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JOB & FAMILY
SERVICES

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HCJFS REQUEST FOR PROPOSAL
MEDICAL CONSULTATION SERVICES
RFP SC02-18R

ADDENDUM 3

Questions asked after RFP Conference:

Q1. For Service Components A 1-12, which population of children will require each service component? For example, for Service Component A 1, is the request to participate in visits for children in custody, children receiving services from HCJFS, children screened in after reporting, or another group? For Service Component A10, is the request to provide consultation for transitional age youth in custody or transitional age youth with HCJFS involvement, or another group?

A: The population for all service components would be based on the specific needs of the child or family and could be any child who is an active member of an open Children's Services case regardless of custody status.

Q2. For Service Components A 1-12, is there an estimate of how many children or families, or what percentage of each population, will require those services? For example, for Service Component A10, is there an estimate of what percentage of transitional age youth will require consultation? 100%?

A: We are unable to provide an estimate at this time. However, since these services would be based on the needs of a specific child or family, there would not be any requirement to serve 100% of the population.

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Q3. For Service Component A 3 H, is there an estimate for how many case conferences there will be that will require medical professional participation?

A: We are unable to provide an estimate at this time. However, it's anticipated that the provision of written reports or summaries would be sufficient in lieu of attendance for a large percentage of conferences.

Q4. For Service Component A 3 H, how many semi-annual reviews occur at HCJFS annually? Is the expectation that the service provider has representation at all of them?

A: This service component is applicable to only those cases in which medical consultation services were utilized, which would be a much smaller subset of the semi-annual reviews. We are unable to provide an estimate at this time. However, it's anticipated that the provision of written reports or summaries would be sufficient in lieu of attendance for the majority of semi-annual reviews.

Q5. For Service Component A 4, how many screened out allegations involving medical neglect or physical injury occur annually? Is there an estimate of how many of these screened out allegations will require consultation?

A: Data from the last three years indicates that an average of 115 medical neglect reports are screened out annually. However, it should be noted that in many reports the concerns may be documented as 'neglect' rather than the subset of 'medical neglect', particularly when the referral source has only general information or concerns regarding such issues. Provision of data regarding physical abuse screen outs would not be an accurate reflection of those reports that potentially need consultation, since physical abuse captures many circumstances that extend beyond the scope of this service. It's anticipated that that only a small percentage (<5%) of screened out reports would require consultation.

Q6. What level medical professional (i.e. MA, RN, MD) is desired for Service Component A1-12, or is it up to the discretion of the service provider and each the needs of the situation?

A: The desired professional would be a Registered Nurse (RN).

Q7. For Service Component A-C, is obtaining and collecting and storing the medical records the responsibility of the service provider or HCJFS?

A: This is the responsibility of the service provider.

Q8. For Service Component A 4, is this review a chart review? Or is the service provider requested to do a visit with the child in question?

A: Consultation would be needed regarding information reported or known to HCJFS about the allegation and could include a chart review. A visit would not be requested for this service component, unless the child in question is already an active member of an open case. If the child is an active member of an open case a visit may be requested.

Q9. For Service Component A 8 D, this is a request for consultation regarding psychotropic medications. Is the expectation that a psychiatrist be available for this consultation? Component A 9 B also addresses child behavior. It was our understanding that behavioral health is carved out but these items would require some integration. Please clarify preferences.

A: A psychiatrist would not need to be available for this consultation and the expectation would be to assist HCJFS in providing integrated care for a child.

Q10. Does the Program Director (Page 10) and the Clinical Director (page 22) refer to the same position?

A: No. Section 2.5 of the RFP is only meant to provide examples of positions required to submit resumes with proposals. For this service, a Program Director is required as detailed in Section 1.2.2(B).

Q11. For Service Component B 6, can you clarify what population of children may require referrals for consultation within a 1-2 hour window? Is this only for children with a new open report undergoing investigation or could this be for the population of children in custody? Do you have any estimates on how many such field requests are anticipated? For example, how many priority-one and priority-two allegations are there per year and how many of those are likely to require field medical consultation?

A: We would like to clarify the information provided in Component B 6 to reflect the following: “Referral Response Time - Provider shall respond to referrals within one business day for consultation. For field visit requests regarding new allegations of child abuse or neglect, the provider shall be available for a field visit within two hours of the request.”

The field requests with the two hour response time would include those children who are subjects of a new report of maltreatment. We are not able to provide an estimate of the number of field requests at this time as this is a new service component.

Q12. For Service Component B 14, can you please clarify the work space needs for HJCFS staff? Is it for one individual only? Can the space be shared? Does main office mean a clinic setting, i.e. where patients are seen, or in an office environment? What are the requirements of that space?

A: Work space would need to be available if requested for program review purposes, but would not require space availability for daily work.

We need to clarify that those serving in the role of medical consultants under this program would be provided office space so that they can be co-located at HCJFS with child protection staff professionals.

Q13. For Service Component B14, can you please clarify the request for access to "all provider files, records, or other materials"? Would this be for access to records related to this Medical Consultation program only? Or is this request for access to other provider records, i.e. medical records, outside of this Medical Consultation program? What releases will need to be in place for those reviews, particularly for children who are not in HCJFS custody?

A: Access to the records for all individuals served within this program would be required. This would include other medical or provider records for these individuals. Required protocols and releases will be developed or modified as needed upon program implementation.

Q14. For Qualifications 2.5, what is the definition of experience with a similar program?

A: A similar program would be any program providing medical services and/or recommendations for services or treatment. Previous or current experience working with Child Protection services and families is desired.

Q15. For Service Component A 11, are there any parameters for the health education activities for children and child protection staff? Which population of children are requested to have health education activities? i.e. children in custody, children with child welfare involvement, children with child welfare report? Would it be expected that all of this population would need health education? Is there a preference for 1:1 vs small group vs. large group training for children? Is there a preference for 1:1 vs small group vs. large group training for child protection staff? Are there any mandated training requirements or modalities?

A: The population of children could include any child who is an active member of an open Children's Services case, regardless of custody. The health education activities would be requested to meet a specific need for a child and would not require education of 100% of

any one population of children. This may include 1:1 education or small group training. It would not likely involve a large group training for children or adults being served by HCJFS.

Health education activities for child protection staff would most likely occur in small or large group training, though there may be specific cases in which education on a topic related to a specific case may occur in a 1:1 setting. There are no mandated training requirements or modalities identified at this time.