Addendum 2

RFP: Community Living Arrangement FY 2024

Questions & Answers

Question:

What is the estimated mortgage for the home?

Response:

The current lease is $8,006 monthly.

Question:

What is the estimated lawn care for the home?

Response:

CIL spent roughly $1,200 on lawncare in 2023.

Question:

What is the estimated snow removal for the home?

Response:

No estimate available.

Question:

Does the generator run the entire house or just certain things?

Response:

It is a whole house generator.

Question:

What is the annual estimate on electricity and oil for the home?

Response:

No estimate available. We added two additional bedrooms and 3 mini splits.

Question:

Will the new hot water heater be installed by CIL or is it the provider's responsibility?

Response:

The new hot water heater will be installed by CIL or potentially through a development project.

Question:

The driveway is shared, is there any agreement in place right now with the neighbors for plowing and usage?

Response:

The shared driveway is part of a condo. Per condo documents the cost of clearing the shared driveway are split. There is no other agreement with the neighbors regarding the driveway. If the neighbors refuse to share the cost then DDS agency will have to cover the full cost.

Question:
What day program does Individual 1 attend?
Response:
Individual 1 attended the mobile work crew here in Southbury training school as well as the poultry farm.

Question:
And what about Individual 2? What day program does he attend?
Response:
Individual 2 attends Cottage two-day program here, our campus as well.

Question:
I know you said that it was remodeled home, but are we going to have to fill the home? Is it going to be furnished and what about the gentlemen's adaptive equipment?
Will that be coming with them, or will we be also acquiring all of that?
Response: The furnishing would be part of the startup funding for the home. As far as the adaptive equipment that would come with the individuals.

Question:
assuming they're at all on 7, the six people, and that they're all there by June 1st.
Response:
Yes, our hope is once a provider is selected, that additional individuals from STS will express interest in moving to this home. The families, individuals and guardians do not know who the provider will be, there is some hesitancy in making a placement decision. If there is no interest from STS individuals, we will be looking at our portability and emergencies list. We would want to consider compatibility with the STS individuals,

Question:
Do we have to pay any rent or a monthly amount?
Response:
Room and Board will be established through a Capital Development Agreement with DSS. CIL currently owns the property.

Questions:
Down the road, if there's like things need to be replaced like the roof, like the windows who takes care of that?
Response:
Any repairs would be through a typical capital improvement project

Question: How much can be in the cash advance?

Response:
Typically, 30 days of the entire budget.

Question:
On page 26 in the RFP, under the scope of service, transition planning for permanent services is does that apply to this RFP ?

Response:
That should not be there. that's an error, this has been corrected.

Question:
The psychiatric provider for at least one or two of the gentlemen are seeing, would we be able to continually use them, or do we have to find our own?
Response:
We ask that the provider find their own.

Question:
All the support that the individuals need -all the behavior, all the physical, the occupational therapy, clinical nursing - then needs to be part of the budget.
Response:
Many providers access community resources using the individual's insurance. If there are specific supports needs and insurance is cannot be used, the PRAT-URR process will need to be utilized to seek additional funding.

Questions: The benchmarks and the Messier settlement agreement. Kathy please insert benchmarks

Response: The Benchmarks associated with transition include:
Benchmark #7: "Community transition for class members identified through the IDT determinations and redeterminations will occur within six (6) to eighteen (18) months from determination (or annual redetermination), or as indicated in the class member's transition plan, with reasonable accommodation to the specific needs, desires, and circumstances of the class member. Resources will be made available to implement the class member's transition plan."

