**RFP# 1726VF**

**High Fidelity Wraparound for Preventive Services**

**Questions and Answers**
**November 9, 2017**

1. Q: We currently have 55 HFW slots with 5 Care Coordinators – 11 cases each and 1 Supervisor. Can we apply for an additional 17 slots to bring us to 72 slots, add 1 Care Coordinator which would bring us to 6 and have 1 supervisor or is any additional slots separate from what we currently have?

A: If any of the existing HFW ECDMH contract agencies would like to apply for additional slots under the RFP they can do so and if chosen the additional slots would be added to the existing contract per the fiscal and procedures outlined in the RFP.

The existing HFW CC agencies would not apply for slots from the RFP to increase their current capacity; the RFP is distinctly separate.

The existing HFW CC agency practice will align with the practice standards and requirements outlined in this RFP and updated policies and procedures manual.

The existing 5 HFW CC Agencies contracted services will remain under the same fiscal model in 2018. These slots will transition to the new fiscal model as described in the RFP in 2019.

The existing HFW CC agencies that do not have existing ECDSS Prevention contracts will not have intensive preventive cases in 2018 but will in 2019.

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2. Q: Our current Preventive Services team is comprised of staff from various educational backgrounds and levels of experience. Will there by a grandfather clause that allows for a supervisor who does not have a Master's degree however has several years experience in the child welfare arena? Similarly, with staff who do not have required years of experience, will exceptions be made for them in the current contract?

A: Supervisors: If current supervisors have a minimum of a Bachelor's degree and five years of documented experience in the Child Welfare system, they can be grandfathered into the new program. Any new supervisors hired must meet the minimum qualifications outlined in the RFP.

Care Coordinators: If current CC's have a Bachelor's degree and a minimum of one year documented experience in the Child Welfare system, they can be grandfathered into the new program. Any new CC's hired must meet the minimum qualifications outlined in the RFP.

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3. Q: Will kinship cases be weighted differently in the caseload size, given the involvement with multiple homes and complex family structure. Similarly, will Intensive cases be assigned to agencies on a prorated basis?

A: The awarded agency supervisors will need to manage the assigned cases including worker case mix of Traditional, Intensive and Kinship. As Contract overseers the ECDMH, in consultation with ECDSS, will not mandate a caseload mix.

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4. Q: Will Intensive cases be seen twice daily during the workweek (Monday through Friday) or inclusive of the calendar week (Monday through Sunday)?

A: Per the Preventive Services Guidelines Manual: Chapter 1 pages 1-4 and local practice implementation a family must be seen within 24 hours from the date of the referral and a combination of supports need to be put in place to see the family daily and available to the family 24/7. The combinations of supports are based on the family risk level and need and can be provided by the CC or designated support.

The regulatory length of stay for an Intensive Case is approximately 30 days until the step down to a Traditional Case occurs which is coordinated by the Care Coordinator but approved by the DSS Caseworker.

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5. Q: Can existing staff be afforded a grandfathering in that do not meet the years of experience requirement?

A: Please see response to Question #2.

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6. Q: What is the expectation with the current cases, would they remain open and with the current worker?

A: The awarded agencies and the County will meet to develop a transition plan for the current families being served. The County prefers to work with the agencies to discuss the best transition process for the families being served.

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7. Q: Can you define mandated preventative verse voluntary preventative?

A: The system only provides Mandated Preventive (MP) Services. "Voluntary Preventive" is a Mandated Preventive Service case without a court order and meets one of the six MP criteriA:

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8. Q: Could you please better define the expectations regarding implementation? If we are one of the three agencies chosen for the 1st quarter is there a hard deadline to January 1 start date?

A: Please see response in Question #6. There are no hard date expectations until the transition process is defined but will occur during Quarter 1.

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9. Q: Conflict of Interest: Currently, the Wraparound policy is that a Care Coordinator cannot also be a vendor (even if for a different agency). Will this policy still apply to the new Preventive/Wraparound model?

A: Yes, the policy applies. Although, a HFW Agency can have both a CC program and a Vendor Services program staffed by different individuals.

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10. Q: Page 12: please define the required contact for Traditional and Kinship. The RFP states minimum 2 F: F but does not define weekly or monthly.

A: Minimum is 2 face to face contacts with the family per month. At each face to face contact the expectation is that the HFW CC will meet with each child and facilitate the Global Safety Assessment.

