

Intimate Partner Violence – Family Assessment Intervention Response (IPV-FAIR)
Questions and Answers
Deadline for Submission January 23, 2015

These are the Questions and Answers that were submitted and posted on the original RFP that are still relevant to this RFP

1) Will the RFP's be evaluated by all internal DCF staff or will there be some non-DCF staff with expertise doing the evaluations as well?

A - Members of the community have been invited to participate. They will receive a stipend for their participation. Two community members have agreed to participate and we are looking for two more. The remainder of the evaluation team will be DCF staff.

2) Will there be a bid for an ASO?

A - No

3) Appendix 9 and Appendix 11 appear to be the same. Is this an error?

A - Appendix 9 is requesting the actual form and Appendix 11 is requesting any available data that you have.

4) Can you clarify DCF's position on subcontracting as other RFP's have encouraged subcontracting but points were reduced when subcontracting was used?

A - See page 5 of the RFP, "The Department strongly supports and encourages broad community improvement. Applications evidencing meaningful partnerships and contractual relationships with qualified organizations and entities reflective of the communities to be serviced will be viewed favorably." Points will not be subtracted when subcontracting is utilized.

5) With regard to the Letters of Agreement to be provided in the Appendix: Should LOAs be limited to formal subcontract/service agreements? Or, do you want applicants to include letters that document referral/coordination linkages with the types of organizations listed under "Community Connections and Support Linkages" on page 13 of the RFP? Do applicants need to provide letters that demonstrate "community connectedness" (Question 4)?

A - LOA are expected to be submitted for any formal subcontract/service agreement. LOA are not needed for "Community Connections and Support

Linkages” or work with those providers that demonstrate “Community Connectedness”

6) For which of the required appendices does an organization’s BizNet filing/record suffice?

A - None. The hard copies have to be included in the RFP.

7) The “Best Practices and Quality Assurance” section of the RFP (p. 25) asks for data regarding family satisfaction surveys and program evaluations from the last three years. What if an applicant only has data from the past two years?

A - Please submit any available data that you have.

8) In the “Appendices” section of the RFP (p. 27), Appendices 6 through 8 refer to the “Bidder’s CHRO Compliance Package.” Where are applicants able to access that package? I didn’t see a link in the RFP or on the Biznet SCP Solicitation site.

A - The link is on Page 32 of the RFP.

9) Does the Department have a preference for one agency doing all four sites?

A - No. There is the opportunity to apply for one site, multiple sites or statewide. Separate applications are required for each site.

10) How would an emergency occurring after hours be handled?

A - All of our community home-based services that we deliver presently have the ability to respond after hours as well as most of our clinics. If your agency already has a 24/7 response system protocol that may be sufficient. As per the RFP on page 12, “The contractor will provide 24-hour emergency and crisis intervention through phone, pager, or face-to-face availability. The contractor will maintain close contact with its clients that allows for immediate identification of crisis and ongoing clinical follow-up services as necessary.”

11) Does the Department have any recommendations on to how the teams are formed related to service delivery of additional matters such as crisis response?

A - As per the RFP on page 20, “The staffing team model will include a minimum of one Program Manager, and two staff assigned to each family. The base team will be one Clinician and one Family Support Navigator. “ In the job responsibilities of the Program Manager, the RFP indicates the Program Manager will ensure 24/7 emergency/after-hours response. Page 20

of the RFP states that the Program Manager will provide direct service to families when needed.

12) The RFP section on Training mentions a five-day initial training and a three-day Fathers for Change forum with a two-day follow-up session (RFP, p. 22). Are these training costs (including travel, lodging, and meals) covered by DCF or does the applicant have to budget for them?

A - All of the training will be provided in CT. The only cost to the providers will be the time of attendance, local travel and food expenses for your staff.

13) Is the training costs for initial/follow-up/maintenance/consultation the responsibility of the provider or the Department?

A - See answer above (#24)

14) Will trainings be offered to accommodate staff turnover/transitions?

A - A plan is being developed to accommodate staff turnover/transition.

