DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

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Substance Screening, Treatment, and Recovery for Youth
RFP #210625002
Questions & Answers

1. **Can DCF provide data on anticipated numbers served by the 3 prioritized sites?**
Based on existing referrals for the ACRA-ACC contract being replaced, the following tables show the number of admissions for the priority areas from FY 2017 through FY 2020. In addition, we have DCF-involved post majority youth and young adult parents from covering the priority areas.

Priority Areas	FY 2017 (n=319)	FY 2018 (n=292)	FY 2019 (n=290)	FY 2020 (n=179)	Grand Total
Team A					
Bridgeport	60	51	39	35	**185**
Stratford	12	11	11	5	**39**
Norwalk				1	**1**
Waterbury	21	22	28	9	**80**
Team B					
New Haven	21	21	17	12	**71**
Meriden	11	9	6	11	**37**
Middletown	5	1	5	1	**12**
Norwich	6	5	7	2	**20**
Team C					
Hartford	13	16	9	3	**41**
Enfield	9	10	9	5	**33**
Manchester	4	11	6	3	**24**
New Britain	10	9	23	7	**49**

In addition, according to a 2-year statewide CAPTA report, 32.1% of notifications were for women between the ages of 20-24.

2. **What does the Department mean by partnerships with other agencies?**
The Department anticipates that applicants will demonstrate formal partnerships with local community providers, schools, possibly licensed clinical sites, etc. to facilitate greater geographical coverage for service provision. Partnerships may include locations to deliver SSTRY and receive referrals.

3. **Is DCF looking for a partnership with a clinical site?**
Possibly. See Question #2.

4. **Do providers need an additional license to serve children up to 24?**
The Department of Public Health issues Substance Use License to providers providing substance use services. To the best of DCF's knowledge, there are no client age restrictions or requirements, but we would encourage providers to independently verify that information with DPH.

5. **Does the RSS position have to be Bachelor level or can life experience be substituted?**
   Life experience can be used to supplement education level for the Recovery Support Specialist positions.
6. **Will the RSS be expected to perform SBIRTS?**
   Yes.

7. **Can we refer to ourselves for treatment based on performance of an SBIRT?**
   Yes, but ultimate decision on treatment provider is the client's choice.

8. **What is the required licensure level for clinicians?**
   Refer to Questions 43 and 50.

9. **Does DCF expect a licensed site in each of the cities/towns named or 1 in each of the 3 sites?**
   A licensed site in each of the priority cities/towns is expected.

10. **Does DCF expect SBIRTS to be delivered at a specific site?**
    SBIRTs can be delivered in any setting as long it is done in a confidential area and there is a bathroom available where a urine screen can be completed in a confidential way.

11. **Do SBIRTS have to be delivered by a licensed clinician?**
    No.

12. **Can the RSS be working with a client while the ACRA clinician is working with the client?**
    There is an expectation of some overlap between the 2 functions, but primarily services will not be provided by the RSS and the CRA clinician simultaneously.

13. **Can program services be provided virtually?**
    On a case by case basis, this might be allowable based on the specific needs of a family, but the Department's current expectation is for the provision of services in-person and face-to-face.

14. **Is DCF expecting clinical sites to be licensed to perform SBIRTS?**
    Screenings, which include toxicology, can be done at a non-clinical or licensed location.

15. **Is DCF expecting staff of this program to perform the SBIRTS?**
    Yes.

16. **Can referrals from other programs be accepted based on an SBIRT another provider conducted?**
    Yes.

17. **Can SBIRTS be performed via telehealth if appropriately licensed?**
    See Question #13.

18. **Can applicants partner with agencies who have a licensed site if they don't?**
    Yes.

19. **Will DCF accept proposals for subcontracting?**
    No.

20. **How does subcontracting differ from partnerships, which DCF is promulgating?**
    DCF will not accept proposals that contract the work and services of this program to another agency (subcontracting). DCF is encouraging applicants to creatively identify solutions to the geographical challenges presented in this RFP by developing

partnerships for referrals, partnerships for use of space, etc. But DCF's expectation is that the awarded applicant and their staff directly provide the required services.

