DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

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Commissioner

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Governor

Parent Child Interaction Therapy RFP

Questions and Answers:

1. **Page 9 of the RFP under Section 3. Service Requirements, (a) Evidence Based Services, asks that proposers describe "agency's prior success implementing evidence-based services aimed at adolescent behavioral health treatment (including substance use), adolescent and caregiver engagement, and/or recovery supports." However, the program targets young children ages 2-7 years. *Would you like proposers to answer the question as stated, or should we respond with our success serving young children?***

    a. Amend 3(a) as follows: Describe your agency's prior success implementing services aimed at younger children. Data should be used to demonstrate your success whenever it is available.

2. **Page 9 of the RFP under Section 3. Service Requirements, (c) Community Needs, Partnerships, and Presence, 1., asks that proposers describe "identified adolescent needs within the major cities/towns in the catchment areas, especially those affecting persons in need of substance use treatment and recovery supports. However, the program targets young children ages 2-7 years. Would you like proposers to answer the question as stated, or should we respond to a different question?**

    a. Remove 3(c) in total from RFP, do not include response in RFP.

3. **Page 9 of the RFP under Section 3. Service Requirements, (c) Community Needs, Partnerships, and Presence, 2., asks that proposers describe their "agency's history and success of partnering with…institutions that support families, pro-social activities, adolescent job employment, and services related to adolescent substance use recovery." Because the target population is young children ages 2-7, should proposers respond with success serving the target population? Please advise.**

    a. *Remove 3(c) in total from RFP, do not include response in RFP.*

4. **Page 9 of the RFP, under Section 2. Cultural and Linguistically Competent Care, iii. 1., says, "Please include a Workforce Analysis as Appendix 10." However, there are no Appendices 1-9. Also, on the Required Outline, there are no appendices listed, nor is this item included on the list of required attachments. How should the Workforce Analysis be labeled and included with the proposal?**

   a. The sentence: "Please include a Workforce Analysis as Appendix 10." Is stricken from the RFP and should not be included in the response.

5. **Are training costs for this evidence-based program to be included in our budget request or will DCF be funding the training from another source?**

   a. Training costs will be funded by DCF under Connecticut's Family First Prevention Services Plan.

6. **The funding for this program does not appear include enough money for supervision of the therapist and program. Is the funding amount inclusive of clinical supervision and administrative oversight?**

   a. Yes, the funding is inclusive of clinical supervision and administrative oversight.

7. **Are any PCIT services billable?**

   a. The department is looking to third party reimbursement whenever appropriate.

8. **Does the supervisor need to also be trained on PCIT to do supervision of the clinician?**

   a. Model developer does not require supervisor to attend training. However, supervisors are expected to attend the PCIT training along with trainees. The therapist will be required to have fidelity check consultations with the PCIT team throughout the training period. The therapist will attend consultation calls (typically via Zoom) scheduled twice monthly, starting after the introductory workshop. The purpose is to ensure that therapists are adhering closely to the established protocol.

9. **Will the model allow for modifications using Microsoft Teams or other tele-observation platforms in place of the two-mirrored rooms?**

   a. Yes, in addition to the one-way mirror observation, PCIT has been adapted for remote delivery through video conferencing platforms and recorded in-person sessions.

10. **Can we include transportation support in the grant to help families with transportation issues?**

    a. Yes, you can include transportation cost as part of your submitted budget.

11. Will DCF be the only "portal" of entry to the program? Or will we be able to take referrals from other providers and take self-referrals (parents who refer themselves)?

a. Referrals can come from DCF, the community or families may also self-refer.

12. What contractual benchmarks have been set for this program?

a. PDI Phase of PCIT:

i. Increased compliance with adult (caregivers, teachers) requests
ii. Increased caregiver confidence (and decreased stress)
iii. Improved behavior at home, and in public
iv. Decreased frequency, severity, and/or duration of aggressive behavior
v. Decreased frequency of destructive behavior
vi. Decreased defiance

b. CDI Phase of PCIT:

i. Increased feelings of security, safety, and attachment with caregiver(s)
ii. Increased attention span
iii. Increased self-esteem
iv. Increased prosocial behaviors (sharing, taking turns)
v. Decreased frequency, severity, and/or duration of tantrums
vi. Decreased hyperactivity
vii. Decreased negative attention-seeking behaviors (whining, bossiness, sassiness).
viii. Decreased caregiver frustration

13. You are looking for four providers, what catchment areas? We are not defining the area.

a. The department is not delineating a specific catchment area, the applicant should submit proposed catchment area as part of proposal.

14. Section 3C says target population age 2 to 7?

a. This has been amended.

15. How many case per year?

a. The number of families a PCIT therapist can serve a year will depend on several factors – length of treatment for each family and the therapist's workload. Because the average length of PCIT treatment typically varies between 12 to 20 sessions, some families may complete in fewer than 12 sessions while others may take more than 20 sessions to meet treatment completion requirements. If a therapist were to see one family per week for an average of 16 sessions, potentially 30-35 families could be served in a year. However, it is important to note that a therapist's other responsibilities may limit the number of PCIT families on their caseload. The required caseload size is a minimum of 2 cases to become certified, ideally each therapist should carry 5+ cases going. Three families are acceptable for part-time therapists. Please note: A therapist cannot become certified if s/he has less than 2 cases.