There are additional requirements that include:

Remedial Expert Recommendations/requirements	**Responsible Person(s)**	**Timeframe**
1.The Remedial Expert will be provided the opportunity to attend transition planning meetings and training sessions with provider agency.	STS	Remedial Expert's availability to be taken into account when transition meetings and training sessions scheduled.
2.Transition plans will be provided to the Remedial Expert no later than two weeks in advance of moves from STS, along with supporting plans and documents (e.g., ambulation plan, behavior support plan, dining guidelines, level of supervision, safety awareness plan, etc.). While not an exhaustive listing, additional documentation such as quarterly nursing and physical assessment reports for the past 4 quarters, physician orders, and residential and day services quarterly reports will be provided with the transition plan. The Remedial Expert may request additional documents and information.	STS	Minimum of 2 weeks prior to move
3. Health and wellness conditions, as identified by an individual's medical providers and nursing care plans, will specify parameters for care. STS providers will work with the new provider during the transition to assure that, for each identified need, the new provider has a documented protocol for direct support staff to reference and	STS Private Provider	Prior to transition meeting

follow, specific to the individual's needs and includes direction for change in condition. These protocols must be developed early enough in the transition planning process for discussion at the transition meeting and to allow for training of each protocol during the transition training sessions and for the agency to train staff during in-house sessions.		
4. A complete copy of the individual's current medical record will be provided to the new provider the day of transfer from STS. Prior to the transition planning meeting, the Active Problem List, the Inactive Problem List, the Nursing Care Plan, the Nursing Quarterly/Annual Physical Assessment, the Annual Physical and any other relevant health documents will be provided to the agency and Remedial Expert and will be utilized for development of the transition plan. The new provider may have access to any health records through contact with the primary RN at Southbury Training School. The DDS Nursing Health and Safety Assessment form will be provided to the new agency and the Remedial Expert by the STS RN at least two weeks prior to the date of transition	STS	Prior to transition meeting (copies of medical/nursing documents) 2 weeks prior to move date (DDS Nursing Health & Safety Assessment form) Day of move from STS (copy of medical chart)
5. STS will provide the Individual Personal Equipment List as a part of each class member's transition plan and will ensure the Individual Personal Equipment List is current, identifies all equipment and assistive technology, as well as who is responsible for maintenance and oversight.	STS Private Provider	Component of transition plan
6. The transition plan will also include identification of community medical providers and dates for scheduled appointments following transition.	STS Private Provider	Component of transition plan
7. The community agency will provide a description of its management structure and emergency on-call system including nursing oversight for inclusion in the transition plan.	STS Private Provider	Component of transition plan
8. STS will provide a current Emergency Fact Sheet with original picture and insurance cards to the new provider on the day of transfer. The community provider agency will develop an Emergency Fact Sheet on the day of transition and will ensure direct support staff are trained in emergency procedures and use of the Emergency Fact Sheet (e.g., ensuring the fact sheet and related information is taken by staff when an individual must be transported to a health care facility for scheduled, urgent, or emergent care.	STS Private Provider	By Day of move
9. When a guardian (or class member) consents to move forward with the transition process, a referral for advocacy services will be considered by the IDT. An advocate will not be considered to be in lieu of or a replacement for involvement of guardians and family members, but an additional team member to assist with all aspects of the transition both during development of the placement and post transition. Documentation of the team's discussion/consideration will be clearly articulated in the IP.	STS Private Provider Advocates	When consent signed
10. New provider staff will be provided with both classroom and direct support training opportunities. Classroom training will be provided by each relevant discipline at STS to cover the identified	STS Private Provider	Prior to move, throughout move and following move

