DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Vannessa Dorantes
Commissioner

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Governor

Multisystemic Therapy RFP

Questions and Answers

1. **The RFP identifies a licensed therapist, does that mean masters level licensure or clinical level licensure?**

   Therapists are licensed behavioral health professionals with master's degree in a behavioral health field. Masters level licensure is acceptable for therapist.

2. **Is there any exception to that expectation? Like if we have a new graduate who is pending licensure?**

   There are no exceptions. New graduates may have an associate level license. Their position would be contingent on obtaining their license.

3. **Is that the same for the supervisor and associate level license or full licensure?**

   No, supervisors would require a clinical license.

4. **Would an LMSW be acceptable for a supervisor versus an LCSW for example?**

   An LMSW would not be acceptable for a supervisor position. On a case by case basis, a supervisor candidate who is almost done completing for their LCSW Department of Public Health requirements may be hired. Their position would be contingent on obtaining their clinical license.

5. **On page 11, it's question 2-iii-1, it's noted to add a workforce analysis as Appendix 10, but appendix ten is not noted on the table of contents. Is that an error?**

   Yes - Under question 2-iii-1 the following statement is **deleted** from RFP: Please include a Workforce Analysis as Appendix 10.

6. **If you have someone that's currently doing the job and they do not have the qualifications, is there any room around credential?**

   No. At this time the State Statute remains the same. We will not be able to grant an exception.

7. **Can the chart on page 12 under staffing be added as an addendum?**

   Yes, this chart can be added as Attachment 7.

8. **On Page 6, it states that one electronic submission will be accepted, but on page 14 it says it must be printed and bound and provides requirements. Which is correct?**

   Acceptable submission is one signed electronic copy of the original proposal.

9. **On page 12, question 4, can you please clarify the directions on the staffing table? As I'm understanding it, we're going to have overarching agency numbers and then any numbers that are related to adults or adolescent community based care programs. Are you looking specifically for those? I guess question #2 is, are you looking specifically for only adolescent programs or any program that serves the child in adolescent population?**

   The Department is looking to understand your staffing and contract capacity by different programs. Information on the adolescent services similar to this RFP would be best along with other adolescent services. Staffing information on several programs with similar staffing positions is better, so the Department can understand how the agency is staffing and maintaining staff. If your agency does not serve adolescents or you want to highlight similar programs on the adult side, you may add.

10. **The CSSD current contracts provide vehicles for our in home therapist. What is DCF stance on cars?**

    The identified funding for this RFP does not delineate an identified amount for cars or transportation. It would be up to each applicant how they identify the cost for this activity in their budget.

11. **So if there's room in the budget, could we propose that as an organization?**

    Yes.

12. **The current CSSD contract includes client flex funds through ABH. Are we required to put any client expense funds into our budget?**

    Proposals may include a budget for client expenses.

13. **On page 14, you're saying that you only want an electronic copy submitted?**

    That is correct.

14. **Clarification on spacing, are you looking for 1 1/2 or double spaced.**

    Spacing is identified on page 14 as 1.5.

15. **Attachment #2 says proof of clinical license. Does that mean the clinic license or do you want the licenses of the clinicians of the therapists?**

    It would be the clinic license.

16. **Why is this contract being put out to bid?**

    The department is mandated to follow State Procurement standards.

17. **Is the funding being offered a flat funding or are there any increases?**

    Yes, the identified funding is flat funding.

18. **Can you post the current providers for each area?**

    Current CSSD providers are:

    Wheeler Clinic- Bridgeport/Norwalk-Stamford/ New Haven/ Waterbury
    CT Junior Republic- Danbury/Torrington
    The Village for Families and Children- Hartford/ New Britain/ Rockville/ Willimantic

    NAFI- Middletown/ Waterford.

19. **Will DCF cover the MST training cost?**

    Trainings themselves for the initial trainings are covered by the agency.

20. **Can we build that into the budget?**

    Yes.

21. **How much is the cost of the training?**

    In state training through Advanced Behavioral Health costs are $500 per person. Training through MST Services costs are higher and dependent on location and other travel expenses.

22. **For new staff to attend subsequent MST, would that be additional cost?**

    Yes, it would be additional cost, but trainings are offered out/in-state regularly.

23. **Is it the expectation that we will be billing for the services that we provide?**

    Yes.

24. This is a typical grant funded program in the way that it's structured, not a fee for service payment structure, but that the department would like us to leverage third party billing?

That is correct. The department is looking to third party reimbursement whenever appropriate.

25. I just wanted to clarify that there are 4 therapists per team?

Confirmed there are 4 therapists per team.

26. Question 4(a) can the chart be added as an addendum? If so what number addendum would that be?

See question 7.

27. The RFP states that the therapists need to be licensed. Would an associate license be acceptable?

See question 2.

28. Will you please post the letters of intent when they are all received?

Yes.