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11. Q: Page 11 of the RFP referencing Vendor First Face to Face practice is in conflict with page 14 outcomes for Vendor Services. Please clarify the expectations.

A: The goal for vendor first face to face is within a maximum of 36 hours for Intensive cases and within 7 days for traditional HFW cases. All vendor services selected should be based on the presenting needs and strengths of the family. If a community or natural support can meet this need (and it is documented as such) then a vendor would not be needed to address the safety concern.

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12. Q: If selected to be a phase one agency, can you please clarify the training dates through CCNY. Will there be multiple training date opportunities?

A: HFW CC training will be offered twice monthly with follow up face to face coaching at each agency. CCNY will work with county and community partners to ensure all deadline and implementation dates are met.

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13. Q: Can you define the use of the CARES Team as one of the minimum contacts for the Intensive cases. Should the agencies expect to establish an MOU with CARES for this service? Will CARES adjust their response practices to align with the needs of this service?

A: The CARES team is a mobile crisis team to be used by families in times of crisis. It is not the role of the CARES team to assess all the children and youth in the family and as such, cannot count as one of the required visits.

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14. Q: Is there a minimum required time for each required Intensive visit and is there a time frame between visits that would disallow a visit to count as a separate visit? If the first visit is for a significant amount of time (3 hours), is there an expectation you have to come back for a second visit?

A: One daily visit is required for intensive cases. If family necessitates additional visits on same day due to crisis or other need, HFW CC is expected to be available to coordinate services to meet family needs.

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15. Q: Regarding Intensive: Is there a capacity within each agency for the number of intensive cases that can be carried (With a caseload of 1:12, anything more than one intensive case would be a significant burden on the Care Coordinator's schedule. Absent vendor services the face to face contact required for an intensive case could consume the majority of a Care Coordinator's day. Similarly, with vendor services in place to support an intensive case, the PFPM budget will be quickly exhausted and could throw the team PFPM overall budget off balance). With these identified concerns, having a disproportionate amount of intensive cases could be a strain on one agency. Can there be a plan to either cap, or evenly distribute Intensive cases?

A: Please see response to question 3

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16. Q: How will it be decided that an intensive case is no longer categorized as intensive? The RFP says "until risk is reduced". Will this be a formal assessment? Who is responsible for making the determination?

A: Please see answer to question 4. Additionally, length of stay for intensive cases is 30 days with potential for a 30 day extension. Documentation of progress towards families identified goals will be available via Fidelity EHR and CONNECTIONS for case discussion between HFW CC and DSS Case Manager.

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17. Q: Vendor service notes: Page 12 states "Vendor Service Notes: DSS Caseworker will copy and paste notes into CONNECTIONS". Is this accurate? Or is it meant to be the Care Coordinator?

A: RFP Clarification - HFW CC will be the individual's cutting and pasting all vendor notes into CONNECTIONS.

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18. Q: Are the current HFW slots going away or being absorbed into HFW for Prevention Services? If so, when will this happen? If not, how will the different cases be identified?

A: The existing HFW CC agency practice will align with the practice standards and requirements outlined in this RFP and updated policies and procedures manual.

The existing 5 HFW CC Agencies contracted services will remain under the same fiscal model in 2018. These slots will transition to the new fiscal model as described in the RFP in 2019.

The existing HFW CC agencies that do not have existing ECDSS Prevention contracts will not have intensive preventive cases in 2018 but will in 2019.

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19. Q: How is traditional vs. intensive services determined? Is a standardized tool used to determine the level of service required by the family? If so, who administers it?

A: Level of service is determined by the ECDSS Case Manager prior to assignment to HFW CC Agency

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20. Q: Please confirm that the Care Coordinator is not also the DSS Caseworker.

A: Confirmed. Roles are clearly defined in the policy and procedure manual to be released in December.

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21. Q: Based on previous data what percentage of the 672 slots do you anticipate to be intensive? Could all 72 slots end up being intensive?

A: Currently only 9% of cases are Intensive. We anticipate this will be a fluid model and level of service will continue to be based on family need.

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22. Q: Are the qualifications for the Supervisor negotiable?

A: Please see response to Question #2.

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23. Q: Should applicants include the $500/family/month flex funds in their budget request? Will the funds be passed through the prevent agency or will they be provided from CCNY directly?

