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Forensic ICM Questions and Answers

1. Does the 4,000 character limit per answer apply if the choice to upload a document is made?

No, but the response must be clear, succinct and responsive to the question itself.

2. Wondering about the overlap between this initiative (the RFP) and Health Homes and what guidelines are needed to ensure there is no conflict there? If the referred clients have Medicaid, would they become a part of the Health Home or would that possibly happen after the 3-12 month period that they are receiving the intensive services?

There is no overlap or conflict between the ICM Program and Health Homes. The ICM Program is transitional, serving the target population for 3-12 months post-release from prison. Once discharge from the ICM Program is clinically indicated, the ICM Program will facilitate the referral and transition to longer term care coordination services (e.g., Health Home, ACT, Forensic ACT, Shelter Partnership Act, Intensive Mobile Treatment). This transition should include a warm handoff, including a case conference and sharing of clinical information, between the ICM Program, the participant, and the new provider. The transition should not occur until the new provider has accepted the referral and the warm handoff, including case conference, has occurred. The ICM Program will assist the participant in attaining active Medicaid immediately upon reentry to the community from prison to promote eligibility for longer term care coordination services.

3. Would a separate documentation system be needed aside from what is used when members consent into a Health Home?

The Health Home system is not part of this initiative. For the ICM Program, individual participant charts should be maintained that include detailed progress notes from all clinical contacts and casework, as described in Section 5.2 of the RFP. In addition, see reporting requirements outlined in Section 5.2.1 of the RFP, including data entry into the OMH CAIRS system and DOHMH Portal (for AOT clients). Awardee may develop its own tracking and monitoring system to facilitate ease of reporting requirements (e.g., real time census for RCS).

4. Would staff be able to service a mixed caseload of both AOT and Forensic Homeless clients as long as the caseloads do not exceed 1:12?

As described in Section 1.2 of the RFP, all participants served through this initiative must be adults with serious mental illness (SMI) returning to the five boroughs of New York City from New York State prisons who are homeless and will release undomiciled to the New York City Shelter system. In addition, some participants may be on an Assisted Outpatient Treatment (AOT) order.

5. For question 6.4b, do we need to answer for each licensed OMH program we have or can we aggregate that info?

It is acceptable to provide an aggregate response that accurately and comprehensively summarizes the information requested.

6. Are there any assessment tools providers are required to use?

As described in Section 5.2 of the RFP, the ICM Program must assess for suicide risk, violence risk, substance use, health, and clinical needs using standardized screening and assessment instruments initially and then repeated as needed. The RFP does not stipulate which standardized assessment tools must be employed.

7. Is 12 months the maximum time someone can participate in the program? Are there any exceptions?

Yes, 12 months is the maximum term for each participant, as the program is transitional. Most participants should be eligible for discharge at 3-6 months post-release. The ICM Program should be working with each participant on discharge planning almost immediately upon admission and ensure a warm handoff to longer term care coordination services is completed during the 3-12 month period.

8. How do we submit reports to RCS?

RCS staff will elicit the required information from the ICM Program via email.

9. What are the goals of the program?

The goals of the ICM Program are to facilitate the reentry to the community of individuals who are homeless and SMI returning to NYC from prison. During the program period the participants should attain successful linkage to all benefits, housing and behavioral health services in a manner that is client-driven, safe and comprehensive. Upon discharge, ICM Program participants should be successfully integrated into their community and be linked to longer term housing, behavioral health services and care coordination services that are supportive and promote stability and wellness.

10. What is the expected communication with RCS?

RCS facilitates all referrals from CNYPC to the ICM Program. As such, RCS will request a point person to receive and confirm that referral information is received and accepted. In addition, RCS will require census and staffing information (i.e., number of vacancies, staffing changes) upon request.

11. In our experience, it is more effective to provide this type of service based on borough. Is it possible for this to be borough based? Does it have to be NYC wide?

The ICM Program is citywide, as the NYC DHS system, following the centralized intake and assessment process, places participants throughout the NYC shelter system, and placement location is not determined until after intake. ICM Program engagement with participants begins pre-release and connections between the program, the participant, providers and parole are often established by the time the shelter placement is determined.

12. Can the Coordinator/Program director be full time?

Yes, the Coordinator/Program director can be full time provided that the other staffing requirements are met within the allotted funding amount.

13. Are we expected to provide treatment?

No. The ICM Program is expected to provide case management and care coordination as outlined in Section 5.2 of the RFP. The ICM Program is expected to continuously assess the participants for all clinical needs and facilitate linkage to all necessary treatment, behavioral health and social services.

14. What are the criteria for discharge from ICM? Is there any follow up after discharge?

The ICM Program is transitional, with the goal of connecting each participant to longer term care coordination services.