15) Re question # 5 in the RFP, Implementation Plan: Is Implementation Plan to end after the hiring and training of staff but prior to first referral? I would like to confirm that the Plan is not expected to cover the work that will take place with clients (See page 25 – “Delineate all the necessary activities, including but not limited to hiring and training staff, acquiring office space and any other tasks that would need to be completed prior to begin working with clients.”)

A - In regards to answering question #5 in the RFP, the implementation plan is not expected to cover the work that will take place with clients.

16) What does the Department think about cases in which it's an older teenager that is the offender to Mom?

A - This service will address families impacted by Intimate Partner Violence (IPV) only. Intimate Partner Violence describes physical and sexual violence, threats of physical or sexual violence, and psychological abuse, including stalking by a current or former partner or spouse. It can occur within opposite-sex or same-sex couples and can range from one incident to an ongoing pattern of violence. (Center for Disease Control and Prevention)

17) Is it the expectation the DCF will interview the perpetrator in any of these cases before the family is referred to IVFP?

A - The Department makes diligent efforts to engage all family members.

18) In the RFP it mentioned that the contractor would maintain a wait list. Can you go into more detail on the requirements for maintaining a wait list and whether or not there be any expectation of services?

A - The waitlist protocol is under development at this time.

19) Do you see the provider doing any work around prioritization of access or is that solely a function of the DCF gatekeeper?

A - The DCF Gatekeeper will be responsible for prioritizing referrals through collaboration and continued review and analysis of need, capacity, and utilization.

20) Within the model it states that DCF will participate in monthly planning sessions (in the home) with the team to discuss the current situation. Would they also participate in planning meeting with providers as part of the treatment model?

A - In the RFP on page 17, “The contractor will be the primary leader in the coordination of team meetings. On a monthly basis, the contractor along with DCF (and/or Community Partner Agencies) will coordinate child and family team meetings with the family to discuss progress, challenges and barriers to reaching the goals developed by and with each family. These meetings, whenever possible shall be integrated into already existing structures for the families, which may vary in each Region. Should additional stakeholders be involved due to providing services to the family, they may also be invited to participate in the team meetings.” It has not been determined that the monthly planning sessions will be held in the home.

21) Please define the clause “clinicians will be license eligible”. Does this mean that the candidate needs to possess a degree which offers licensure? Does this mean the candidate has completed all requirements for licensure, but has not taken the actual exam? Is there an expectation that the candidate will be licensed within a specific time frame post hiring? If yes, what is the time frame? These factors impact the salary of the clinician.

A - For clarification regarding the phrase “clinicians will be licensed eligible”, the Department is seeking “Clinical professionals who have a Master’s Degree in a behavioral health field and are licensed or working toward their license.”

22) In terms of staffing is the Department going to negotiate or grandfather in certain providers that have had extensive experience?

A - The Department’s practice have generally been when a provider would like to advocate for an exception that they document and explain the potential exceptional circumstance.

23) On page 20 of the RFP in regards to credentialing for the Program Manager, is an LPC acceptable?

A - Yes.

24) If applying for multiple regions with a single point of entry agency affording the administrative and programmatic oversight can you reduce the FTE per region or change the Program Manager description in a manner that still meets all of the required service elements of the RFP?

A - No.

25) On page 20 of the RFP it states: “The two adult caregivers or partners involved in the IPV should not be treated by the same clinician until such a time when and/or if dyad couple work is recommended. A second clinician would be utilized to service the other caregiver or partner to the IPV prior to such a treatment recommendation.” With only two clinicians per site, how does the Department envision this working with the staffing model outlined in the RFP?

A - In addition to each clinician servicing one of the adult caregivers, the Program manager may also provide direct service to families as needed. Additionally, the family may also be linked with other community based providers to meet the unique needs of each family.

26) In those cases where each parent is to be served by a different clinician – does the family count on each team’s caseload for any period of time when it is not recommended for the same clinician to treat both?

A - On page 22 of the RFP, “Each Clinician/Family Navigator team will be expected to service 10 families. The Contractor is expected to maintain capacity to annually serve a range between 40-60 families dependent upon length of service for the family (4 – 6 months).

27) For those families where the perpetrator is either not the biological father, too dangerous or absent, will services still be provided to the victims and the children?

A - Yes.