A: Flex funds are provided to CCNY directly and are not included in the agency submitted budget.

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24. Q: Please confirm no other budget information (aside from the information in the attachment) is required.

A: Confirmed.

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25. Q: What detail is required when reporting on expenditures? Where will costs be reported?

A: Quarterly cost reports are required per the ECDMH contract; agencies will be oriented to the reporting requirements upon award.

All flex funds costs are reported and recorded in Fidelity EHR which generates invoice and payment.

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26. Q: Will all awardees be notified at the same time (in December)?

A: Yes.

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27. Q: Should applicants include Schedule C (Equal Pay Certification)? It is requested in the RFP narrative but is not listed on the checklist. Please advise.

A: Applicants do not need to submit the Equal Pay Certification with the RFP submission but will be required with the formal contract.

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28. Q: Will all referrals go through SPOA? Will Intensive Prevent cases follow the same referral process as Traditional Prevent?

A: All referrals will go through a Centralized Intake process.

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29. Q: How will ongoing training be provided for new staff, for example in case of turnover? Will Train the Trainer be offered?

A: CCNY offers training for all new staff. Training is offered twice per month in addition to on-site coaching post-training to ensure fidelity to the HFW model.

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30. Q: What role does the Care Coordinator play in respect to Vendor Services?

A: The Care Coordinator authorizes and coordinates services for the family based on presenting strengths and needs. Some of those services may be purchased from the vendor network if needed. The HFW CC coordinates and approves these services in accordance with the wraparound model and policies and procedures.

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31 Q: The RFP indicates that all Preventive Services (Intensive/Kinship/Traditional) will be under the new model and referred through SPOA: There is a clear distinction in the RFP in regards to service expectations specific to Intensive. How will these cases be weighed against the 12:1 model requirement for caseload of the Care Coordinators?

A: Please see answer to question 3.

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32. Q: Kinship Cases also bring multiple families to service. Clarify how these cases will be weighted in assignment?

A: Please see answer to question 3.

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33. Q: There is no information within the RFP pertaining to Family Court/Treatment Court involvement in Preventive Services. Who is responsible for Court Menus, PHR, Orders of Protection? Is it a requirement for Care Coordinators to attend court? Provide Court Summaries?

A: Court menus are the responsibility of CPS as part of the disposition of neglect petition. HFW CC is responsible to collaborate with DSS Case Manager to refer and coordinate the needed services. HFW CC is responsible for the permanency hearing report and court summaries. They should appear in court for ongoing cases.

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34. Q: Child Welfare is inclusive from infancy to age 18 through the language of the RFP is only indicating Youth. Please clarify targeted population?

A: Target population is families with children 0-18. See page 1 of the RFP, paragraph 1.

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35. Q: Referencing CFT monthly meetings – Are these meetings included in the F/F time required of the Care Coordinator?

A: CFT monthly meeting only counts as a required face to face meeting if HFW CC meets with all children individually and does the required Global Safety Assessments.

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36. Q: Regarding Vendor Services as related to the role of Care Coordinator? Who is responsible for oversight of performance (ie., paperwork, timeliness, utilization) and ensuring that documentation is placed into CONNECTIONS?

A: HFW CC is responsible for cutting and pasting all vendor notes from Fidelity EHR into CONNECTIONS. The Policy is that all vendor notes must be entered into Fidelity EHR within 48 hours of service provision. This is tracked in analytics reports provided by CCNY. HFW CC monitors vendor performance on each of their assigned cases. Supervisors monitor and manage performance of the HFW CC. ECDSS Case Manager provides oversight on entire case.

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37. Q: It was only mentioned in the RFP that “SED Youth” required a CANS. Please provide clarification on Assessment tool to be used with “Client/Parent” and the family. Are we required to complete a CANS Assessment on all Children/Youth connected to a case? Please clarify the expected date for when the “universal OCFS” assessment tool will be determined

A: Post RFP release, ECDMH and ECDSS conferred and are in the process of confirming an assessment tool to be used. All agencies will be notified of the tool selected and trained in the use of the assessment tool. We do not have any indication of when OCFS will make a decision about their tool.

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38. Q: Within the RFP the training requirements do not include the required trainings for Child Welfare. Please clarify the training expectations as they relate to Child Welfare; Mandated Reporting, CONNECTIONS (FASP's, PHR's, and other CONNECTIONS training requirements), Trauma Informed Care, Human trafficking, to name a few?