29. The MST model has a length of stay of 3-5 months. Our organization is an existing MST provider, and our experience shows that many clients need longer than 4 months to achieve success. On page 9 of the RFP, the following is listed as a required MST outcome: "95% of adolescents/families served will achieve an average length of service of 4 months". We are concerned that contractors will not be able to meet the 95% benchmark, as our experience shows that many clients need longer than four months in the program to achieve success. *Why is the length of stay outcome set at 95%, when the model has a length of stay of up to 5 months?*

The Department understands that families have treatment needs that vary and are individual. MST averages 3-5 months or 4 months. That benchmark was set in order to meet contractual utilization by taking into consideration MST recommendations. The Department will be analyzing outcomes and reviewing metrics on a regular basis to make changes as needed.

30. **Page 3 of the RFP shows that staffing is set at four Therapists per team. At the top of page 10 of the RFP, it states, "Annual utilization for each combined team will be 60 families completing MST annually." This would require that each Therapist serve 5 clients at a time and discharge them by month 4. Our experience as a current MST provider shows that many clients need longer than 4 months to achieve success. Setting annual utilization at 60, which would necessitate an average 4-month length of stay, is contrary to our experience with the MST model. Sixty (60) clients per year is not achievable if clients do not close by month 4*. *Would***

you consider reducing these standards, so that the top priority is giving participants the time they need to achieve success?

See question 30.

31. At the bottom of page 3 of the RFP, #2 says that applicants must register with the State Contracting Portal. The items bulleted under #2 include 1) Secretary of State recognition, 2) Non-profit status, 3) Notification to Bidders, and 4) Campaign Contribution Certification. We will upload these items into CTSource for our organization. These documents are not included on the Required Proposal Submission Outline on page 17 of the RFP. Should these documents also be included as grant attachments?

No, just uploaded CTSource.

32. On page 11, Section 2.iii.1., the RFP states, "Please include a Workforce Analysis as Appendix 10." I do not see any mention of Appendices 1-9, nor do I see Appendices listed on the Required Proposal Submission Outline on page 17 of the RFP. Questions on this: Is the Workforce Analysis page 4 of the Notification to Bidders (https://portal.ct.gov/-/media/CHRO/NotificationtoBidderspdf.pdf? What should be included as Appendices 1-9? Should the Workforce Analysis be included as an Attachment, rather than Appendix 10?

See question 5.

33. The Required Proposal Submission Outline on page 17 of the RFP lists "Proof of Clinical Licensure" as Attachment #2. *Is this clinical licensure for the staff, the organization, or both?* Please advise.

See question 15.

34. **For question 4.a.1. on page 12 of the RFP, we are required to list our organization's contractual staffing numbers by role. This chart will be quite large, which will take away our ability to answer other questions within the 20-page limit. *Could this table be included as Attachment #7 and not be part of the 20-page limit?***

See question 7.

35. What is the cost for MST training per staff?

See question 21.

36. Will CSSD provide flex funds, as needed, for the clients it refers? If so, what will be the process?

See question #12. The process is yet to be determined.

37. Do funds for client needs (for clients referred by DCF or the community) need to be included in the budget?

See question 12.

38. Can you confirm that the Department is requiring an itemized annual budget and budget narrative for only the first year of contract (July 1, 2023-June 30, 2024)?

Yes.

39. Can the Department give an example of when third-party billing would be appropriate?

The Department is expecting contractors to bill for third-party reimbursement for all insured clients when the service is reimbursable.

40. Can the Department post the organizations that submitted an LOI broken out by each DCF Regional Office?

RFP is not Regional Office Specific, LOI will be listed by Team.

41. Can the Department post the organizations that currently provide MST broken out by each DCF Regional Office?

Current contract is not DCF Regional Office Specific, see question 18 for current CSSD providers.

42. Should the cost of drug testing be included in the budget or is that an item that the Department would like contractors to leverage third-party billing?

Costs of drug testing should be included in the budget for families who are uninsured or when the costs are not reimbursable.

43. Is the inclusion of client support funds in the budget encouraged by the Department?

See question #12.

44. Is the proof of clinical licensure on page 17 (Attachment 2) for the organization?

See question #15.

45. Are subcontractors permitted?

The use of subcontractors is not permitted for this contract.

46. Who are the current providers for each geographic area? Does DCF wish to retain them or is it open to new providers?

This is an open Procurement.

47. Does DCF expect providers to be billing 3rd party payors for MST services? Should these funds be included in the budget?

See question #23. Yes, all funding sources should be included

48. How much money should be budgeted for MST training for one team? For a single individual who may need it in the event of staff turnover?

See question 21.