28) How does the Department envision the teams involvement in cases or during periods of time when one or more of the household adults is outside of the household such as in residential treatment?

A - This determination will be based on the individualized needs of the family.

29) How will DCF make a determination of child safety if the initial assessment determining low, medium, or high risk occurs after referral to the IPV-FAIR program?

A - The Department will continue to assess child safety throughout the intervention with the family. In the RFP on page 11 regarding safety plans, it is indicated that “Safety plans will be developed to enhance and ensure safety by assessing risk and developing a personalized, practical plan to increase safety. The safety planning will include identifying goals for the family; identifying risks; identifying strengths and resources; and identifying options. Safety plans are expected to be changed or amended based on the needs of the family and any change in the family situation.”

30) On page 12 of the RFP under Supportive Service Array it states that the “provider will offer/refer individual, group, family, and/or support interventions for the family, based on assessed needs”. Please clarify what’s expected to be offered versus referred?

A - The comprehensive assessment will be delivered by this staff and then the determination of delivering the service or linking to another provider will be based on the agency’s service array and the needs of the family focusing on current presenting needs and considering long term support and sustainability.

31) What expectations does DCF have for services to families when no contact orders are in place?

A - Based on the individualized needs of the family, services would be delivered in compliance with no contact civil or family court orders and/or if there has been an arrest with associated orders.

32) Can DCF provide more clarity re: inclusionary and exclusionary criteria?

A - On page 9 of the RFP, the Target Population for the IPV-FAIR service is detailed. On page 14 of the RFP details the inclusionary the exclusionary criteria for Fathers for Change.

33) Will fathers be asked to sign releases of information to share information with the Department?

A - Yes, releases of information would be necessary to share information among providers and the Department.

34) Will the programs serve families with men who meet the exclusionary criteria for Fathers for Change? Or, will the programs only serve families in which the Fathers for Change model can be applied (i.e., who meet the inclusionary criteria)?

A - If the men meet the FFC criteria, we would expect utilizing this model for these men. For the men that do not meet the criteria, the program will provide services/linkages to meet the identified need of the men.

35) What are the expectations on the model for those families receiving this service that do not fit the Fathers for Change criteria?

A - The service would address the needs of fathers who do not meet the criteria for Fathers for Change through the assessment to determine the needs and secure appropriate services.

36) The Fathers for Change model focuses on the father as the most common IPV perpetrator. If a contractor encounters a family where the mother is the perpetrator, what treatment model would the contractor follow? The treatment outcomes for perpetrators (listed on p. 23) seem to focus only on fathers.

A - Fathers for Change was designed for Fathers and is appropriate for couples with either unidirectional violence perpetrated by the father or bidirectional violence in which mothers are also violent. In that instance, mothers could participate in parallel in the sessions related to affect regulation skills and hostile thinking. She is already included when appropriate in the communication, co-parenting and parenting sessions. There is not at present a model for mothers who are the unidirectional perpetrator. If such a case were to arise, it could be brought to consultation with Dr. Stover to discuss if a treatment application for a mother could be implemented.

37) In the Fathers for Change model clarify how the victim receives treatment if it's within the team with the other clinician or would they be referred out to other services?

A - The Fathers for Change clinician will meet with the victims and assess need for additional/other services. This can be a clinician on the same team and would provide the best communication and coordination related to the case services. If the victim were in need of services the agency did not provide, they certainly could refer to another provider outside the team.

38) Will applicants have the opportunity to propose interventions for families who do not fit the criteria for Fathers for Change, or will they be specified/determined by DCF? Given that the Department expressed limited availability of models, some

variability (while maintaining the same expectations for outcomes) could promote the development of best practices?

A - The applicant has the opportunity to propose interventions for families who do not fit the criteria for Fathers for Change. With the limited availability of models the Department is strongly promoting the development of best practices.

39) Would the Department want Dads to be engaged in Fathers for Change at the same time?

A - The assessment of the needs of the father would contribute to the determination of the timing of the intervention.

40) Does the Father's for Change run concurrently with the work being done with the protective parent and family? Does Father's for Change have the same length of service? (16 weeks of service for both)

A - Fathers for Change can run concurrently. The IPV-FAIR has a length of service of 4 to 6 months. Fathers for Change is anticipated to run approximately 16 weeks but with the assessment and post assessment, it will take about 5 months, similar to the timeframe for the victims.