A: This will be detailed in policies and procedures manual but in summary:

CCNY will provide HFW CC training which includes mandated reporting.

Agencies are responsible for coordinating the state trainings for their internal staff. This includes CONNECTIONS training which encompasses FASPS, permanency hearing, etc.

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39. Q: Throughout the RFP there are outcomes and services reflective of Child Welfare that are not addressed: RFP pg. 14: Please clarify child welfare outcomes; ie., children remaining in the home, SCR reports indicated or under investigation, children returning home or moving to a lower level of care, employment, etc.,

A: Child welfare outcomes are included in this model. For example, children location at time of case closing, children remaining in home, events, improvement in family functioning, etc.

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40. Q: Referencing Standards and Practice. Clarify who is expected to attend the Utilization Management? Can this be supervisors?

A: Supervisors are expected to attend.

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41. Q: Management of capacity section: The RFP states "allowances will also be made during the startup time frame for new contract to achieve a full caseload" – would they be able to give specifics around this – is there a ramping up percentage minimally we will have to achieve and how long is the start-up time frame – one month or one quarter?

A: Transition plans will be developed for each phase and based on discussions between ECDMH, ECDSS and agency.

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42. Q: Upon signed contract – when do you propose that the High Fidelity Wrap training would occur? This will impact the ramping up numbers.

A: Scheduling and timeframes (and impact on each other) will be taken into consideration for how and when an agency can "ramp up."

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43. Q: What is the training going to look like for the new data base (Fidelity Electronic Record) – also is there an agency-cost to have access to the fidelity electronic record?

A: There is no direct cost to the agency for the electronic health record. Staff will be trained in the EHR during HFW CC training.

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44. Q: I am assuming that fidelity to the high fidelity wrap model will be tracked in the fidelity electronic record – will we be able to run our own reports off of this mechanism?

A: Agencies can run reports from the electronic record. Additionally, CCNY provides monthly analytics reports that allow for performance monitoring and management of staff and caseloads. CCNY also assess fidelity to the model and provides feedback and coaching to agencies.

The ECDMH in collaboration with ECDSS will also conduct periodic site reviews.

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45. Q: Will there be expectations on vender service availability and will allowances be made

A: Question is unclear. Please see previous responses to questions regarding vendors.

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46. Q: Will intensive cases have additional vender services budged as the contact expectations are much greater?

A: The budget per family per monthly <u>average</u> is $500. It is the expectation that budgets are managed across an entire caseload capacity (or agency caseload capacity) as some families may require more than $500 per family per month while others require less. Training in this method is provided during HFW CC training as well as in one-on-one coaching with the agency.

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47. Q: In question 1.e., the RFP asks respondents to describe familiarity with HFW and local practices. Please clarify what is meant by "local practices".

A: Local practice is defined as Erie County HFW as indicated in policies and procedures (updated manual to be disseminated by end of year)

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48 Q: I would like to know if your RFP is for non for profit agencies only? Does this RFP support small businesses?

A: Please see page 1, Introduction.

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49. Q: In the RFP it says provide 24 hour on call support through the Care coordinator/ identified vendor. Please clarify. Does that mean a care coordinator does not need to be on call and if a vendor is hired to answer those calls that is acceptable?

A: HFW Agency is responsible for implementing on-call support for intensive services cases as defined by the referral. A vendor is not an appropriate “on-call” service or plan.

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50. Q: The MST program in Erie County is currently funded and contracted through ECDMH and ECDSS. The latter funding and contract for MST is encompassed in a broader Catholic Charities preventive services contract (traditional, refugee, kinship and mst). The approximate cost of MST within this broader contract is $485,000. In preparation for Catholic Charities submitting for the RFP to provide high fidelity wraparound for preventive services, please indicate:

- if it is the county's expectation for MST to also be included in this RFP to allow 2018 funding for continued MST provisions currently funded by DSS.
- if this is the case, please also indicate instructions in how to best answer to the RFP while also ensuring the high MST standard received by current youth and families.
- if this is not the case, please indicate directions to re-contract this approx. level of funding for 2018.

A: MST is not part of this RFP. Implementation of 2018 contract for MST will follow historic processes.

