSWER – Please refer to the HBCI program guidance and the RFP; HBCI is not a Medicaid billable service.

37. Is the HBCI funded with straight state dollars? Are there Medicaid funds intermixed?

ANSWER – Please refer to the HBCI program guidance and the RFP; HBCI is not a Medicaid billable service.

38. Would it be allowable to pair HBCI with other services?

ANSWER – Please refer to the HBCI program guidance regarding collaboration with community partners and referrals to supports following HBCI services. It is expected that HBCI programs will have a close relationship with community partners and consider the needs of the child/youth in making referrals and collaboration.

39. Is there data available on size of the current/anticipated level of need?

ANSWER – Applicants are expected to gather this information as a part of the RFP process.

40. Please outline how staff can be required to be on call 24/7.

ANSWER – As a crisis -oriented program, it is expected that the program offers 24/7 crisis response services. Programs may accomplish a 24/7 crisis response in a variety of ways including but not limited to, an on-call response system via the larger agency, shared on-call amongst the program staff, or individual staff members providing on-call to their respective caseload.

41. Caseloads: The RFP mentions (6) per intervention specialist, please give more detail.

ANSWER – The RFP states that an HBCI team is expected to serve an average of six (6) children/youth at a time, and the typical length of service in the program is six to nine (6-9) weeks. It is expected that an HBCI program serving children/youth with I/DD are expected to serve 36 – 48 children/youth annually.