41) Does the Father's for Change model see females who have participated in Intimate Partner Violence or will females need to be linked to other programs?

A - Fathers for Change was not designed for mothers who are the sole perpetrators. Referrals to other services within the community will need to be secured.

42) Please clarify whether a DPH license is required to provide and bill for Father's for Change and work with the protective parent.

A - See page 13 of the RFP. "Fathers for Change is a clinical model to be implemented by either a licensed clinician or a master's level or high clinician supervised by a licensed clinical supervisor in an outpatient setting." Therefore, appropriate CT licenses are required. As per the RFP, you must work to maximize 3rd Party Reimbursement.

43) Which agencies are currently providing these services?

A - Fathers for Change is currently not being offered in Connecticut and IPV-FAIR is a new program model. The Department currently funds 6 Integrated Family Violence Service programs. Those programs are offered through The Center for Family Justice; Family Centered Services of Ct; Child & Family Agency of Southeastern Ct; Catholic Charities of Hartford; Community Health Resources and Family Services of Greater Waterbury.

44) Is it possible to provide a list of any instruments, tools, etc. required by the Fathers for Change model along with the associated costs? If you cannot identify each item, can you provide a ballpark estimate of the amount that should be budgeted for this program component (exclusive of staff)?

A - There will be no cost to the provider for assessment tools. Assessment tools should not be included in the response budget.

45) Is there a cost to any of the tools?

A - See answer to question #61.

46) Clarification was needed regarding the creation of the assessment tools?

A - The Department has asked for recommendations in the RFP response. A definitive assessment tool will be selected prior to contract negotiations.

47) Is DCF developing the tool or is it the injury and risk prevention people?

A - The Department will review recommended tools in consultation with the Injury Prevention Center.

48) How does the Department envision the provision of Father's for Change for fathers concurrently working with CSSD?

A - Fathers would continue to utilize CSSD programs as referred. Collaboration among providers will be necessary to plan and secure services for/with the family.

49) Is the Department working with CSSD in terms of the Court's? Some of the Dads may be going through Explore, Evolve or FEPP at the same time.

A - Fathers would continue to utilize CSSD programs as referred. Collaboration among providers will be necessary to plan and secure services for/with the family.

50) Since a father must have a child age 10 or under to be eligible for Father's for Change, what service will be offered to fathers with older children?

A - IPV-FAIR would address the needs of fathers who do not meet the criteria for Fathers for Change through the assessment to determine the needs and secure appropriate services.

51) Families where there is no index child under 10 years old, would those cases still be accepted?

A - Yes, Fathers for Change is the model if they meet the eligibility criteria. If they do not meet the Fathers for Change eligibility criteria, the assessment would determine the services to be provided to the family.

52) Are there any particular interventions being recommended for those families where Fathers for Change is not being done?

A - Upon assessment, referrals can be made to the most appropriate services available in the community.

53) In terms of the “Length of Service” (p. 19 of RFP) the RFP states that, at minimum, the contracted provider must have one face-to-face contact with the family. Is this in addition to the clinical contact required for the Father’s for Change model?

A - The length of service will be four (4) months with a potential extension to six (6) months. The request for an extension will be made through consultation with the involved team and the DCF Gatekeeper. Minimally one face-to-face contact with the family will be conducted weekly. It is the expectation that contact with the family will be 1-3 times weekly, based on treatment needs. Additional phone contact will supplement the face-to-face contact with the family. The unique needs of the family will determine if additional face-to-face contact is needed.

54) The geographic area covered by each of the four IPV-FAIR sites is quite large. Considering Father’s for Change is a clinic based model, how does the Department suggest that contracted providers ensure that the service is accessible knowing that transportation is often a barrier to treatment?

A - One of the service provision components indicates in the supportive service array that the contractor will identify and eliminate barriers to success. For example, provider may provide transportation. Also in the RFP on page 21 of the RFP, the Family Support Navigator will assess, provide and/or link to transportation. We also encourage partnerships across communities should that meet the unique needs of the family.