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51. Q: We are curious about the roles of DMH/DSS in this joint venture, and are interested to know the responsibilities of each entity in the monitoring and assessment of these contracts.

A: ECDMH, in partnership with ECDSS, will monitor the contracts and program outcomes. The official contract will be held with ECDMH and in accordance with ECDMH contract processes.

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52. Q: The RFP does not address a transition plan for agencies selected in the initial roll out. Please describe the approach to continuing to care for Preventive cases during to transition to HFW model. Will current cases be automatically transferred for services or are they intended to be re-processed thru the SPOA Committee?

A: Please see answers to previous questions regarding transition of cases.

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53. Q: Refugee families are not addressed specifically in any area of this RFP. Our experience indicates that there are critical differences in the needs and service provision for these families. One difference is the use of translators for both agency Preventive staff and, under the new model, for vendors. Please clarify where in the budget translation cases would be provided the funds to pay for interpreter services. Also, please clarify the use of interpretation vendors to provide services – is this for both the identified vendor service providers such as skill builders and therapists, and/or Care Coordinators?

A: Consistent with county contracts, these service costs are expected to be included in agency gross costs.

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54. Q: Refugee families require a higher number of units of service per family due to the multiple areas of need and difficulty navigating community resources due to language barriers. Intensive families require exponentially higher resources. Kinship families require case management among 2 to 3 or more households. How are these needs weighted in terms of caseload?

A: Please see answers to previous questions regarding caseload management.

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55. Q: Pg.1 #1 Please clarify regarding incidents of abuse or maltreatment: are these alleged or indicated, court ordered or voluntary?

A: All cases are initiated and opened by ECDSS staff and meet the mandated preventive guidelines and eligibility requirements.

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56. Q: Explain how voluntary services are accessed under the new model.

A: Please see answer to question 7.

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57. Q: Pg. 2 Roll out will result in a grand total of 864 slots when all contracts are converted. Currently, there are 2100 slots in PS. How will PS reach 1000 slots as indicated by Commissioner? Is there a plan for adding additional providers in 2019 to cover the shortfall?

A: Current contracted capacity through ECDSS is less than 1,000 slots in 2017.

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58. Q: Pg3 #1 " a small portion of the flexible funds …" currently PS uses a significant amount on providing necessary items such as beds, cribs , diapers and formula often needed while awaiting WIC, SNAP etc. Will there be another revenue source to provide these funds? The vast majority of PS cases involve infants, toddlers and preschoolers.

A: Budget per family per month is $500 with expenditures to be planned for and authorized through the child and family team process. Additionally, the county has emergency services funding for such items as described above. HFW CC will learn the process for accessing the county emergency services during training.

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59. Q: Contract extension

A: This is not a question.

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60. Q: Pg.6 What is the estimated timeline for the process of CS/CPS referral to SPOA, and SPOA assignment to agency?

A: All referrals will be made through a centralized intake process. Intensive preventive occurs within 24 hours.

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61. Q: Pg.6 Under principals and components of successful CFT: please clarify the role of Family Court in ordering and monitoring services.

A: HFW CC is expected to provide court report to update Family Court on services and outcomes.

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62. Q: Pg.6 How will families be afforded choice over their case plan? What changes in Family Court will allow this process to be family-driven?

A: If services are court ordered; families will still have a choice of community service provider, vendor, etc. There will be non-negotiable instructions from family court that will need to be included in the plan of care and developed through the CFT process but families will also have a voice and choice in identifying additional family vision and goals apart from the mandated requirements.

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63. Q:P6 6 Please clarify the role of the role of the Law Guardian?

A: There is no longer a Law Guardian role; children have an Attorney for the Child (AFC) and the role has not changed. Best practice is to include the AFC in the CFT process.

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64. Q: P6. 6 Please clarify the process for how violations will be filed.

A: ECDSS Case Manager, with direct consultation from HFW CC, files violations.

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65. Q: Pg 7 clarify expected date of OCFS universal assessment roll out.

A: OCFS has not given any date.

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66. Q: Pg.8, clarify what assessment will be required in 30 days. PS members looked at the CANS-Family as an option. Clarify if this can be used?

A: Please see response to question 37.

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67. Q: Pg. 8 under Crisis/Safety plan, no indication of typical child welfare crisis such as medical emergency, parents drug and/or alcohol use, no utilities, lack of food, medication etc. Do they remain part of the risk /safety plan?

