Functional Family Therapy - Foster Care / 220222006

Questions

1. Do you want to see a budget for 7/1-6/30? Because the start data is August 15, 2022, please let us know how to handle year one of the budget. Budgets should be submitted for an annual period (7/1-6/30), with 1 line delineating all startup costs (which will not be annualized in future years).

    - First year funding will be prorated based on contract start date.

2. The RFP is requesting substantial information in limited space. Could you give additional space, so that applicants can thoroughly answer all required questions?

    - No, 20 pages is sufficient for the portions of the RFP to which the 20 pages limit applies.

3. On page 11, under (c) Culturally Responsive and Diverse Organization, the RFP states, "Provide a copy of your agency's Notification to Bidder's Package as Attachment 6. Utilizing your Workforce Analysis, please provide a narrative assessment of how your agency's staffing composition is reflective of the population in the community(ides) you are proposing to serve." *Should the narrative description of how our agency's staffing composition is reflective of the population we are proposing to serve be included as part of Attachment 6, or should it be included as part of Section 2c2 of the Main Proposal.*

    - The narrative portion should be included as part of the Main proposal, not the attachments. The Notification to Bidder's Package is the attachment.

4. On page 11, under (c) Culturally Responsive and Diverse Organization, the RFP states, "If your agency has developed and implemented a CLAS Plan…, please describe what follow-up has occurred within your agency to further the Plan's implementation. Provide a copy of your agency's CLAS Plan as Attachment 7. *Should the follow-up description of our agency's CLAS Plan implementation be placed with the CLAS Plan as part of Attachment 7, or should it be included as part of Section 2c3 of the Main Proposal?*

    - The description (narrative) portion should be included as part of the Main proposal, not the attachments. The CLAS Plan (if there is one) is the attachment.

5. What is the payment structure to the agency and foster parent? Is there a set per diem rate to the family? to the agency? If, so what is that rate for each?

    - Foster parent stipends will not change as part of this procurement and the provider awarded a contract as a result of this RFP will not be involved in stipend payments, unless paying for respite nights. DCF will manage monthly stipend payments directly to the foster parent.

6. What are the expected tasks of TFC case management?

- RFP- Section 3 (k) For the 25% of the children completing the FFT FC program who do not reunify and no longer need the EBT they will receive the following services: Once per month face to face visitation, assessment of needs with corresponding treatment plan and coordination of services. Families of these children will receive 14 days of paid respite to be coordinated and paid for by the child's DCF Social Worker. Documentation will be maintained by the Contractor in Care4.

7. How is TFC case management determined?

    - Children who complete FFT FC and do not achieve legal permanency. Please refer to Part II, Section C.3 (k) of the RFP.

8. How is TFC being paid to the contracted agency?

    - The contracted funding allocated in the RFP will be paid on a quarterly, prospective basis, upon receipt and acceptance of a line item budget submitted at the beginning of each fiscal year, with funding cost settled at the end of every fiscal year and unspent funds returned to the State (as per state statute). This quarterly payment will include respite funding but will not include the daily rate for children maintained under the TFC Case Management component of the program. This rate will be paid separately to the provider on a monthly fee-for-service basis.

9. Is there an expected set aside amount required by the agency for providing wraparound services to the family/child, such as mentoring, after school care or summer camp programming?

    - No

10. What is the expected process of transition of current children/youth/families to the new model implementation?

    - Children will be identified by DCF using The NCTSN Trauma Screening Tool and RRG Mental Health Consultation. Mental Health consultation is between the DCF CPS Team and RRG Licensed Clinical Staff. Families will receive an introductory overview of FFT FC. TFC Families who do not want to participate in FFT FC can end their foster care license or transition to DCF and provide a Core level of foster care. At the time contracts are awarded DCF will have a complete implementation plan.

11. What is the formula DCF used to determine the funding amount for each area office?

    - DCF undertook a rigorous cost analysis process prior to arriving at the allocations per office. This analysis included review of current TFC salary ranges, salary ranges for positions of like type across all DCF funded services and review of salary ranges for required positions through the website Zippia. The highest salary range across these 3 milieus was used as the assumed salary range for each Team. An 18% indirect rate and a 25% direct cost rate were then applied to salary costs, with respite funding applied to that

rate. These costs were then apportioned out based on the Team allocation needed for each office (based on capacity).

12. Have you considered that a half-time supervisor is a difficult position to have for foster care? (How does FFT LLC view half-time supervisors?)

    - Clinical Site Supervisors carry cases and work to administratively manage the team (in phase 1) and clinically supervise the team (in phase 2 +). Given the size of the team we can manage the case requirement of the Site supervisor to fit.

13. Connecticut (CT) has spent the last ten years reducing the number of children in foster care. If CT is already doing better not placing children in foster care, the children who are in foster care have more challenging family situations. Is it reasonable to expect *only* 25% of the children in placement to not be reunified with their families?

    - The 25% is stated as "project approximately 25%" In other places where FFT FC is being delivered, the overall average is lower than 25%.

14. Is it the expectation that the services to be provided through case management be provided by the same clinician who has been working with the youth through FFT FC, or would services shift to another trained staff member?

    - TFC Case Management does not require a Therapist to provide services. TFC Case Management can be provided by a Bachelors level staff member at the agency.

15. Based on DCF's experience with children referred to FCT, what do you anticipate will be the proportion of kids that will be matched in two days?

    - DCF is contracting for the following: - Please see SOS Section B Service Delivery Requirements subsection 2. Referrals- For routine referrals the Contractor will identify a placement within 2 business days of receiving the referral. A disclosure meeting and placement plan to take place within 3 business days of the match.

16. On page 15 and 36, we request that you add LMFTA and psychology residents to the qualification list.

    - LMFTA will be added. Psychology residents who will have a full caseload will require a waiver by The Department and will be required to provide services under the supervision of a licensed MH practitioner. Psychology interns will not require a waiver and will practice under the supervision of a licensed MH practitioner.

17. What travel costs related to training/model consultation does the provider need to include in their budget?

    - Training will be virtual. No travel needed.

18. Will it be the expectation that the provider pays families for the 30 hours of model training (pre-certification)?

    - No. DCF does not pay foster families to complete training.

19. What is the expectation regarding payment for the 6-9 hours of FFT FC training that foster parents must complete?

    - There are no expectations. DCF does not pay foster families to complete training

20. For non-clinical siblings, what are the expectations around case management?

    - Expectations will be the same as TFC Case Management. FFT FC is a family-based intervention and all siblings will be included in treatment as a member of the family.

21. Will there be an additional reimbursement to the provider?

    - In the TFC Case Management Support 'slot', the FFT FC provider will continue to support the placement but will transition to a fee for service structure for such support, at a rate of $17.74 per day, per child for the duration of the child's placement with the family. This rate will be paid separately via an issued rate letter for the duration of the child's remaining placement with the family. Any payment for TFC Case Management Support is not calculated in the funding allocations per DCF Area Office delineated in this RFP.

22. For kindship placements outside of a FFT FC slot, can you clarify expectations? (Page 43 of the RFP)

    - In such cases FFT FC Parents may provide a core level of foster care at the DCF rates with the daily administrative rate of $17.74. This includes monthly face to face visitation, case management services and the development of a treatment plan for kinship placements. FFT FC services will only be provided should DCF assess the need for said child.