16. Funding is separate from training?

a. Yes, this is grant funded utilizing State dollars. Training will be paid for by the department.

17. What amount of staffing for funding level?

a. The department is not delineating a staffing model, the applicant should submit staffing structure as part of proposal.

18. Is there any IV E reimbursement?

a. IV E will be sought by the department once this service is added to the Department's Family First Prevention Plan. Any reimbursement gets returned to the State's general fund.

19. Is this connected to BSFT?

a. No.

20. What are the qualifications for the clinician?

a. The ideal candidate has a master's degree in mental health, social work, or marriage and family therapy. However, individuals with a master's degree in a related field, or a bachelor's degree plus 3 years of clinical experience may be

qualified. At minimum, individuals must have ease in working with all family members and have basic knowledge of how family systems operate.

21. Is this an in home or clinic-based service?

a. Though PCIT is typically delivered in clinic settings, such as community agencies and outpatient clinics, it can be delivered in the home.

22. Do you foresee this interfacing with QPC, RTFT?

a. No.

23. There is reference in the RFP for a one way mirror?

a. Yes, in addition to the one-way mirror observation, PCIT has been adapted for remote delivery through video conferencing platforms and recorded in-person sessions.

24. Can we get the new model scope? Can we get it before the question period expires in case there are additional questions.

a. Yes, the Department will complete an Amendment to the RFP and post on DAS website prior to the question period ends.

25. Why can this service not be billed as an outpatient service through Medicaid/DSS?

a. The department is looking to third party reimbursement whenever appropriate.

26. What is the maximum number of cases each staff should have at any given period?

a. The number of families a PCIT therapist can serve a year will depend on several factors – length of treatment for each family and the therapist's workload. Because the average length of PCIT treatment typically varies between 12 to 20 sessions, some families may complete in fewer than 12 sessions while others may take more than 20 sessions to meet treatment completion requirements. If a therapist were to see one family per week for an average of 16 sessions, potentially 30-35 families could be served in a year. However, it is important to note that a therapist's other responsibilities may limit the number of PCIT families on their caseload. The required caseload size is a minimum of 2 cases to become certified, ideally each therapist should carry 5+ cases going. Three

families are acceptable for part-time therapists. Please note: A therapist cannot become certified if s/he has less than 2 cases

27. Are services to be offered in the home or at the office?

a. PCIT can be conducted in office, in the home, community where the family is most comfortable.

28. Are training costs for this evidence-based program to be included in our budget request or will DCF be funding the training from another source?

a. Training costs will be funded by DCF under Connecticut's Family First Prevention Services Plan.

29. Does the supervisor need to also be trained on PCIT to do supervision of the clinician?

a. No, there are no training requirements for the supervisor. However, supervisors are expected to attend the PCIT training along with trainees. The therapist will be required to have fidelity check consultations with the PCIT team throughout the training period. The therapist will attend consultation calls (typically via Zoom) scheduled twice monthly, starting after the introductory workshop. The purpose is to ensure that therapists are adhering closely to the established protocol. Ongoing supervison will be provided by the model developer to ensure fidelity to the model.

30. Will the model allow for modifications using Microsoft Teams or other tele-observation platforms in place of the two-mirrored rooms?

a. Yes, the model allows for modifications using Microsoft Teams, or other tele-platforms in place of the two-mirrored rooms.

31. Will you confirm that providers are not expected to show any third-party income in the budget and that PCIT is fully grant-funded?

a. Yes, this is confirmed.

32. Who is responsible for initial and ongoing costs associated with PCIT training? Should the costs be included in the budget?

a. Training costs will be funded by DCF under Connecticut's Family First Prevention Services Plan.

33. What is the funding source for this program? Is it federally funding through Medicaid?

a. This is service is grant funded utilizing State funding.

34. If the service is delivered in a licensed, outpatient clinic, are services billable?

a. The department is looking to third party reimbursement whenever appropriate.

35. Please clarify where PCIT is delivered. Is it clinic based? In the community? Is the use of two-way mirror as outlined in the RFP required?

a. PCIT can be delivered in the clinic, the family home, or the community. Using a two-way -way mirror is not required, PCIT has been adapted for remote delivery through video conferencing platforms and recorded in-person sessions. The use of two-way mirror is not a requirement of the model.

36. In the Amended RFP, the first page states, "to change the preferred location and regional designation of teams" and the only changes in red are additional model information. Was this an error?

a. Yes.

37. Just verifying with the amended information sent out the population can now go up to the age of 12?

a. Yes.

38. What credentials are required for the therapists?

a. The ideal candidate has a master's degree in mental health, social work, or marriage and family therapy. However, individuals with a master's degree in a related field, or a bachelor's degree plus 3 years of clinical experience may be qualified. At a minimum, individuals must have ease in working with all family members and have basic knowledge of how family systems erate.

39. Please post letters of intent after the submission date.

a. Yes, a list of letters of intent will be posted.

40. Is there a limit on how many staff we can train in the model? And if so, what is the limit?

a. There is not an identified limit.

41. Question 3 a4 and question 5b both speak to retention and minimizing staff turnover. Can these two questions be combined given the page requirements?

a. Answers must be submitted in the order prescribed in the RFP, you can reference answered under question answered under 3.