21. **How will training occur (SBIRT / CRA/ACC)?**
DCF will arrange for the initial provision of training and model certification for this program.

22. **Do providers need to budget for training- initial and turnover?**
DCF will pay for initial training and model certification of staff, but staff turnover training is the responsibility of providers.

Note: program supervisors can be certified to train staff in this model.

23. **Explain how SBIRT leads to a full evaluation, what is the full evaluation?**
The SBIRT is the assessment that identifies the need for treatment. The evaluation is performed by the treatment provider at time of intake.

24. **Bridgeport & Stratford are geographically close, can service sites be combined- same with any prioritized areas that are geographically similar?**
Applicants are free to propose this structure.

25. **The RFP states that daily caseload per FTE is 15. Given travel requirements, this could be challenging. Is that ratio accurate?**
Yes.

26. **Do the priority areas correlate with the towns covered by DCF Area Office?**
No. DCF is specifically targeting the towns delineated in the RFP.

27. **How will referrals be prioritized?**
Providers will be responsible for prioritizing referrals based on identified need, as this program will be fed by multiple referral sources. It is DCF's expectation that a DCF referral be prioritized above a community or self-referral when there is capacity in the program to do so.

28. **If services are provided in-home, will home base site licensure suffice?**
DPH does not license home based services outside of home health and hospice agencies.

29. **Will the 1115 Waiver with DSS be in place in time to cover this service?**
We do not anticipate the waiver being in place at time of contract award.

30. **How should proposal budgets be submitted (Year 1 and Annual)?**
One annual budget should be submitted with the proposal. If there are startup costs associated with the program, they should be included as 1 line item in the budget. It will be assumed that the annual operating budget for the program will be as detailed in the proposal's budget minus the startup line.

Note: Budgets will be prorated for the first year based on start date of the program.

31. **Does DCF have an expectation of length of time for SBIRT (30 minutes / 1 hour)?**
SBIRTS traditionally require 30 minutes to complete.

32. **Does DCF expect 15 clients seen per day or 15 contacts per client per week?**
The caseload expectation is 15 clients per staff member. The contact expectation is 1 hour per week per client.

33. **Will providers be expected to transport clients?**
When able, providers should arrange for transportation needs of clients, but this is not a budgetary expectation of the program.

34. **Can training costs for MOU partners be included in the budget?**
No. See Question #20.

35. **Will DCF provide training for an MOU-delineated partner?**
No. See Question #20.

36. **How long is the staff training component for this model?**
See page 27 of the RFP.

37. **Who are the current providers of this service?**
Current (ACRA/ACC only) providers of this service are:

Child & Family Guidance Center
Children's Center of Hamden
Community Health Resources
CT Junior Republic Association

38. **Do sites need to be both DPH and DCF licensed?**
DCF would be responsible for licensing a new Child Guidance Clinic, but substance use licensure is administered solely by DPH.

39. **What are the expectations of the provider for addressing emergencies?**
Providers will be expected to maintain an emergency response procedure, but are not expected to maintain 24/7 staffing availability.

40. **Is there an annual caseload expectation?**
45 clients annually per FTE.

41. **Has the Department determined how many transitional age youth would qualify for this service right now?**
All transitional age youth in the state of CT who meet criteria are eligible to receive SSTRY. The anticipated volume of this population has not been determined.

42. **What level of licensure is required for clinicians funded through the RFP?**
All therapists need to be licensed including associate level licensure.

43. **Are LMSW, LPCA and LMFTA allowable levels of licensure?**
Yes.

44. **Can an MOU be utilized for MAT services?**
Yes. MAT services are considered part of this model, so a collaboration for referral for this treatment would not be considered subcontracting.

45. **As our agency focus is adolescents to age 19, can an MOU with a pre-established Community Center for Integrated Health (CCIH), partner agency be used to serve 20-24-year-olds?**
The awarded agency may have an MOU with a CCIH, but the awarded agency staff will be expected to directly deliver SSTRY services to all clients.

46. **Can SBIRTS be given over telehealth or telephone?**
No. SBIRTS require a drug screen as part of the short brief intervention, which must be performed in person.