23. What is DCF anticipating as the transition from current FCT placements to the new model both in terms of inclusion in slot capacity and reimbursement implications for families?

    - FCT Foster Family daily rate will not change. No new children will be added to the FCT program. Individual children receiving FCT will be screened for appropriateness of FFT FC services.

24. What is DCF anticipating as the transition from current TFC placements to the new model both in terms of inclusion in slot capacity and reimbursement implications for families?

    - All children currently receiving TFC services will be reviewed for inclusion into FFT FC. Foster parent reimbursement will not be impacted.

25. What is DCF anticipating as the transition from current Medically Complex placements to the new model both in terms of inclusion in slot capacity and reimbursement implications for families?

    - These children are not included in the slot capacity. No new cases will be accepted into this category for TFC medically complex agencies. This refers to Medically Complex Private Class 1, 2, 3, and 4.

26. Will FFT Partners do all of the training and consultation, or will the training be subcontracted to others?

    - All of the training and ongoing Consultation is provided by FFT Partners LLC.

27. Who pays the foster parents? What is the rate?

    - DCF staff will be entering payment into LINK and made directly to foster parents. The rate is the same $55.55.

28. Who is responsible for paying for respite care?

    - The FFT-FC provider is responsible for respite care. Office funding allocations delineated in the RFP include 18 nights of respite per child, per year based on capacity established per Office.

29. Is this clinical service billable to Medicaid?

    - No

30. On page 23 of the RFP it lists "financial profile" under Section F. Can you confirm what should be provided in this section?

    - Proposers must submit cover letters from their auditor for the last three (3) annual audits of their agency and a copy of their most recent financial audit, included as Attachment 8. If the three (3) most recent audits are available via the Office of Policy and Management's EARS system, such must be noted in the proposal, and cover letters and the last audit should not be included in the proposal. If an agency has less than three annual audits, you should explain that in this section.

31. Is the contractor responsible for all salaries, mileage, phones, trainings, G&A, support programs for youth such as afterschool care, and transportation?

    - The provider is not expected to assume any responsibility for after school programming or non-placement or disruption transportation.

32. What is the staff to client ratio?

    - All staffing requirements are listed in the RFP Section 4 Staffing Requirements

33. In regard to the impact of non-TFC siblings placed with the same worker: The children would require differing levels of support and will both need to be managed and reported on. This will impact the caseload and work balance. Who will manage the non-therapeutic child, the clinician or FSS worker?

    - TFC Case Management can be provided by a Family Support Specialist. The case load can increase to accommodate non clinical siblings. This is a family based intervention.

34. Is there WRAP funding?

    - No

35. Who pays/arranges summer camp, transportation, mentoring, tutoring, etc.?

    - See Section 4 Staffing subsection iii. FFT FC Family Support Specialist b. Responsibilities. FSS - Identify and refer children and families (both birth and foster) to community-based services see also section 5 TFC Service Components Foster parents are expected to: Arranging before and after school activities; Arrange for transportation to and from activities and providing supportive participation in the activities. DCF will use WAF to pay for services not otherwise contracted or insurance based.

36. What supports are available for when clients have crises? How does the staffing model support the management of recurring crises while maintaining program model fidelity?

    - The primary goal of FFT-FC is to stabilize youth in their first foster care placement and move them toward permanency as quickly as possible. We prepare clinicians to manage the crisis that occurs and prevent ongoing cycles of crises. The RFP identifies the need for emergency placements in the case that is needed. As noted, those families also receive FFT-FC training. The delivery of the FFT intervention and maintaining the fidelity of the model is not dependent on the family's recurring crisis.

37. Has DCF done an analysis to estimate how many families will be lost due to disinterest in this model (particularly with the reduction in rate once children are moved to "support" level and increased expectations around provision of care)?

    - There is no data analysis since FFT FC is a new contract. Families will have a choice as to what level of foster care they wish to provide. Foster parent rates will not change if children are moved into TFC Case management from FFT FC.

38. How will agencies transition from TFC/FCT to new FFT FC model?

    - Once contracts are awarded DCF will work directly with the awardees on the transitioning of families. FFT Foster Care Partners have a training and implementation plan that will roll out based upon model requirements and contract award.

39. What will happen to families and kids who have been stable long term and will keep the child but are not interested in the new model?

    - These families will either be transitioned to DCF for a Core level of foster care support or remain with the TFC agency with a Core level of support / TFC Case Management.

40. Is there a fee to use CARE4?

    - Care4 is included in the overall training cost. Providers will have no additional costs related to Care4 use.

41. Is this new FFT model billable to HUSKY?

    - No, not at this time.

42. Is CARE4 the new all-inclusive EHR?

    - Care4 is a cloud-based tool used by all FFT, FFT-FC sites. It brings client-specific evidence to the treatment being provided. Care4 is both a clinical decision support tool and a participant-based research tool.

43. Will all new referrals be attached to a bio family already agreeing to this program?

    - Some children referred to FFT FC will not have an identified permanency resource.

44. If not, who finds them and prepares them?

    - The FFT FC Recruiter is responsible for child specific recruitment. See Section 4 Staffing subsection iv Recruiter & Licensing Specialist b. Responsibilities. FFT FC is provided once to the FFT FC Family and again to the permanency resource by the FFT FC Therapist.

45. When does the clock start ticking?

    - Recruitment is required as soon as the referral is made.

46. When a child disrupts to another agency does the clinical work start all over with new timelines?

    - If a child is removed from a foster family and placed into a different foster family, the clinical work does start over with the new foster family.

47. How were the service numbers for each area office derived?

    - Numbers were based on DCF data for children currently placed and children waiting for TFC.

48. What happens to kids already in our program with no identified kin who are in long-term stable placements?

    - If children do not qualify for FFT FC they will receive TFC Case Management Services.

49. There are no funds for agency vehicles. Will FCT be converted to mileage reimbursement?

    - No

50. How many assessments/surveys are required for FFT-FC and how frequently are they done? What impact will this have on visits and time required for the work? Who does them?

    - There is a comprehensive intake and discharge assessment process. During treatment families complete a short weekly survey rating the alliance, progress and impact they experienced in that session. That material goes into Care4 and is turned into session planning feedback for the clinician. This process takes between 5 and 10 min.

51. The RFP states that DCF is not responsible for finding placement when children disrupt from a TFC-approved home, but the Department – not the contractor – is custodian of the child. Please clarify who is responsible for placement.

    - The Department, like with most of its direct service obligations, contracts with private provider partners for adherence to those obligations. We are contracting and paying for a provider to manage placements/disruptions. The Department will never leave a child with no resources, but the ability of the contracted provider to meet its contractual obligations regarding management of disruptions will be a measured outcome of the contract.

52. How many TFC case management support slots are supported by the staffing model provided by the Department?

    - TFC Case Management will be Link paid and not part of the FFT FC slot capacity. DCF anticipates up to 25 % will require TFC Case Management.

53. Is the $17.74 rate for the foster families, or for the providers?

    - $17.74 is the daily rate for TFC Case Management which will be Link paid.

54. The RFP states that cases that do not reach permanency will transition to a core level of support. Will they be supported by DCF or by the private providers?