55) Does the Department expect the Fathers for Change outpatient work happening at multiple sites?

A - This should be determined based on the needs of the area being serviced by the team. We encourage partnerships across communities should they meet the unique needs of the family.

56) The RFP states that the Fathers for Change promising practice model should be delivered in an outpatient clinical setting and the provider is expected to obtain 3rd party reimbursement. What licensing requirements is Fathers for Change currently operating under in Connecticut (child or adult)?

A - Fathers for Change is currently not being offered in Connecticut. Services would be billed under adult services since the program is focused heavily on the father. He is the identified client not a child in the family.

57) What diagnosis code is typically used to bill for Fathers for Change sessions?

A - Fathers for Change will be delivered by licensed or license supervised master's level clinicians. Fathers in the program will typically carry diagnosis related to substance abuse, mood disorders, trauma, disruptive behavior disorders, or a Vcode. There are a range of possible diagnoses that could be appropriate depending on the assessment findings. Fathers for Change can be implemented with other treatments if indicated. For example if a Father has PTSD or a major depressive disorder, referral for treatment related to this disorder can be initiated either prior to or during their involvement with Fathers for Change.

58) How is Fathers for Change being delivered (licensing, diagnoses)?

A - See answer to question #74.

59) How many or what percentage of families does DCF anticipate participating in the Fathers for Change intervention?

A - The Department is unable to determine the percentage of families that will meet the criteria and participate in Fathers for Change at this time.

60) Is there any estimation as to what proportion of families referred will have fathers that will meet the criteria for the Fathers for Change model?

A - Unable to determine at this time. See answer to question #76.

61) How does the Fathers for Change intervention measure “reduced level of violence,” “Increased positive parenting behaviors”?

A - The Fathers for Change intervention measures “reduced level of violence” and “increased positive parenting behaviors”, through no new reports of violence to police or DCF as well as self and partner reports on paper and pencil measures. Fathers report weekly engagement in positive activities with their children using a brief pre-session checklist. We also conduct pre-treatment and post-treatment play assessments that are scored for positive and negative parenting behaviors.

62) Will the urinalysis be completed by the program?

A - Yes, urinalysis is for Fathers for Change clients only.

63) The RFP indicated that the provider will be creating an annual Quality Assurance Plan. How does that tie into the external quality assurance process/practice put in place by the injury prevention people?

A - See answer to question 80 above.

64) How will the evaluations and outcomes be collected statewide if there is not an adherence to an alternative model that is not Fathers for Change?

A - The Department is in the process of developing measureable outcomes in partnership with the Injury Prevention Center.

65) Will there be another set of data being accepted other than PSDCRS such as Carla Stover or Yale?

A - The Department is committing to utilizing PSDCRS. Any additional need for data will be determined prior to contract negotiations.

66) What services would be eligible for 3rd Party Billing?

A - All agencies can bill for all applicable services that meet criteria for 3rd party reimbursement.

Additional Question raised after Q & A.

The information in the RFP and Q&A, such as the statements quoted below, seemed to imply that applicants were expected to provide staffing of two teams, each composed of a full-time clinician and a full-time navigator that would carry the specified caseload.

- *The base team will be one Clinician and one Family Support Navigator*
- *Each Clinician/Family Navigator team will be expected to service 10 – 14 families at a time, serving 30-42 families annually (based on a 4 month length of service).*

The projected slot capacity spreadsheet could be read to permit each catchment to have more than two teams. Is it possible for a contract to have more than two clinician-navigator teams, with less than the full FTEs each, if the combined time/effort of all teams equals 2 FTE clinician and 2 FTE navigator, such as in the example below?

Catchment Area X

Team 1: .5 Clinician-.5 Navigator

Team 2: .5 Clinician-.5 Navigator

Team 3: 1 Clinician-1 Navigator

I didn't think that this was consistent with the staffing model defined by DCF, but the information presented in the Projected Allocations of Slot Capacity by Area Office seems to leave open the possibility.

I would very much appreciate clarification.

- A -** The staffing team model will include a minimum of two (2) staff assigned to each family. The base team will be one (1) Clinician and one (1) Family Support Navigator.