The criteria for discharge due to program completion are as follows:

- a. The participant is fully linked to vocational services, psychosocial clubhouses, community supports, community based behavioral health programs, and medical providers.
- b. Referral and advocacy to obtain entitlements, including obtaining identification, has occurred.
- c. All housing options have been secured or explored, including completion of HRA 2010E and housing referrals as indicated.
- d. Longer term care coordination plan is established.
- e. Warm handoff to long term care coordination provider has occurred.

The criteria for discharge due to reasons other than program completion are as follows:

- a. Deceased: Self-explanatory.
- b. Refusing Services: Individuals who request discharge despite the team's best efforts including: at least 6 face to face attempts within the first month and continued face to face attempts for at least another 2 months (totaling 3 months of outreach). During the months following the first month the number of attempts should be based on what is clinically appropriate. Special care must be taken to arrange alternative treatment, particularly when the recipient has a history of suicide, assault, or forensic involvement. Please note, if the recipient is

decompensating during this period the ICM Program is responsible for facilitating hospitalization and continuing the engagement process.

- c. **Missing:** Individuals who are lost to follow up for a period greater than 3 months after persistent efforts to locate them have failed. Persistent effort must include: a minimum of 6 attempted face to face contacts, within the first month, at the last known address or any other likely location(s); weekly diligent search of the HRA shelter system, NYC hospital system, NYC jail system and the NYC morgue for up to 3 months; and a missing persons report filed with the police either through the recipient's family, residence or the ICM Program itself as a last resort. If a recipient is missing prior to the ICM Program's first face-to-face contact than the team will only be responsible for one month of diligent search as described above.
- d. **Relocated:** Individuals who move outside the 5 boroughs of NYC and have no immediate plans to return. The ICM Program must arrange for transfer of mental health service responsibility to an appropriate provider and maintain contact with the recipient until the provider and the recipient are engaged in the new service arrangement.
- e. **Long Term Hospitalization:** Individuals who are hospitalized for 3 months or longer in a long-term unit/facility with no imminent discharge plan. The ICM Program will be responsible for notifying the hospital, by letter, that the client can be readmitted to the ICM Program if a vacancy is available. The ICM Program should request that the letter be put into the client's inpatient chart.
- f. **Long Term Incarceration:** Individuals who are confined to a correctional facility for 3 months or longer with no imminent plan for release.
- g. **Skilled Nursing Facility:** Individual has been placed or will be placed in an agency that better serves them and, therefore, has no need for ICM services. A physician must determine the need for a medical, nursing home placement.

There is no follow up required after discharge with warm handoff has occurred.

15. Does outpatient/clinics meet the connection (i.e., transition planning and linkage) requirement?

The expectations of the ICM Program are outlined in Section 5.2 of the RFP and include: (1) linkage to vocational services, psychosocial clubhouses, community supports, community based behavioral health programs, and medical providers; (2) referral and advocacy to obtain entitlements, including obtaining identification, has occurred; (3) all housing options have been secured or explored, including completion of HRA 2010E and housing referrals as indicated; (4) longer term care coordination plan is established; (5) warm handoff to longer term care coordination provider has occurred.

16. Can clients leave prison with pending ACT applications?

If ACT level of care is clinically recommended by the prison unit treatment team, CNYPC Pre-Release Services will submit the application through NYC DOHMH SPOA. At the time of release, the ICM Program will be notified of all participants for whom ACT applications have been submitted. The ICM Program is expected to admit the participant to the caseload and follow up with NYC DOHMH SPOA on the referral. Once the ACT team assignment is made, the ICM Program will facilitate a warm handoff to the ACT team.

17. How much monitoring will be required (in terms of OMH participation in case conferences, audits, etc.)?

The ICM Program will be monitored via the reporting requirements outlined in Section 5.2.1 of the RFP, as well as periodic audit of participant charts.

18. Can six face-to-face visits a month be reduced over time based on clinical necessity?

Yes. The ICM Program is required to provide at least 6 face to face attempts within the first month and continued face to face attempts for at least another 2 months (totaling 3 months of outreach). During the months following the first month the number of attempts should be based on what is clinically appropriate. The level of intensity and rationale should be clearly documented in the progress notes.

19. Will RCS create connections with community providers prior to a person's release from prison? Can the provider change this if necessary?

CNYPC Pre-Release Services works with RCS to facilitate access to mental health housing, care coordination and clinic services. Clinic assignments are based on client preference and recommendations from ICM Program and AOT Program (if applicable). The ICM Program can facilitate linkage to other providers post-release if clinically indicated but is expected to do so in collaboration with the participant, the AOT Program and parole (if applicable).