    - Families will have a choice to remain with the TFC Agency for TFC Case Management or transfer to DCF.

55. The RFP does not identify the position of Program Director in the proposal or the scope of service, is it expected that the Clinical Supervisor oversees all aspects of the program as well?

    - The Clinical Supervisor will have both administrative and clinical oversight of the program.

56. Will consideration be given to grandfathering in or waiving licensure requirements for the clinical supervisor and therapist positions for years of experience if there is managerial clinical licensure oversite?

    - FFT FC Clinical Supervisor- DCF will allow a 1-year provisional waiver for staff who are license eligible. Candidate must have 1-year experience providing direct supervision and 2 years' experience providing services to children and or families with significant behavioral health needs. Requests for the 1-year waiver should be submitted with the RFP. Those receiving a waiver will be required to obtain their full license within the 1-year time frame (Example LCSW, LPC or LMFT).

    - FFT FC Therapist- Licensed, or licensed eligible mental health professional. DCF will allow a 1-year provisional waiver for staff who are master's license eligible. Candidate should have at least 1-year experience providing services to children and or families with significant behavioral health needs. Requests for the 1-year waiver should be submitted with the RFP. Those receiving a waiver will be required to obtain their license within the 1-year time frame (Example LMSW, LPCA, LMFTA)

57. Can part time Therapist/Family Support Specialists positions be utilized to reduce costs?

    - Sufficient staffing is required to meet model adherence and contract requirements. Waiver will be considered on a case by case basis. Waivers should be submitted with responding to the RFP.

58. Is there a cost per person involved in training in the FFT model?

    - Training cost is a part of the contract between the state of CT and FFT Partners. The initial team training cost is based on a team rate. If a clinician leaves during the first year of implementation, there is no additional cost per person involved in the training. Hence, if there is clinician turnover within the first year, this is no charge for replacement training. In subsequent years, there is a cost per clinician training.

59. If a youth completes the FFT service and does not reunify can their support services in this home be transferred to another staff to provide care management?

    - Yes TFC Case Management can be done by another staff member who is a Bachelors level.

60. If staff are holding a caseload of 12 how can they add case management time to that case load for the cases that move past the 9 months?

- The FSS provides case management. The integration of case management is an essential feature of coordinated care in the FFT-FC model. This ratio has been easily managed by other teams.

61. How was the caseload capacity determined for the Therapists and Family Support Specialists?

    - 12:1 is the “average” caseload. Caseloads will fluctuate as family's complete treatment and new families start. Previous trials suggest that model fidelity can be maintained at this ratio.

62. How is a therapist or Family support specialist in a 40 hour work week expected to minimally have 1 in home family session with each assigned youth a week (+12 hours), provide supervised visitation with birth family (12 hours) attend family court and administrative case reviews, conduct assessments with both families, develop treatment plans and facilitate their reviews, develop safety plans as needed, document in CARE4, as well as participate in all model and agency trainings, peer and individual supervisions, and staff meetings, and commute to and from out of office expectations?

    - In home Evidence Based Practices have been operating successfully in Connecticut for the past 20 years with similar requirements.

63. Does this budget include costs associated with program implementation such as travel expenses/time needed to travel to sessions, training (materials), licensing expenses, respite costs, billing, and administrative oversight?

    - Yes

64. What exactly does the proposed budget cover?

    - The established budget covers all salary, fringe, direct fixed costs, indirect (A/G) and respite costs associated with operating the program.

    - The established budget does not include foster parent stipends (other than respite payments), funding for 'WRAP' services determined to be needed for the child by the DCF CPS Team, or the TFC Case Management rate to be paid to providers on a fee-for-service basis.

65. Does the proposed budget include foster parent stipends?

    - No

66. Who will be paying for the Care4 software?

    - Care4 is included in the contract there is no additional cost.

67. Besides data collection in the Care4 program does DCF have any other requirements for data entry in PIE?

    - Providers will also be entering data into PIE. The department is working on a mechanism to ensure data integration from Care4 data into PIE in an effort to avoid duplication however that is not finalized to date.

68. Will the foster parent rate of stipend change to the core rate if the child remains in the foster home after completion of the FFT service?

    - At this time foster parent rates will not change

69. If a foster parent maintains a child in their home who completed FFT and no longer meets the needs for this level of care would a waiver be required to place a new FFT referred youth in this home?

    - No, however the agency is responsible for managing the acuity of said child(ren). FFT FC is a clinical level of treatment and Foster Families and TFC agencies would be required to meet the needs of children placed.

70. APRN/Psych: Is this expenditure included in this proposed budget?

    - Yes

71. The budget reflects higher education requirements including licensing and APRN/Psych time how does the proposed budget support these higher staffing standards which will result in major increases in the salary and benefits?

    - The budget was inclusive of the salary structure commensurate with the APRN/psych positions.

72. What funding will be covered by Medicaid?

    - None

73. If a clinical supervisors ratio is 1:6 therapists who supervised the recruiter and family support specialists?

    - The Clinical Supervisor will provide at least monthly supervision to the FSS and recruiter.

74. With the numbers presented in the RFP, and a budget of $13.75 million for 588 slots, that is a daily rate of approximately $65 a day, less than half of the current wrap TFC rate of $139.77. How would it be possible to fund an agency's solvency, plus the addition of a therapist also visiting the home weekly?

    - The TFC rate quoted above would have been inclusive of the $55.55/day stipend payment to foster parents and the $10.10/day Wrap payment per child. The new model

relies on DCF directly paying the foster parent stipend and DCF staff assessing and determining any wraparound services needed for the child and implementing those within the DCF regional support structure.

75. Each respondent is to submit a budget. Will payment be based upon budget submitted meaning there could be as many as 14 different rates for the service?

    - No. With this redesign, there are no more 'rates'. The budget was designed as detailed earlier in this document and tied to the capacity needed by Area Office. As such, like DCF pays its other contracted providers, line item budgets will be submitted at the beginning of each fiscal year for the allocated annual amount. Those budgets are reviewed and approved by DCF. Payments throughout the fiscal year are made quarterly prospectively (July, October, January, April). At the end of each fiscal year, the provider is required to submit a year end expense report based on their approved line item budget. That expense report is reviewed and cost settled by DCF staff.

76. What is the slot ratio for the TCF Case Manager? Given that it is currently 1:9, how would a 33% increase in caseload size be compensated for or possible, by one FTE?

    - Caseload ratios for this component of the program mirror caseload ratios of DCF FASU staff, as the function under this component of the program mirror DCF FASU functions.

77. Will foster parent payments be paid directly from the state?

    - Yes

78. Will there be a foster parent rate increase recognizing their additional responsibilities?

    - No

79. Will funding be added to cover the costs of an Office Manager?

    - No

80. Will funding be added to cover the costs of a Program Director?

    - No

81. What if insurance cannot be obtained to pay for clients with acute behavior needs\issues. Who would pay for the necessary support?

    - Children's Behavioral Health needs are met by insurance-based funding and DCF contracts. Services are coordinated by FFT Therapist ad payment by insurance company and or DCF contracts.

82. Why is the funding different in area offices that serve the same amount of slots?

- It isn't. It's exactly the same funding for the offices serving same capacities.