A: Yes.

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68. Q: Pg.9 Transition Plan, the role of the case manager needs to be clarified here. PS agencies do not close cases. Will Plan Amendments suffice?

A: Roles are clarified in the updated policies and procedures manual to be disseminated December 2017. ECDSS Case Manager closes the case in consultation with HFW CC.

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69. Q: Pg.10 There is concern that the Vendor Network does not have the vendor services needed to support this model, for example community interpreter, professional translators and group recreation. Vendor services are difficult to find in rural communities. Who assumes responsibility to do the service if no vendor is available?

A: Current vendor agencies are recruiting and new vendor agencies are being added to the network as well. All agencies are also encouraged to consider becoming a vendor provider. Interpretation and translation services are expected to be included in the gross cost of the agency (consistent with current expectations). HFW CC is expected to identify community and natural supports to provide services as well.

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70. Q: What are the limitations or restrictions for agencies who provide both Care Coordination and Vendor services and wish to utilize their own vendors?

A: Agencies can provide both services and self-referral is monitored closely to ensure family voice and choice is honored. Historically, up to 50% of vendor services could be self-referred.

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71. Q: Pg. 11 Capacity standards: We anticipate that individual workers' caseloads will be mixed among Intensive, Kinship and "traditional" families. How are Intensive, Refugee and Kinship families, who require significantly more time for visits and case management services, weighted when determining caseload? Please clarify if a vendor can be counted for weekend / evening coverage.

A: Please see previous response to Question 3.

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72. Q: Pg.11 Intensive cases require 2 HV per day. Do agencies have leeway to determine if families require 2 HV per day, or perhaps a longer, more intensive, visit once per day?

A: Please see answer to Question 4 and 99.

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73. Q: Page 13, under Management of capacity. What is the method and frequency to report our "actual expenditures", and to whom will we report this information? What is the expected the time frame for payment of expenditures?

A: Quarterly cost reports will be due to ECDMH. Contract providers receive payments through quarterly invoices.

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74. Q: Pg. 13 Please clarify who will be responsible for ensuring we get the referrals for our slots when we report we have openings, we also need to know what their expectation is for an acceptable timeframe for us filling an open spot, ie. same day, within 24 hours, 48 hours.

A: Capacity is managed through an automated "slot table" generated via Fidelity EHR and is based on case closing dates. Please see pg. 11 of the RFP for first face to face expectations.

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75. Q: Pg.13 description of deficit funding, will there be a grace or start up period where deficit will not be taken? Intake is controlled by SPOA with referrals from DSS. Clarify the process in particular for IPHBS.

A: All referrals will be processed through a centralized, standardized intake process at ECDSS and ECDMH. Deficit funding is advanced quarterly with end of year reconciliation based on actual expenditures in the cost reports.

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76. Q: Pg.14 There are few child welfare related outcomes. How will this impact agencies during state CFSR reviews?

A: Outcomes are recorded, monitored and tracked through Fidelity EHR. Per ECDSS, the state CFSR is complete and the PIP is being developed.

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77. Q: Please clarify, is this a contract with the Mental Health Dept. or DSS? If it's a joint contract, can this be clearly identified as to who will be performing specific roles?

A: Please see response to question #51.

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78. Q: Pg.1 - #1 please clarify on "incidents of abuse or maltreatment": are these alleged or indicated, court ordered or voluntary?

A: Please see response to Question 55.

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79. Q: Please clarify how voluntary services are accessed as we frequently have Native families that call requesting services.

A: All preventive services are mandated and not voluntary and must be processed through the ECDSS intake.

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80. Q: Pg. 2 - Roll out will result in a grand total of 864 slots when all contracts are converted. Is there a plan for adding additional providers in 2019 to cover the shortfall?

A: We do not anticipate a shortfall.

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81. Q: Pg. 3 - #1 " a small portion of the flexible funds …" currently PS uses a significant amount on providing necessary items such as beds, cribs , diapers and formula often needed while awaiting WIC, SNAP etc. Will there be another revenue source to provide these funds? EAA? The vast majority of PS cases involve infants, toddlers and preschoolers. Clarify validity of need for CFT meeting in family emergencies.

A: Please see response to Question 58.

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82. Q: Could expenses used in Flex dollars for emergencies be added to gross operating costs as in interpreters (see pg. 17)?