47. **What is the drug of choice of DCF clients in transitional care, broken down by region?**
SSTRY serves all eligible youth and young adults in CT. DCF-client specific information is not available. However, national data shows marijuana, alcohol, and tobacco as the primary substances of choice for this population.

48. **Are contractors required to have a licensed site in each priority city?**
See Questions 9 and 18.

49. **Will there be a DCF gatekeeper or how will referrals come in?**
DCF will have gatekeepers for DCF referrals that will be reviewed and sent to provider with release of information. All other referrals will come in from the community directly to the provider.

50. **The RFP indicates that the therapists must be licensed. Is this referring to an LMSW or an LCSW license?**
Refer to question 43. In addition, LADC are acceptable as well.

51. **How long does it take for a supervisor to become certified in CRA-ACC?**
Supervisors may be certified anywhere from 6 to 8 months dependent on the need to perform and pass all CRA procedures and with their assigned client and ratings for their therapists.

52. **Would DCF like just a Year 1 budget or a budget for Years 1-3?**
See Question 30.

53. **Can the Year 1 budget include start-up funds?**
Yes, see Question 30.

54. **Is there a particular template applicants should use for the budget and budget narrative?**
Yes. Please utilize the link to the RFP Budget provided in the RFP.

55. **If we provide ACRA training to an MOU partner that provides MAT, is it acceptable for that partner to deliver the ACRA service to the clients?**
No. The awarded SSTRY provider is required to deliver the CRA-ACC and SBIRT services directly. See Questions 20, 34 and 35.

56. **Will the Department release a list of all attendees at the Bidder's conference?**
No, due to the virtual provision of the Bidder's Conference, a list of <u>every</u> agency in attendance is not available.

57. **Will the Department release a list of all agencies that submit a LOI?**
Yes, this will be posted to both the CT Source and DCF websites after deadline for submission of Letters of Intent.

58. **In light of the numerous questions and page length, can we put a description of the "10 most creative or non-conventional and effective community linkages opportunities" (referenced on page 30, at the end of question 6) in an appendix?**
A full description can be included as an additional appendix, but must be labeled as Appendix 14.

59. **What does "licensure compliance" (Page 21, Section C.1.D) entail?**
Licensing compliance means being in compliance with all applicable laws and regulations under DPH's substance use license.

60. **For "proof of siting:" does the Department wish to see a lease or license? (Appendix 5)**
A lease, license, letter from the municipality, etc. are all acceptable documents of proof of siting.

61. **In Appendix 9 and Appendix 10, is there a specific form we should use?**
For Appendix 9, there is no specific form or format for this information.

    For Appendix 10, there is a standard Workforce Analysis form promulgated by both the State and the federal government (available via the State or Federal CHRO websites).

62. **The proposal outline skips from E to G. Will there be an updated Proposal Outline/Table of Contents?**
This was a clerical error in development of the RFP. Proposals should substitute Section G for "F" and Section H for "G". A writeable version of the Proposal Outline with this correction will be made available as an attachment to the RFP on both the CT Source and DCF's websites.

63. How did you calculate the annual number of SBIRT's per team?

The expectation to conduct 100 SBIRTs annually per team is a very conservative number given the large geographic team areas and the large age range of the population. DCF is aware that medical professionals, schools, and other community providers perform SBIRTs already, and this RFP is not intending to reduce their capacity to do SBIRTs but to increase it. Some youth and young adults may need to have an SBIRTs at different times when situation arises or changes increasing the overall need. SBIRTs are not a one and done type of screening.

The Department kept in mind the ACC responsibilities RSS have within this contract.

64. Please confirm the required license that is needed from DPH. Is the requirement for a Substance Abuse Treatment or Mental Health license or both?

DPH reviews the services that are being provided and aligns the licensure category with the service delivery. It is not unusual to have multiple licenses in one location.

65. What documentation do we need to have for a facility in which we own the building?

If referring to proof of siting, anything indicating appropriate zoning for the services to be provided is sufficient.

If referring to proof of licensure, please refer to DPH licensing regulations.