83. Are future employees to be trained by FFT staff and for what period of time?

    - The training cost are a part of the contract between the state of CT and FFT Partners. The initial team training cost is based on a team rate. If a clinician leaves during the first year of implementation, there is no additional cost per person involved in the training. Hence, if there is clinician turnover within the first year, this is no charge for replacement training. In subsequent years, there is a cost per clinician training.

84. The RFP is looking for 13-14 agencies to be awarded. Has it been considered that if 2-3 agencies close as a result of this process, not all of their families will be willing to transfer to other agencies and will likely retire, further widening the gap between resources and the need for placement?

    - Based upon experience not all families will choose to close, past experience has shown families committed to caring for children have transferred to other Child Placing Agencies.

85. Has the Department considered the impact on agency resources if 25% of youth do not transition after the FFT period but remain in a TFC bed meaning that the agency loses a TFC slot?

    - 25% is a projected analysis, the actual numbers are yet to be determined since EBT has never been provided in therapeutic foster care. Continuous recruitment will be needed to fulfill contractual obligations in FFT FC capacity.

86. What if this level of care is not in line with the families' needs? Perhaps a family may need 3 or more visits per week for several weeks. Is this compensated somehow? What would be the next step toward a higher level of care or services for this family?

    - FFT FC is delivered on a as needed dosage meaning families receive the support they need. FFT FC is an EBT and will be the highest level of foster care offered.

87. A worker (therapist and family support person) is contracted to see 12 families in a week. This will require evening and weekend hours for family visitation. In addition, workers are to be accessible daily to their families for support, meetings and supervision. Has the Department considered this will make it more difficult to find and keep qualified staff as they would need to give up weekends and evenings?

    - Caseload size and dosage of contact are based on the Evidence Based Treatment of FFT in FC. Requirements in are in line with other similar Evidence Based Practice(s). In home Evidence Based Practices have been operating successfully in Connecticut for the past 20 years.

88. Has the Department considered that many of our experienced staff may leave due to this change in hours and increased demand for their time?

    - Staff turnover is to be expected when contract and program requirements change.

89. Given the need for a continuum of care, what state services will be available to support the community providers when caring for children and families?

    - All FFT FC youth will have access to Insurance based services as well as the full complement of DCF contracts in addition to WAF and USE plans for non-contracted services.

90. What is the stipend for foster parents, and who pays it? Is this included in the funding allocations published in the RFP?

    - $55.55 and DCF pays this directly to the FP- no provider involvement

91. The allocated funding seems insufficient to pay for the staffing, particularly considering the clinical salaries that will be required to attract staff given the credentials required and the workforce challenges.

    - Funding was developed using the highest of the salary allocations for the Team's positions based on a review of existing pay scales in DCF contracts for comparable positions, the existing TFC rates and Zippia rates. Added to this was the current DCF average of 25% direct expenses and 15% indirect expenses plus respite costs at $55.55 per night, 18 nights per year, per slot.

92. Is the Department anticipating that providers are billing Medicaid for FFT? The RFP makes no mention of this and does not require that applicants be or be able to be enrolled as a CMAP providers.

    - Not at this time.

93. Does the plan or model provide for Wraparound funds? Are providers expected to include these in their budget?

    - No. If a child is in need of WRAP funding, that determination will be made by the DCF CPS Team, and requested through DCF's internal WAF process.

94. Providers are anxious about caseloads, which are increased to 12. Can you share your thinking around the decision-making that helped inform this change?

    - This is the caseload ratio promulgated by the FFT FC model.

95. The RFP states multiple times that the Department is not responsible for finding placement when children disrupt from a TFC approved home. Can the State, as guardian, abdicate itself from this role, as custody is not being transferred to the private provider?

- The Department, like with any direct service, contracts for its obligations. We are contracting and paying for a provider to manage placements/disruptions. Obviously, the Department will not leave a child with no resource, but the ability of the contracted provider to meet its contractual obligations regarding management of disruptions will be a measured outcome of the contract.

96. The RFP does not address children currently in placement who are in stable long-term placement with families who consider the child part of their family and where there is no plan for reunification.

    - Children in current TFC placement who are deemed eligible to receive FFT-FC services will be 'placed' in the FFT-FC program on day 1 as a new 'slot' and will progress through the program as described in the RFP. Children in current TFC placement who are deemed ineligible to receive FFT FC services will remain in current placement at a rate of $55.55 per day to the foster family, and will be 'placed' with the FFT FC provider as TFC Support only, at a rate of $17.74 per day to the provider for support services as defined in the RFP.

97. There is concern and some confusion about the children who do not reunify. Where does the 25 percent estimate come from?

    - This is the average percentage of children who do not reunify based on the outcomes promulgated by the model.

98. Can multiple agencies be awarded a contract for one AO?

    - Yes

99. Will a data position of some type to be considered?

    - No

100. What happens when the contracted agency is not able to match the referred youth?

    - It is the responsibility of the contracted agency to find placement. Contracted agencies can work with other partners, it will not be the responsibility of DCF to identify the placement resource. Outcome measure will be closely monitored for contract compliance.

101. Is this considered a grant contract whereby funds are required to be spent according to a line-item budget and unspent funds need to be returned to DCF?

    - Yes, funds are to be spent per DCF contract. If revisions are needed, agencies can submit budget revisions. Unspent funds will be returned to the department.

102. In the bidders conference, it was noted that no startup funding would be provided however, on page 18 of the RFP it requires a detailed listing of startup costs in the budget requirements section. To clarify, is startup funding available for this grant or not?
    - Start up costs may be proposed. Agencies should identify those costs in the proposed budgets. There would be no additional funding to cover the start up cost.

103. The ratio for clinical supervisor to therapist is 1:6 as stated on page 14 of the RFP. Given this information, why does New Haven for example need 1.5 Clinical Supervisors when they will only have 5 therapists on staff? Same for Waterbury, the RFP is requiring 2 clinical supervisors when only 7 therapists are needed, should the requirement not equate to 1.5 Clinical Supervisors?

    - That is a data entry error in the RFP. The FFT FC model promulgates a 1:4 supervisor to therapist ratio.

104. Although the new FFT-FC model is contract based, it can be broken down into a per slot cost for the purposes of comparison. Following is the formula we used to calculate the "per slot cost" under the FFT-FC model: $13,750,000 (Total Funding)/ 588 (total # of slots)/365 day/yr = $64.07 per slot cost. CPAs currently receive $74.12 per TFC child per day. This amounts to a 14% reduction in funding. Is it the goal of this contract to reduce funding for this population? If so, is that because DCF is going to look to other potential funding sources for FFT-FC services, e.g., Medicaid?

    - There are no other funding sources for this contract.

105. Psychiatrist/APRN Does the funding include paying the prescribers for their services?

    - Yes

106. Psychiatrist/APRN Does medication management services need to be provided in the service location, i.e., are services to be provided in the home, in an on-site program office, in a prescriber's private office, or virtually?

    - Services can be office based.

107. Psychiatrist/APRN How do prescribers fit into the model, e.g., Do they need to be trained in FFT-FC?

    - Psychiatrist/APRN will receive training in FFT FC and are part of the clinical team similar to other In Home EBT.