care plans from each individual's IP. Signature sheets of attendees will be submitted to the Remedial Expert. New provider staff may shadow the individual and direct support staff at STS. STS direct support staff will mentor in the new home throughout the transition and move. The STS and new provider team will jointly determine, based upon the individual's progress with the transition, the actual length of the STS mentoring.		
11. The Community Case Manager will visit the class member in his/her home within two weeks of transition. A comprehensive case note will be written that reflects assessment and monitoring of the transition plan. Issues identified will be followed-up with the appropriate agency and/or regional individuals. The case manager will use the transition plan as a guide to conducting this initial visit, and will describe the visit, including any issues/concerns in a comprehensive case note. The Remedial Expert will be notified when the visit is completed and will access the case note for review. Additionally, a regional nurse will make an initial visit within the month of the class member's transition from STS. Any concerns will be communicated in writing to the regional office and the Remedial Expert will be notified.	Region	Within 2 weeks of move (community case manager) Within 1 mo. of move (regional nurse)
12. If a referral to a vacancy is desired by an individual or guardian, the STS Case Management Supervisor will contact the Regional Resource Administrator to learn of any health and safety concerns or enhanced monitoring activities for the identified vacancy. The Remedial Expert will be notified of any concerns identified and resulting plans of action that will be implemented to ensure a safe transition if a decision is made to move forward.	STS Region	ASAP after guardian/individual expresses interest in vacancy.
13. In addition to visiting within 30 days of transition as required in the Settlement Agreement, the Remedial Expert will conduct follow-up visits at discretion or random during the six months following the class member's move from STS. Any concerns from these visits will be communicated to the regional office.	Remedial Expert	Within 30 days following move & then at random/discretion for 6 mo. following move.
14. For three months following an individual's transition, the provide provider agency will notify the Remedial Expert of reportable incidents including emergency room visits, unplanned hospitalizations, injuries classified by DDS as moderate or severe, and all allegations of abuse/neglect/exploitation within 5 working days of the incident.	Private Provider	Within 5 working days of incident (for up to 3 mo. following individual's move)
15. For all newly developed residential programs, the Remedial Expert will be provided with the initial licensure survey findings and any plans of corrective action from the DDS Quality Improvement Division. Follow-up licensure survey activities related to the initial survey will also be provided to the Remedial Expert. The Remedial Expert will request from the DDS Quality Improvement Division, any Plans of Corrective Action from the initial survey.	Central Office QI	When initial licensing survey/POCs are completed
16. In the event a class member dies within a year after transition from Southbury Training School, the Defendants will conduct a thorough and expeditious mortality review according to DDS	Region	Mortality Review to be held and report issued within 90 days of death

protocol. (It is understood that exceptions may occur due to autopsy or law enforcement investigation. Any such delays in the mortality review process will be communicated to the Remedial Expert.) This mortality review will focus on identification of contributing factors, cause of death, and provide recommendations as appropriate based on the findings. The review will determine: Was the death anticipated or unexpected? Could the death have been prevented? Were systems issues identified from the review? Were individual-specific issues identified from the review? What actions should be taken to improve the health and safety of individuals?		

Question:

Can our staff get a chance to shadow STS staff as part of the transition?

Response:

We can do that; we typically have found it more successful to support people on visits to the home prior.

Question:

Is the remedial expert part of this RFP?

Response:

She will monitor and attend meetings and do follow up with this after.

Question: Kathy:

And how long does that go on for?

Response:

Typically, for the first year. Although if there are concerns that come up for a class member at any time, she may get involved.

Question: And the physical and occupational therapy is billed through their insurance.

Response:

If direct hands clinical therapies are needed, that would have to go through their entitlements, if your agency had a some of the larger agencies do have the clinical supports on staff. Depending on what is needed it could be reviewed at PRAT/URR.

Question:

Of the three individuals presented appear to be small group like a one to three staffing ratio. Is there any nursing requirement that's needed?

Response:

No, nurisng is not needed in the compliment.

Question:

On page 6 of the RFP #4 Contract Awards it is written that, "Total Maximum Funding Available: Funding to be determined by LON Scores. The current three individuals have LON 7 funding. In addition start up and cash advance funds are available. A budget should be established based on LON'7s funding ($731,502.00)" Based on the letter from DDS dated 12/28/22 a LON 7 funding in a 6 bed home is $157,701. Six people at that annual amount would equal $946,206. Those rates do not include the last wage adjustment. Please clarify the funding available and whether it will be subject to increase when the rates are increased.

Response:

Current LON 7 rate is $161,722
$161,722 x 6 beds = $970,332