20. How long do we need to continue to engage if a client has been lost to contact?

Individuals who are lost to follow up for a period greater than 3 months after persistent efforts to locate them have failed may be discharged. Persistent effort must include: a minimum of 6 attempted face to face contacts, within the first month, at the last known address or any other likely location(s); weekly diligent search of the HRA shelter system, NYC hospital system, NYC jail system and the NYC morgue for up to 3 months; and a missing persons report filed with the police either through the recipient's family, residence or the ICM Program itself as a last resort. If a recipient is missing prior to the ICM Program's first face-to-face contact than the team will only be responsible for one month of diligent search as described above.

21. What are the criteria for discharge from ICM? Is there any follow up after discharge? If yes, for how long will the team be expected to follow up?

See response to Question 14.

22. How much monitoring will the team receive from OMH? Required?

The ICM Program will be monitored via the reporting requirements outlined in Section 5.2.1 of the RFP, as well as periodic audit of participant charts which should include progress notes reflective of all contacts or attempts to contact/engage with participants.

23. Will the team be responsible for completing AOT reports?

The ICM Program will be expected to comply with the ***AOT Procedures for Care Coordinators and ACT Teams*** as defined by NYC DOHMH.

24. Do we submit the provider contact form with the application or is that only if we're awarded?

The provider contact form is a required upload that must be submitted as part of the application/proposal.

25. Is this a fully funded contract based program? It does not seem like there will be an opportunity to bill.

Correct. This is a fully funded program through direct contract with OMH.

26. Can we define the geographic boundaries of the area to be served? For instance, can we propose to serve only Manhattan, the Bronx and Brooklyn?

See Response to Question 11.

27. Confirming that "non-parolees" refers to those that have maxed out – Will 'bottom up' referrals of individuals who fit program eligibility be accepted or is the model set in stone?

The program serves only the target population as defined in Section 1.2 of the RFP.

28. Where are the quarterly meetings convened (in person/web conference)?

The Quarterly Reentry Meetings are held at the OMH NYC Field Office at 330 Fifth Avenue, New York, NY.

29. Will the referral packets contain the clients' psychosocial, psychiatric evaluations and medical records?

The RCS referral packet will include the draft Discharge Summary including psychosocial information and Physical Exam including TB Test results.

30. If one of the DOCCS mental health parole officers gives us a referral of a client who has already been (recently) released and is not yet connected to services, can we accept/count that referral as part of our 1:12 caseload?

The ICM Program may only accept referrals through RCS. The ICM Program may contact the CNYPC Director of Pre-Release Services to discuss all other referrals. There may be instances where other referrals may be appropriate and accepted.

31. It has been our experience that those who are connected to psychiatric services pre-release are escorted to parole on the day of their release from prison. There have been occasions where clients have been brought to parole outside of the normal work day (8:00 AM-5:00 PM) and/or have missed parole altogether because they arrived in NYC after 7:00 PM and were brought straight to the shelter for intake. In these instances, is “within 24 hours of release” acceptable for the warm hand-off (providing that prior to his/her release, the client is given a 24 hr. emergency # to reach an ICM team member post-release)?

Yes, it is acceptable to facilitate the warm handoff within 24 hours of release if the day of release plan changes due to circumstances not controlled by the ICM Program (e.g., late client arrival).

32. The 1115 waiver decision notwithstanding, are current forensic ICM-eligible clients releasing with their Medicaid already active or with “in-patient” status?

Most participants will release from DOCCS with Medicaid in suspension status or with inpatient eligible only status. Exceptions include clients who refuse Medicaid, have private health insurance, or are undocumented and not eligible for Medicaid upon release. Individuals releasing from DOCCS will not have full active Medicaid coverage on the day of release. The coverage is activated upon release to the community.

33. Using the Health Home + as a reference, for the purposes of caseload stratification and resource management, would either a Team Approach or a Mixed Caseload approach (Forensic ICM and non-ICM individuals) be allowable if the ICM ratio does not exceed 12 recipients to one FTE ICM staff person?

As described in Section 1.2 of the RFP, all participants served through this initiative must be adults with serious mental illness (SMI) returning to the five boroughs of New York City from New York State prisons who are homeless and will release undomiciled to the New York City Shelter system. In addition, some participants may be on an Assisted Outpatient Treatment (AOT) order.

34. With regard to the face-to-face contacts, in the instances where 6 encounters are not attainable, are clearly documented best efforts acceptable (i.e. client is confirmed to be admitted to an in-patient facility)?

If a recipient is missing prior to the ICM Program’s first face-to-face contact then the team will only be responsible for one month of diligent search as described in the response to Question 14. See also response to Question 14 for all acceptable criteria for discharge.