108. Psychiatrist/APRN How do prescribers fit into the model, e.g., Do they have specific FFT-FC documentation that they need to complete?

    - All documentation will be completed in Care4.

109. Psychiatrist/APRN How do prescribers fit into the model, e.g., If a child is referred and they already have a prescriber, can the child keep their current prescriber, or do they have to be transitioned to the FFT-FC prescriber?

- Children can keep their current prescriber.

110. Are all current TFC, FCT, and MC children going to begin the new FFT-FC model, or will they be assessed for FFT-FC and only those kids deemed eligible for FFT-FC be referred? If it will be based on an assessment, what will happen to current TFC, FCT, MC children who are not deemed eligible for FFT-FC? Will they be transferred to DCF core services, or will they remain with placing agencies under the case management model.

- Children currently in TFC and FCT placement will be redetermined for FFT FC.

111. Will DCF need to transfer clients and/or families among agencies in LINK? If so, what will the coordination between DCF and providers be to ensure that this change is made correctly and in a timely manner?

- DCF is preparing for the possibility of Foster Families transferring and will collaborate with all stakeholders to ensure a smooth transition.

112. Given the number of questions and the late date in posting, will the department consider delaying submission to a later date? Will it consider delaying the program start date?

- No

113. If a child needs to be removed from their placement for any reason (e.g., disruption, foster parents no longer able to provide care, etc.) and the child is placed in a new home, will they need to begin the full FFT-FC intervention again?

- Yes

114. Given that FFT-FC is comprised of two phases of service implementation (6-9 months of services while the child is in placement, and 3-4 months of post-reunification services), if a child is not going to be reunified and their permanency plan is for their current foster family to assume legal guardianship (i.e., they will be staying in the home they're currently placed in), will the child/family receive the same 3-4 months of post-reunification FFT-FC services or will their FFT-FC services be complete after the first 6-9 months?

- FFT FC services are complete if the child remains in the TFC home

115. What happens if after the child/family completes their prescribed course of FFT FC treatment it is determined that they are not ready for discharge? Does another unmodified round of FFT-FC begin? Does FFT-FC continue in a modified form? Are the client and/or family referred to another provider, e.g. IICAPS, outpatient therapy, etc.?

- This will be case specific as to the reason why the child is not discharging. Clinical services are matched to client need.

116. Can the child be in individual therapy while in FFT-FC?

- Yes, with close collaboration of the FFT FC Treatment team.

117. Per the RFP, foster parents will receive FFT-FC training from the model developer, will periodic FFT FC training be offered as new homes are recruited? And how will this be handled after implementation?

- The Foster Parent Training will be delivered by the FFT-FC local team. They will be trained to deliver the training and then deliver it as new parents are recruited.

118. Can information entered in the Care4 system be downloaded into an agency owned electronic record keeping system and/or can agencies run reports in Care4 system for the purposes of internal compliance monitoring, QI procedures, etc.?

- Care4 has the capability to link (via API) to other systems. In addition, all the material in the system is downloadable to excel, pdf, or word. Care4 also has internal reports and other compliance features that agencies can use for compliance and QI (etc). Training on the Care4 system will be offered to the administration/QI teams at local agencies

119. Will interns be allowed to work in the FFT-FC model?

- Yes, under the supervision of a licensed practitioner.

120. Is it accurate that the Department is looking for 13 teams (page 3 of RFP) but number of awards is “up to 14” (page 4 of RFP)?

- Yes

121. How will the provider (contractor) be compensated if the referrals exceed the identified number of “slots” from the Area Office?

- While we project sufficient slot capacity for each office, the department will address the overcapacity as it becomes known. The Department does not expect you to place children when over capacity without compensation.

122. Is there any allowance for deviation from the daily respite rate of $55.55 for some of the more challenging youth?

- No. DCF established rates are not allowed to be changed.

123. What is the expected / realistic “turnaround” time between identifying the need and getting approval for a wrap service contractor to provide the service?

- The need for additional fee for service needs should be collaboratively addressed through the CPS and the process to access those funds must follow agency protocol through use of WAF or USE plans.

124. Will the Department pay the wrap services providers directly?

- Yes

125. Will selected provider agencies receive the specified funding amounts as a grant, or based on some census/utilization/fee-for-service formula?

- The selected provider will be paid through grant funding. The board of care of the child will be paid directly to the foster parents through a LINK payment.

126. Please confirm that selected provider agencies will receive the amount specified in the RFP as a base grant PLUS a daily rate of $17.74 per day for each child in foster care placement who is in a TFC Case Management Support 'slot'.

- Yes.

127. Each respondent is to submit a budget. Will payment be based upon budget submitted meaning there

- The budget total for each area office is the budget award for this RFP

128. There could be as many as 14 different rates for the service?

- No. With this redesign, there are no more 'rates'. The budget was designed as detailed earlier in this document and tied to the capacity needed by Area Office. As such, like DCF pays its other contracted providers, line item budgets will be submitted at the beginning of each fiscal year for the allocated annual amount. Those budgets are reviewed and approved by DCF. Payments throughout the fiscal year are made quarterly prospectively (July, October, January, April). At the end of each fiscal year, the provider is required to submit a year end expense report based on their approved line item budget. That expense report is reviewed and cost settled by DCF staff.

129. How will agencies be paid? By cost reimbursement, unit rate, or something else?

- The contracted funding allocated in the RFP will be paid on a quarterly, prospective basis, upon receipt and acceptance of a line item budget submitted at the beginning of each fiscal year, with funding cost settled at the end of every fiscal year and unspent funds returned to the State (as per state statute). This quarterly payment will include respite funding but will not include the daily rate for children maintained under the TFC Case Management component of the program. This rate will be paid separately to the provider on a monthly fee-for-service basis.

130. If we submit and are awarded two area offices can we ultimately just decide to provide services to one given size limitations?

- No. If you are awarded an area office we would expect you to serve the office your are awarded.

131. Can you include the Timetable/Schedule and Tasks and Deliverables as one attachment or are they counted as part of the 20 page limit?

- The workplan and implementation Timeline is part of the 20 age limit.

132. It appears that when New Jersey implemented FFT-FC it was done with a targeted, phased implementation plan. They began with a cohort of 15-20 families who wanted to work with adolescents, and then moved to a second cohort of a similar size, etc. Given this information, it does not appear that there is enough time between when the contract is supposed to be awarded and when services are supposed to begin to do a statewide implementation of FFT-FC. Based on this we have the following questions:

- The FFT-FC project in NJ was not a phased approach. Youth were accepted as they met criteria and as case load opening appeared.

133. What is DCF's plan to help coordinate or oversee the statewide implementation of FFT-FC?

- We have a carefully constructed implementation plan for the rollout of FFT in collaboration with the State. The State is already working closely with FFT-Partners to determine implementation guidelines and benchmark

134. Is the expectation that placing agencies will be solely responsible for the introduction and implementation of FFT-FC to foster families and clients?

- Methods to introduce FFT-FC to foster families is a component of the implementation plan and training offered to agencies. This will be done in collaboration with the State, FFT-Partners and community agency partners.

135. If that responsibility does fall solely on the placing agencies, how will FFT-FC model developers be involved in the implementation process?

- FFT-Partners will coordinate the implementation process working with Community placing agencies and the State.