A: Please see response to Question 58.

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83. Q: Pg. 5 - Clarify the last bullet…"Currently funded programs must re-apply in order to be considered for continued funding". PS members were told that contracts would be continued at their current funding level, until such time as they either become HFW or Vendor provider. Clarify if there will be a formal contract extension, that will come from legal before 12-31-17, when contracts expire.

A: There will be a contract extension.

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84. Q: Pg. 6 - Introduction only refers to youth; clarify if cases with infants, toddlers and preschoolers will be served in another model.

A: Please see eligibility on page 1 and response to Question 34.

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85. Q: Pg. 6 - SPOA will initiate the referral: Clarify if SPOA will be available all day to screen and assign cases such as IPHBS? Who will present cases? Can you tell how quickly is a decision made? How will NACS we be notified?

A: Please see answer to Questions 28, 60, 75, and 103. Agencies will be notified via electronic referral in Fidelity HER.

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86. Q: Pg. 6 - Under principals and components of successful CFT: please clarify the role of Family Court in ordering and monitoring services.

A: Please see answer to Question 61.

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87. Q: Pg. 6 - Will families have choice of providers?

A: Families will be assigned based on family choice and agency capacity.

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88. Q: Pg. 6 - Please clarify the role of the role of the Law Guardian?

A: Please see answer to Question 63.

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89. Q: Pg. 6 - Please clarify the process for how violations will be filed.

A: Please see answer to Question 64.

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90. Q: Pg. 7 – Please clarify expected date of OCFS universal assessment roll out.

A: Please see answer to Question 65.

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91. Q: Pg. 8 - Please clarify what assessment will be required in 30 days. NACS has used the North Carolina Assessment Tool and has been looking at the recently released CANS-Family as an option. Clarify if this can be used?

A: Please see answer to Question 66.

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92. Q: Pg. 8 - Crisis plans are reviewed and/or updated minimally every 30 days at CFT meetings. Can the CFT meeting be considered one of the required face to face contact?

A: Please see answer to Question 35.

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93. Q: Pg. 8 - under Crisis/Safety plan, no indication of typical child welfare crisis such as medical emergency, parents drug and/or alcohol use, no utilities, lack of food, medication etc. Do they remain part of the risk /safety plan?

A: Please see response to question 67.

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94. Q: Pg. 9 - Transition Plan, the role of the case manager needs to be clarified here. NACS does not have the authority or ability to close cases. Will Plan Amendments suffice as closings?

A: Please see answer to Question 68.

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95. Q: g. 9 - clarify under PN if releases can be scanned into FEHR record, rather than a specific PN reentering datA:

A: Releases and other supporting documents can be scanned into the electronic record. Progress notes must be entered and not scanned.

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96. Q: Pg. 10 - NACS is concerned that CCNY does not have the vendor services needed to support this model, for example community interpreter, professional translators and group recreation. We know from our experience that Vendor services are difficult to find in rural communities.

A: Please see answer to Question 69.

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97. Q: Who assumes responsibility to do the service if no vendor is available? Can CC agencies be vendor providers or HH providers?

A: Please see answer to question 69.

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98. Q: Pg. 11 - Capacity standards: if loads of CC are mixed with 12 cases, Ratio is too high for IPHBS. Please clarify if a vendor can be counted for weekend / evening coverage. If following Home Builders Model this ratio will not work. Can cases be weighted? (ie IPHBS=3 Kinship = 2/3 depending on the number of 1017)

A: High Fidelity Wraparound is the evidence based model being implemented, not Homebuilders.

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99. Q: Pg. 11 - clarify the required 2 HV per day. Typically, on day one a family is seen for several hours or as long as needed to secure a safety plan that is satisfactory for CPS.

A: Please see response to Question 4 and 72.

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100. Q: Pg. 11-12 - contact requirements for Kinship need to be weighted, for example in a case with 2 1017 plus birth family = 3 cases. Same is true for Intensive cases need to be weighted.

A: Please see response to Question 3.

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101. Q: Required training, need to add Mandated Reporter training, Ages and Stages, ACES, Trauma Informed Care, Progress Note, Human Trafficking, FASP and other Connex training.

A: Please see response to Question 38.