66. It would be greatly appreciated if you could clarify a little further about the ACRA portion of TX regarding the licensing facility/space/room. We have sites that have been licensed by DPH so we are familiar with the licensing process. As far as DPH has been operating, they have required the whole facility to be licensed, not a portion of it. To our knowledge, DPH would not approve licensing just a room or a space in a facility. I am attaching DPH regulations. Perhaps, DPH has changed its regulations but we do not have knowledge of it.

DPH would need to license all locations where CRA (substance use treatment) will be delivered. Please refer to DPH licensing regulations.

67. Regarding the implementation of SBIRT. Would it be possible to partner with universities to train Master's students in this field to administer SBIRT? As we foresee that both clinicians and recovery specialists would have little time left to administer SBIRT once ACRA-ACC program is running.

While you may propose to increase SBIRT through other partnerships, the awarded provider will still be required to conduct 100 SBIRTs annually.

68. For the ACRA portion of TX, we'll be applying for the Team A region. We were wondering if we could utilize our facility in Bridgeport to see clients that live in Bridgeport, Stratford, and Norwalk, which are all neighboring cities. The idea is to see all those clients in Bridgeport by providing transportation to the clients that live in both Stratford and Norwalk. Transportation could be either provided by us or by partnering with a company that offers those services.

Your response should identify how you propose to serve clients within the priority areas. Suggestions will be considered.

69. Since the contract covers youth under age 18 and transitional age adults, will each of the locations in the priority areas need to have a DCF OPC license as well as a DPH substance abuse license? If an agency holds those licenses in other locations in the catchment area will they be considered if they have secured a locations in the priority areas but are still working to secure the licenses on the new locations?

DCF would be responsible for licensing a new Child Guidance Clinic, but substance use licensure is administered solely by DPH.

70. It was mentioned that the startup costs would be identified separately from the rest of the ongoing, annual costs of the grant– can you please confirm that the three year grant amount includes both the startup costs and the 3 years of program costs.

The funding listed in Section 1, C.3 (page 4) of the RFP is the funding available per team, per year ($315,000). A proposal budget must be submitted for 1 year of operation- $315,000 plus any requested startup, listed as 1 line in the budget. Based on date of

contract execution, the $315,000 will be prorated for the remainder of SFY22 and the startup listed will be included separately in SFY22 payments. Beginning July 1, 2022, annual funding will be $315,000.

71. **During the bidder's conference, the idea of "regionalizing" the priority areas was mentioned. Has the Department given any thought to this idea, or will a licensed site be required in each of the priority areas?**
    Regionalizing services did not yield many referrals in the current system. Referrals were received primarily from the priority areas. Your response should identify how you propose to serve clients within the priority areas. Suggestions will be considered.

72. **Please clarify how start up costs should be handled in the year 1 budget. Would the provider be expected to utilize vacancies savings in year one as part of the phase-in process to cover costs? Or should the year one budget be increased by the amount of start up resources needed?**
    See Question 70. Yes, startup costs will impact contract start dates and vacancies will be utilized to fund requested startup costs in Year 1.

73. **Would it be possible to have the SSTRY Clinicians complete the SBIRT process that is outlined as part of a larger screening and assessment in the clinic to make the process billable. This would enable the provider to maximize third party billing revenue to supplement the program expenses, which are high due to the need for multiple locations.**
    Proposals may include additional SSTRY staff to conduct SBIRTs.

74. **Can we get data on the current volume of cases and expected enrollment from each teams geographic region. Can this also be broken down by priority areas.**
    See Question #1 for current program referral information. Proposals should demonstrate a plan to outreach to referral sources in order to identify and engage the eligible population in screening and treatment to meet contract requirements.

75. **Could you please outline the specific questions you are looking to be answered in the Service Requirement section on page 22. The questions and numbering pattern in regards to question (f) looks like a statement and not a question of what you are looking for.**
    Section III, C.3(f) of the RFP requests a description of the applicant's success in achieving 5 delineated goals. That section goes on to provide a description of the Department's expectations for this service type to assist with defining the applicant's answer to the 5 goals identified at the beginning of the section.