136. It also appears that FFT-FC was designed to be done with adolescents. Will there be any modifications in the model to accommodate working with young and latency age children?

- FFT-FC is designed for children/youth of all ages. The model has been adjusted to meet the needs of younger youth. FFT Foster Care is available to children age 6 and up.

137. Also, it appears that the FFT model is not appropriate for all behavioral health diagnoses, including ASD, active substance abuse, cognitive impairments, complex trauma, and internalizing disorders. Will there be modifications to the model to work with children whose diagnoses fall outside of what FFT is designed to treat?

- FFT is designated as a treatment of substance use, trauma and internalizing disorders and has research findings to indicate the improvement of symptoms in all of these areas. FFT is currently being practice in large child welfare agencies/systems with just this type of youth with positive results. ASD youth would receive extra services to supplement FFT treatment

138. While several FFT models are considered evidence based, FFT-FC is currently not. Is CT's use of FFT-FC going to be used to help build the evidence base for FFT-FC? And if so, how will that impact the implementation of the model?

- There will be an evaluation component to the project. There will be no disruption to the implementation as a result. Data will be collected as part of ongoing work flow through the Care4 system.
- FFT is a single model that has a longstanding evidence base. That evidence base suggests FFT has been repeated effectively in stabilizing families, reducing out-of-home placements, improving reunification, reducing mental health and substance abuse issues with youth, and improving youth behavior issues. FFT in foster care (FFT-FC) is the same FFT model used first in the foster home and then in the permanency home.

139. Also, since FFT-FC is not an evidence based model what was the basis for the decision making around the following matters: Staff licensure requirements, Staffing patterns, Implementation plan and timeline, Age of clients eligible for FFT-FC, Inclusion/exclusion criteria for children being referred to FFT-FC

- FFT is a single model that has a longstanding evidence base. Issues of staff requirements, and patterns are based on collaboration with the State regulations. Ages and inclusion/exclusion criteria are the same as for any FFT project.

140. Can DCF and/or model developers share any research they used to help inform these decisions as this may prove helpful in writing a proposal.

- There is extensive literature available on the effectiveness and efficacy of this evidence-based model. This research is widely available on internet or other periodicals.

141. New Jersey no longer uses FFT-FC, can DCF or the model developer tell us why?

- The project in NJ was very successful. After the initial pilot, the State had a change in leadership and struggled with the blending of funding to make the project sustainable.

142. Given that this is not an evidenced model, what is the basis for DCF's assumption that 25% of the kids in FFT-FC will require case management, i.e., how did you arrive at 25%?

- FFT is a single model that has a longstanding evidence base. The assumption is that all cases will need some degree of case management. There is no suggestion that only 25% will need Case Management.

143. Given that there is no evidence for this model, would DCF consider: Pulling back the RFP in favor of a Request for Qualifications and do a fit and feasibility pilot with one or two offices?

- There is significant data and research supporting the efficacy of FFT. The selection of this model was in collaboration with both the department and various stakeholders including Therapeutic Foster Care Agencies.

144. Which sections identified in the RFP do the 20 pages limit apply to? (For example, is section E the one that has the 20 page limit?)

- On page 22 of the RFP the section under Main Proposal 1 - 9 are all inclusive of the 20 page limit.

145. Can you confirm that the funding for this contract is changing to an annual grant in the amount listed on page 4 of the RFP for each Area Office? For example the funding for the Bridgeport Area Office is $1,082,139 to the contracted provider?

- Yes, the amount listed is the grant funding to be awarded for that office.

146. Does DCF have a plan to finance the need to add team members when the number of placements exceed the model slot ratio or need in the area?

- If there is a need for additional slots, the department will take into consideration all variable on a cases by case basis.

147. Can you provide a list of the current Therapeutic Foster Care, TFC-Medically Complex, and Family and Community Ties Foster Care providers by Area Office?

- **Family and Community Ties:**
    1. Aspire Living & Learning, Inc.
    2. Community Residences Inc
    3. Family & Children's Agency, Inc.
    4. Village for Families and Children, Inc.
    5. Wheeler Clinic, Inc.

  Therapeutic Foster Care:

    1. Aspire Living & Learning, Inc.
    2. Boys and Girls Village, Inc.
    3. Children's Community Programs of Connecticut, Inc.
    4. Community Health Resources, Inc.

5. Community Residences Inc
6. Connection, Inc.
7. Family & Children's Agency, Inc.
8. Family & Children's Aid, Inc.
9. Hopewell Inc.
10. Jewish Family Services of New Haven, Inc.
11. Klingberg Comprehensive Family Services, Inc.
12. New Opportunities, Inc.
13. NAFI Connecticut Inc.
14. Village for Families and Children, Inc.
15. Waterford Country School, Inc.
16. Wheeler Clinic, Inc.

Therapeutic Foster Care - Medically Complex:

1. Children's Community Programs of Connecticut, Inc.
2. Community Residences Inc
3. Family & Children's Agency, Inc.
4. Jewish Family Services of New Haven, Inc.
5. Village for Families and Children, Inc.
6. Waterford Country School, Inc.
7. Wheeler Clinic, Inc.

148. Can you describe the process and timeframe to get fingerprinting and criminal background checks of potential foster parents completed for contracted providers?

- There is no change to this process

149. Using average starting salaries that we believe will be required to attract contractually qualified applicants, known mileage costs and minimal occupancy and operational costs, there does not appear to be enough money allocated in the RFP to fully fund the program by about 10- 15%. To account for that, will the department accept proposals that either include the actual estimated funding amount necessary to operate the program as outlined in the RFP or accept proposals with reduced staffing so as to reduce costs to the amount allowed in the RFP?

- The staffing model is consistent with the FFT Foster Care model. It is our expectation that proposals meet the minimum expectations outlined in the RFP.

150. There seems to be an exorbitant amount of psychiatric / ARPN time required in the staffing outline. Would a proposal with less weekly hours of psychiatric/APRN time be considered?

- Yes, as long as the needs of the child/youth is not impacted by the reduction.

151. There is a discrepancy between APRN hours in the staffing table with the Slot Ratios and the table with the # of Hours per Week in the Staffing Requirements section (Item 4). Which source is correct?

- There is no discrepancy, APRN/psych hours are based on 20 minutes per client which equates to 15 hours per 48 clients. The hours delineated in the RFP (section 4 staffing) follow that formula.

152. Can Bachelor level employees in our current TFC program without the exact correct degree be grandfathered into the FFT program in the Family Support Specialist role?

- The department will require a waiver that outlines the candidates experience and recommendation for such approval.

153. Are the Clinical Supervisors and Therapists expected to be on call 24/7 as part of the model?

- An on-call system should be outlined in the proposals. Most EBT have a rotation for on call.

154. How many hard copies of the proposal is DCF requesting? RFP states 5, the Bidders Conference mentioned 9.

- We are requiring seven (7) copies of each proposal submitted. The RFP will be updated with Change.

155. If applying for more than one area office, must applicants submit completely separate proposals for each area office? With separate and distinct responses and budgets for each area office in each proposal? Separate proposals will not allow for fiscal efficiencies if a provider contracts for more than one region. For example, Norwich and Willimantic each require 1 FTE Supervisor for a team of three and Middletown requires a 0.5 FTE Supervisor for a team of one. If the region were combined there would 7 teams and only 2 FTE supervisors would be needed to stay within the 1:4 ration of supervisors to teams, saving the expense of a 0.5 FTE Supervisor.