49. Please provide the following data by provider for the last 2 fiscal years:

a. MST outcomes include:
   - % of adolescents who complete MST
   - % of adolescents/families served achieving an average length of service of 4 months
   - % of MST teams achieving an overall average adherence score of at least 0.61

b. % of adolescents abstinent or showing a reduction in substance use
c. % of adolescents living at home at time of discharge
d. % of adolescents showing improvement in school attendance at time of discharge
e. % of adolescents will no new arrests during treatment (not including probation or parole violations)
f. % of parent/caregivers with the necessary parenting skills to handle future problems

MST Annual Report FY 2021

Performance Measures	VFC-H	VFC-M	CJR-D	CJR-T	WC-W	VFC-NB
# of youth admitted	n=22	n=17	n=18	n=11	n=8	n=28
# of youth discharged	n=19	n=16	n=14	n=4	n=2	n=27
% of youth who completed treatment	79% (n=15)	94% (n=15)	86% (n=12)	50% (n=2)	50% (n=1)	89% (n=24)
Average length of service for those that completed treatment	142	146	152	157	152	147
% of youth who completed treatment and met all or most treatment goals	100% (n=15)	80% (n=12)	100% (n=12)	100% (n=2)	100% (n=1)	100% (n=24)
% of youth who completed treatment and are living at home at discharge	100% (n=15)	100% (n=15)	100% (n=12)	100% (n=2)	100% (n=1)	100% (n=24)
% of youth who completed treatment and were attending school-same or better than at admission	100% (n=15)	93% (n=14)	83% (n=10)	100% (n=2)	100% (n=1)	92% (n=22)
% of youth who completed treatment without an arrest during treatment	100% (n=15)	100% (n=15)	100% (n=12)	100% (n=2)	100% (n=1)	96% (n=23)
% of youth who completed treatment and were abstinent or had a reduction of substance use in the last 30 days of treatment	100% (n=15)	73% (n=11)	83% (n=10)	100% (n=2)	100% (n=1)	88% (n=21)

Performance Measures	VFC-H	VFC-M	CJR-D	CJR-T	WC-W	VFC-NB
# of youth admitted	n=22	n=17	n=18	n=11	n=8	n=28
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% of youth who completed treatment and were abstinent or had a reduction of substance use in the last 30 days of treatment	100% (n=15)	73% (n=11)	83% (n=10)	100% (n=2)	100% (n=1)	88% (n=21)

MST Annual Report FY 2022

Performance Measures	WC-B	WC-NS	WC-NH	NAFI-M	NAFI-N	VFC-W
# of youth admitted	n=7	n=5	n=9	n=12	n=23	n=2
# of youth discharged	n=8	n=4	n=11	n=7	n=17	n=8
% of youth who completed treatment	75% (n=6)	75% (n=3)	91% (n=10)	71% (n=5)	82% (n=14)	75% (n=6)
Average length of service for those that completed treatment	156	134	162	137	174	158
% of youth who completed treatment and met all or most treatment goals	83% (n=5)	100% (n=3)	50% (n=5)	100% (n=5)	100% (n=14)	100% (n=6)
% of youth who completed treatment and are living at home at discharge	100% (n=6)	100% (n=3)	100% (n=10)	100% (n=5)	100% (n=14)	100% (n=6)
% of youth who completed treatment and were attending school-same or better than at admission	100% (n=6)	100% (n=3)	90% (n=9)	100% (n=5)	100% (n=14)	100% (n=6)
% of youth who completed treatment without an arrest during treatment	100% (n=6)	100% (n=3)	60% (n=6)	80% (n=4)	93% (n=13)	100% (n=6)
% of youth who completed treatment and were abstinent or had a reduction of substance use in the last 30 days of treatment	67% (n=4)	67% (n=2)	60% (n=6)	100% (n=5)	86% (n=12)	100% (n=6)

Performance Measures	VFC-H	VFC-M	CJR-D	CJR-T*	WC-W	VFC-NB
# of youth admitted	n=12	n=9	n=24	n=0	n=3	n=10
# of youth discharged	n=12	n=14	n=8	n=0	n=8	n=10
% of youth who completed treatment	83% (n=10)	93% (n=13)	88% (n=7)		88% (n=7)	100% (n=10)
Average length of service for those that completed treatment	158	145	138		149	147

% of youth who completed treatment and met all or most treatment goals	100% (n=10)	100% (n=13)	100% (n=7)		100% (n=7)	100% (n=10)
% of youth who completed treatment and are living at home at discharge	100% (n=10)	100% (n=13)	100% (n=7)		100% (n=7)	100% (n=10)
% of youth who completed treatment and were attending school-same or better than at admission	100% (n=10)	100% (n=13)	100% (n=7)		100% (n=7)	90% (n=9)
% of youth who completed treatment without an arrest during treatment	100% (n=10)	93% (n=12)	100% (n=7)		100% (n=7)	90% (n=9)
% of youth who completed treatment and were abstinent or had a reduction of substance use in the last 30 days of treatment	80% (n=8)	77% (n=10)	100% (n=7)		100% (n=7)	90% (n=9)

*Data for CJR-T was entered under CJR-D.