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102. Q: Pg. 13 - under Management of capacity.... we need to ask clarification on what the mechanism will be for reporting our "actual expenditures" and the time frame for payment of expenditures; and what will be mechanism for reporting our utilization and who will we report this to.

A: Please see response to question 73 and 74.

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103. Q: Pg. 13 - description of deficit funding, will there be a grace or start up period where deficit will not be taken. Intake is controlled by SPOA with referrals from DSS. Clarify the process in particular for IPHBS.

A: Please see response to Question 75.

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104. Q: Pg. 14 - There are no specific child welfare outcomes, such as children remaining at home, indicated SCR reports, children moving to lower level of care, employment etc. Clarify how data will help in CFSR reviews?

A: Please see response to Question 76.

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105. Q: The RFP does not address transition plan for agencies selected in the initial roll out. Clarify where will their current cases be transferred for services or is it assumed they will all be re-processed thru the SPOA Committee?

A: Please see response to Question 41.

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106. Q: We want to ensure cultural sensitivity and compliance with the Indian Child Welfare Act is a consideration in review of all applications.

A: Yes.

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107. Q: Since the Care Coordinating agency has to provide culturally appropriate services including serving individuals with special needs, what kind of special operating expenses can the Care Coordinating agency expect to incur?

A: Gross cost budget is same for every agency.

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108. Q: How long is the startup period? And should the Care Coordinating agency submit a separate budget for the start-up period?

A: No separate budget for startup period. See response to question 41 for info on transition period.

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109. Q: Is the Care Coordinating agency required to pay for the booster sessions? And if yes, what is the cost per employee?

A: CCNY provides all initial and booster trainings at no cost to the HFW CC Agency.

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110. Q: What is the Care Coordinating agency's responsibility in regards to flex funds?

A: Please see response to Questions 46 and 58.

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111. Q: How many the Care Coordinating agencies does Erie County anticipate contracting with in reference to this RFP? Is there are a maximum number of agencies Erie County is considering contracting with?

A: Unknown at this time

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112. Q: Will Erie County train the Care Coordinating agency staff on the CANS-NY and the OCFS Assessment at no cost to selected organizations?

A: Yes. CCNY will train staff on the selected assessment tool.

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113. Q: Is CCNY responsible for monitoring notes and quality services of vendor service agencies?

A: Vendor agency supervisors and HFW CC are responsible for monitoring quality of services provided to their cases. Additionally, CCNY completes numerous audits and analytics reports to measure and monitor quality of services.

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114: Q: Do vendor services agencies get paid for No Shows?

A: Please see policy #54 in the policies and procedures manual on the ECDMH website.
http://www2.erie.gov/mentalhealth/index.php?q=family-voices-network

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115: Q: Is the Care Coordinating agency required to keep track of costs expended per month per family or is that CCNY's responsibility?

A: Vendor services costs are tracked in Fidelity HER.

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116. Q: If a family can attain vendor type services paid via Medicaid or private insurance, would the Care Coordinating agency use the Vendor services through Wraparound funds just until those Medicaid services can get set up?

A: Services paid via Medicaid and/or private insurance should be used first (before vendor services).

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117. Q: Are the required assessments or required forms to be completed with participating families available in languages other than English? If not, can the provider translate the forms in another language to ensure that services are delivered in a culturally and linguistically manner?

A: They are not and yes the provider can translate them if needed.

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118. Q: Are applicants required to submit any insurance documentation/certifications with their proposal on November 28th?

A: No.

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119. Q: Clarification of Vendor dollars $4,032,000 on pages 2-3. Flex funds are included in Vendor dollars for the PFPM dollar allocation, correct?

A: The terms flex funds and vendor dollars/vendor funds are used interchangeably. It is one budget of $500 per family per month.

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120. Q: Interpretation services can be paid for out of Flex funds, correct?

A: No.

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121. Q: Can HFW Care Coordinators in this RFP model also be vendor service providers? What are the restrictions (i.e. not at all, only for families not on their caseload, only for families from other HFW agencies, etc.?)

A: Please see responses to Questions 69 and 70.

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122. Q: Any consideration to "grandfathering" in a non-master's degree Preventive supervisor into the HFW Supervisor?

A: Please see response to Question 2.

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123. Q: Is there any provision for a staff person to be grandfathered into their supervisory position who has a bachelor degree and ten years of preventive services experience?

A: Please see response to Question 2.