- Yes. If contracts are awarded to same provider for multiple offices in the same region, staff ratios will be determined at time of negotiation.

156. A major intended outcome of Connecticut's Family First Prevention Plan includes "enhancement of existing Evidence Based Programs available within local communities leading to families remaining safely together". The California Clearinghouse on EBPs for Child Welfare rates FFT-FC (and FFT-CW) as "Unable to Rate". Given that the Plan emphasizes EBPs, why would DCF move to a foster care model that is not an EBP?

- The California Clearinghouse and the FFPA do not currently rate any of the standard EBP adaptions (whether FFT or not). FFT-FC is a model that has two doses of FFT (one with the

Foster Home and one with the permanency placement). Thus, it is an FFT model in a Foster Care context. Evaluation research suggests this contextualization is effective.

157. The original FFT model is for adolescents (11-18). How does the department envision this working with younger children, as outlined in the RFP?

- FFT is currently used and has been used with youth 0-18 in Child welfare systems in the US. FFT-FC is designed to work with youth 0-18 in a foster care setting. The Connecticut contract applies only to children ages 6 - 17.

158. Given that the model has been adapted for this RFP, what factored into DCF's choice to go to full scale implementation rather than testing feasibility via a pilot program?

- This model was not adapted specifically for Connecticut foster care.

159. Knowing that New Jersey is no longer using this model, how has DCF incorporated their lessons learned into this RFP?

- Lessons learn have already been incorporated into the implementation plan. The major implementation issue was ensuring that the necessary blending of funds was possible and operational at the State level. FFT is working closely with the state to collaboratively implement the model and overcome these and any other issues

160. How are the % of children who will not reunify calculated into the team capacity (page 10) given that this population will not be counted as a 'slot' against the contracted capacity (page 12)?

- The children who do not reunify were not calculated in the slot capacity.

161. How did DCF come to the rate of reunification (75%) given that recent state rates are below 45%?

- The 75% is the goal of reaching permanency, not exclusively reunification.

162. In the RFP, DCF delineates the number of slots per area office. Is this the maximum number of children to be served per year?

- The slot number is based on projections.

163. The Department intends to issue 14 contracts and a proposer can submit multiple proposals to serve multiple area offices. Is there a maximum number of awards per organization? (e.g. An organization can receive a maximum of ## FFT FC contracts).

- No

164. Can an organization add additional staffing (e.g. a Case Manager for the children who will not reunify; a Manager/Director to supervise the Clinical Supervisors)?

- An organization can add staffing however there is no additional grant funds for additional staffing. The $17.74 daily rate can be used toward additional staffing for TFC Case Management.

165. Who is tasked with supervising the Clinical Supervisors?

- All licensed staff must follow Professional requirements as described by the Department of Public Health. Supervisory oversight is at the discretion of the agency.

166. Do the Clinical Supervisors have to carry a client/case load in order to be "certified" in the FFT model? Would the requirement be the same for the Program Director?

- In the FFT Training model, Clinical supervisors take over the responsibility of the FFT program in year 2 as they learn the FFT Supervision Model. To do so, they need to be certified and proficient in the model. That happens in Year1. Program Directors do not need to be certified in the FFT model. It is recommended that Program Directors attend all training, so they are aware of the model and its processes.

167. What does the DCF WAF process cover as far as emergency services? (e.g. Child is suspended from school and needs childcare/supervision for the day)

- See page 39 of SOS 5. TFC Service Components.

168. What is the rationale behind taking away the WRAP dollars from private providers?

- There were multiple reasons for this decision including, greater fiscal oversight, state auditing recommendations and a collaborative approach to service decisions with the CPS team therefore meeting the needs of children.

169. What will the level of care be for current medically complex youth?

- There are no changes to medically complex youth

170. Does the Clinician always work with the same Family Support worker or is this interchangeable?

- Therapist and FSS work as a team

171. Can FPs still become licensed for respite only?

- There are approximately 161 respite only TFC homes statewide. The licensing of respite homes does not impact the contract capacity.
- The need continues to be homes that are willing to be a full-time placement resource.

172. The Team capacity for each area office is different on page 3 of RFP and page 15. For example, New Haven is listed as 1 team on p. 3 and 1.5 teams on page 15. The staffing ratios are also inconsistent. Can the correct team capacity for each area office be clarified?

- The grid on page 3 lists the number of teams. The grid on page 15 lists the number of staff.

173. Can the Department share its justification for funding teams at different levels, as is outlined on pages 3 and 4 of the RFP? For example, 0.5 Team in Norwalk will receive annual funding of $545,173 vs. $334,519 in Middletown and Meriden.

- The funding is based on caseload size.

174. What happens with current youth in our care who may be from an area office in which we are not awarded a contract? Is there a waiver to have youth grandfathered in to remaining with their current foster parent?

- It is not our plan to move children/youth from their existing families.

175. Are there discretionary funds that will be provided by DCF for agency wide events(e.g. Holiday party for youth, Adolescent activities for peer engagement, FP networking and support events etc.)?

- No

176. Is FFT eligible for third party reimbursement? Will Beacon Behavioral Health be utilized?
- Beacon Health Options will not be involved.

177. What is the work expectation of TFC Case Management youth in terms of average hours per month in addition to the one home visit? What documentation will be expected?

- The work expectations are outlined in the Scope of Services.

178. How long is the FFT FC training for the Therapist and Clinical Supervisor? How about others?

- There are three (3) phases of FFT clinical training. Each phase corresponds to approximately one year. Phase 1 is Clinical Training. This phase aims to build the therapeutic competence of each team member to follow the FFT model. Training activities are sequenced through the year and include knowledge enhancement activities, theory to practice training, and applying the FFT model to cases. Phase 2 builds on the therapist training in phase one but focuses on Site Supervisor Training and Fidelity Maintenance. The team receives advanced training, and the individual identified as the site supervisor begins FFT Clinical Supervisor training. Phase 3+ continues both supervisor and team training and continues for the project's life.

Important to note. In Phase 1, Clinicians can begin seeing families approximately two weeks into the training. Specific training activities are described below.

Phase 1: Clinical Training Protocol. Phase 1 training focuses on clinicians learning FFT. The expected duration of Phase 1 is 1 year; however, teams are evaluated before the end of the first year to determine if the team meets the criteria to move on to Phase 2. The following training and services are included

1. FFT Adaptware/Ongoing Training 47 hours of core FFT knowledge training/equivalent to 5 days (40 hours) of training plus 7 hours of additional Adaptware Training. FFT Adaptware online training is a series of 10-15 minutes training units that cover the core knowledge components of FFT. In each unit, trainees view videos and read core FFT knowledge components transcripts. Each unit has a series of application questions in which the learner demonstrates their knowledge of that domain. FFT Consultants are available to answer questions/clarify content. Trainees must complete the Adaptware program. Therapists/Clinicians also participate in additional Adaptware ongoing learning units following Clinical Classroom Training and at the end of the first year.
2. Clinical/Classroom Training (2 on-site or Webinar training days, 16 hours). Onsite clinical training is an opportunity for the FFT model developer to present elements of the clinical model, demonstrate those elements using videotape examples, and conduct an FFT session with a local family (when possible).
3. Case Consultation and Coaching (weekly video calls with FFT consultant, (40 hours). Site consultation meetings occur with an FFT consultant and the local FFT team each week. Weekly consultation is conducted using video conference calling. The goal is to assist therapists/clinicians in applying FFT principles to specific cases and in planning for future sessions.
4. Advanced Clinical/Consultation Training and Supervised Practice (4 Webinars or onsite visits/year- 32 hours). Site Consultation visits are an opportunity for the local FFT team and the FFT consultant to meet and apply the FFT model to specific cases. Each visit is one day long and will involve video or live consultation where a team member works with a family member observed and helped by the FFT consultant.