35. What is the protocol for clients who are lost to contact?

See response to Question 20.

36. For those who are connected to a Health Home Care Management Agency (HH CMA), do they then come off the ICM caseload?

See response to Question 2.

37. Is the expectation of the provision of a direct escort/transport from Parole to the shelter based on the provider's business hours (M-F, 8:00 AM-5:00 PM) or based on Parole's hours of operation (M-F, 9:00 AM-7/8 PM)? NOTE: in section 6.2.6, the RFP references 9-5 PM.

The expectation of direct escort/transport from Parole to the Shelter is based on the provider's business hours. It is acceptable to facilitate the warm handoff within 24 hours of release if the day of release plan changes due to circumstances not controlled by the ICM Program (e.g., late client arrival).

38. Where are the needs assessments and person-centered service plans uploaded? Are there specific templates to use? Similarly, which standardized screening and assessment instruments should the ICM team use for the risk assessments?

The ICM Program may develop its own mechanism for conducting needs assessments and person-centered service plans. There are no specific template requirements. All progress notes and documentation should be stored in participant charts. Participant charts should be stored either in hard copy or electronically in a way that is compliant with OMH and Provider Agency-defined Protected Health Information requirements. The RFP does not stipulate which standardized assessment tools must be employed.

39. Do you envision a scenario in which the assessment and care plan could be facilitated – and billed – via the RCA (if housed within the same organization as the ICM team) and then shared with the ICM staff for immediate connectivity to BH HCBS? Can a team approach (RCA/Health Home) be admissible?

Requirements for serving HARP enrollees should be consistent with Health Home and Health And Recovery Plan (HARP) contract requirements.

40. What database is used for storing progress notes and uploading pertinent documentation?

The ICM Program may develop its own individual participant charting system. Participant charts should be stored either in hard copy or electronically in a way that is compliant with OMH and Provider Agency-defined Protected Health Information requirements.

41. With regard to "adequate level of professional staffing", is there a specific educational or credentialing requirement (beyond the suggested Academy for Justice-Informed Practice BH/CJ Certificate program)? Must the 3 ICM staff be 3 FTEs or a percentage of existing, qualified staff that, together equates to 3 FTEs?

Awardee will hire staff that have the appropriate qualifications to meet the needs of the target population. All staff should complete the Academy for Justice-Informed Practice Behavioral Health/Criminal Justice Certificate Program. The following qualification structure is recommended:

Education and Experience

1. A Master's degree in one of the qualifying¹ fields and one (1) year of Experience; OR
2. A Bachelor's degree in one of the qualifying fields and two (2) years of Experience; OR
3. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR
4. A Bachelor's degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population

Experience must consist of:

1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED; OR
2. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

and

Supervision

Supervision from someone meeting any one of the following:

1. Licensed level healthcare professional² with prior experience in a behavioral health setting; OR
2. Master's level professional with two (2) years prior supervisory experience in a behavioral health setting.

The 3 FTEs must each be full-time, as the ICM Program requires a specialized area of expertise that warrants full-time commitment.

42. What information can/should be submitted in lieu of CAIRS data, since our OMH-licensed clinic isn't required to submit to CAIRS?

Awarded provider will be required to enter data into CAIRS. OMH will guide provider on how to access upon receipt of award.

43. What template should be used for the ongoing quarterly comprehensive assessment and where should those assessments be uploaded?

The ICM Program may develop its own assessment report format and file the assessment in the participant chart. Participant charts should be stored either in hard copy or electronically in a way that is compliant with OMH and Provider Agency-defined Protected Health Information requirements.

44. Is the provider required to have a dedicated office space for ICM staff or would a mix of temporary office space (e.g. hotel offices used on a rotating basis by mobile staff across multiple offices) be allowable?

The provider is not required to have a single dedicated office space.

45. Are there any minimum qualifications for staff? For example, are any staff members required to be social workers?

See response to Question 41.

46. Will the ICM team be provided with client service dollars/wraparound funds like those made available to ACT Teams?

The annual funding for each of the five years is \$338,000 and is expected to cover all program costs. There is no additional funding.

47. Are the 6 visits per month an average number to be achieved across time in the program or a mandatory minimum number each month? For example, could an ICM that provides a high number of visits in the initial months (more than 6) transition to fewer visits in later months as long as an average of 6 per month is maintained?

The ICM Program is required to provide at least 6 face to face attempts within the first month and continued face to face attempts for at least another 2 months (totaling 3 months of outreach). During the months following the first month the number of attempts should be based on what is clinically appropriate. The level of intensity and rationale should be clearly documented in the progress notes.