Phase 2: Supervision Training and Fidelity Maintenance. Phase 2 training involves two primary activities. First, a site supervisor is trained using the FFT Clinical Supervision Process. The site supervisor takes on the weekly consultation responsibilities held by the FFT consultant in Phase 1. Training for site supervisors occurs both individually and within a group of supervisors. Second, FFT Partners provides ongoing Training/Services for quality improvement help by using the FFT Care4 system and the clinical monitoring tools.

1. Clinical/Booster/Supervised Practice Training (Three 1-day Webinar or on-site workshops – 24 hours). Aimed at the entire team, these training activities are intended to help the team use FFT in advanced ways and prevent model drift.
2. Site Supervisor Training (Two 2-day Webinar or off-site workshops-32 hours) Aimed at building FFT supervision skills, these clinical training workshops use didactic tools, role-plays, and actual

supervision practice to help on-site supervisors in their new role. The training also allows for developing a peer community that FFT supervisors from different sites can learn from and rely on.

3. Team Supervision and Individual Consultation Twice Monthly video observation by the FFT Consultant (2 hours) and individual consultation (as needed).
4. Supervision Consultation and Coaching (2 x a month video calls between FFT consultant and site supervisor – 1- 2 hours). Twice each month, the FFT Consultant and site supervisor work together to further the quality of FFT supervision with the team and with the supervisor.
5. Group Supervision Consultation (1-2 hours) Group consultation with supervisors from other agencies/teams and advanced Care4 topics are discussed in the required monthly online supervision meetings.
6. Advanced Online Clinical Training (Adaptware 6 – 8 hours). For teams, there are 3-4 Advanced FFT topics in Adaptware presented to improve FFT practice and supervision. The FFT supervisor will complete the FFT Supervisor Adaptware course.

Phase 3: Certification Phase. There are two primary training activities in Phase 3. First, the team and supervisor receive booster training and Supervised Practice to maintain model fidelity. FFT Partners monitor model adherence throughout the phase. Second, we provide ongoing quality improvement help by using the FFT Care4 online system and clinical monitoring tools.

1. Clinical/ Booster Training /Supervised Practice (2 Webinars or onsite workshops 1-day each – 16 hours).
2. Site Supervisor Conference Training (Two Webinar or 2-day off-site workshops-32 hours)
3. Team Supervision – Quarterly-1 hour of team video consultation with an FFT Consultant
4. Supervision Consultation and Coaching (Quarterly – 1-hour video consultation between the FFT Consultant and the Individual Site Supervisor).
5. Group Certified Supervisors Consultation (Monthly video calls 1-2 hours)
6. Advanced Training (4 advanced topics delivered through Adaptware – 6-8 hours).
7. Advanced Training (4 advanced topics delivered through Adaptware – 6-8 hours).

179. Can you describe other youth who have received FFT FC and been successful?

- In the most recent FFT evaluation, the population served were Foster Care youth who were the most likely to have unstable placements, multiple placements (at least 4), and struggled to reunify and return to a permanency placement successfully. Admission was limited to the most at-risk families/youth with a history of placement instability. Families intended to be included for FFT FC services in this RFP are like similar to those in the study.

180. How long are the interventions in the model? Given the ratio some days will require three home visits, so the time of interventions is critical. How will crises be managed with these ratios, or will DCF manage the crises?

- The interventions' total duration will be approximately nine (9) to twelve (12) months in total, with a minimum of one therapeutic session per week. The initial therapeutic intervention typically lasts around six months and is provided to the youth and foster parents. Upon the youth returning to the permanent placement, the FFT FC services continue lasting approximately three (3) to four (4) months. Given that no two families are alike, the duration for families will vary depending on the risk, needs, and protective factors. The FFT FC model by design reduces the number of crises in foster and permanent families. As a crisis arise, the FFT therapist relying on the therapeutic alliance developed with the youth, foster family, and permanent placement persons will typically be in the best position to intervene. The intensity in terms of the frequency of sessions may temporarily increase to match the particular crisis.

181. The RFP references the need to have homes available for emergency placements. How do emergencies align with the FFT model?

- Emergency placements should be a rare event with FFT-FC, however it does occur. The FFT FC training will be available to the identified emergency placement families. Although these are short-term temporary placements, they sometimes last longer than expected, and efforts to expose these placements to FFT FC training will be a priority. In terms of the overall effect on the treatment provided, this may be one factor that increases the time in the intervention. It is expected that when the short-term emergency placement has served its purpose, the youth will go back to the foster family for continued treatment.

182. Is there any data around the number of recruiting families for this model, taking into account disruption rates?

- In previous trials of FFT-FC there was a very low disruption rate for youth in Foster Homes (less than 5%).

183. Can you elaborate on the overall clinical supervision provided by FFT?

- We provide clinical consultation in multiple ways across the phases of training. Consultation provided follows the published FFT Clinical Supervision model. In addition to the scheduled consultation times noted, FFT Consultants are available for further consultation as needed. See the above answer under training and clinical supervision for additional information on the consultation process and frequency.

184. Who supervises the Clinical Supervisors in this model?

- FFT Consultants are supervised by the FFT model developer and Chief Training Officer. Teams and Site Clinical Supervisors receive consultation from FFT Partner Consultant (as noted above) but is responsible to their agency supervisor for direct supervision. See above answer under training and clinical care.

185. Is the prescribed caseload sufficient to manage crisis within foster care. How does FFT FC stabilize children in foster care?

- The primary goal of FFT-FC is to stabilize youth in their first foster care placement and move them toward permanency as quickly as possible. The FFT core model has a long history of successfully stabilizing family relationships and helping youth and caregivers work together collaboratively. It is expected that there will be crisis, yet the FFT model is designed to help teams manage those crises in a family-focused manner.

186. How many hours is the FP training. Will it be the expectation that the provider pays families for the 30 hours of model training (pre-certification)?

- Training for Foster Parents consists of three (3) sessions totaling six (6) to nine (9) hours. In addition, there will be another 7-9 session of follow up and group support during a year. The issue of payment for the FP will be determined by the state.

187. Is there a cost per person involved in training in the FFT model?

- The training cost are a part of the contract between the state of CT and FFT Partners. The initial team training cost is based on a team rate. If a clinician leaves during the first year of implementation, there is no additional cost per person involved in the training. Hence, if there is clinician turnover within the first year, this is no charge for replacement training. In subsequent years, there is a cost per clinician training.