County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

Board of Supervisors

GLORIA MOLINA
First District

MARK RIDLEY-THOMAS
Second District

ZEV YAROSLAVSKY
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

November 28, 2012

Dear Prospective Contractors and Interested Parties:

RESPONSE TO PUBLIC COMMENTS RECEIVED ON THE RE-RELEASE OF THE REQUEST FOR PROPOSALS (RFP #11-053A) FOR SAFE CHILDREN AND STRONG FAMILIES SERVICES

This response to public comments received on the re-release of the Request for Proposals (RFP #11-053A) for Safe Children and Strong Families is issued by the County of Los Angeles Department of Children and Family Services (DCFS) to prospective contractors and interested parties.

The Public Comment Conference, for the re-release of the RFP for Safe Children and Strong Families, was held on November 8, 2012. The comments (and questions) ranged from areas involving program design; the contractor selection process; required forms; hours of operation; etc. The overarching themes of the public comments were funding and requests to work in partnership with the Department to develop the programs within the RFP.

Attached is a listing of public comments received per program category. The Department will consider these comments during the final development of the Statements of Work and Sample Contracts. However, the Department reserves the right to make the final decision. Prospective contractors and interested parties will have an opportunity to ask questions during the Written Question and Answer period (January 2013) and the Proposers' Conference (February 2013). The Department will provide written responses to all questions received during the Written Question and Answer period and during the Proposers' Conference.

Please continue to monitor the Department's website or the COUNTY's home page at http://lacounty.info/doing_business/main_db.htm for information regarding the re-release of the Safe Children and Strong Families RFP and related activities.

Thank you for your interest in doing business with the County of Los Angeles.

TABLE OF CONTENTS

PREVENTION and AFTERCARE – Resource Center (Exhibit A) **1**

PREVENTION and AFTERCARE – CAPIT (Exhibit B) **12**

ASSESSMENT and INTERVENTION (Exhibit C) **17**

ADOPTION PROMOTION and SUPPORT SERVICES (Exhibit D) **26**

PARTNERSHIPS for FAMILIES (Exhibit E) **33**

GENERAL QUESTIONS (Programs) **40**

CONTRACTS ADMINISTRATION **49**

PREVENTION and AFTERCARE – Resource Center (Exhibit A)

1. Section 3.3 Increase minimum of subcontracting to 50%

2. Section 5.0 Case Navigation: 5.4 Utilize a trained Family Advocate to empower the family to communicate their needs and to build on their strengths. This Family Advocate will be someone who has utilized services to prevent child abuse and neglect with their own family and utilize this life experience to help others navigate the array of services to strength the family.

3. Section 7.36: Utilize evidence-based services preferably.

4. We fully share the commitment to collaborate with the County of Los Angeles (page 3) to provide health and social services that support the achievement of the County's Strategic Plan, mission, vision, goals and performance measures.

5. We commit to a comprehensive, integrated continuum of strengths-based, family-centered and community-oriented resources directed to vulnerable children and families in Los Angeles County.

6. We support the declaration on page 6 that "Contractor shall coordinate with other SCSF Contractors." That is the immediate function of the several Coalitions

7. We support the Department's recognition that these ***prevention initiatives*** need to function by SPA area

8. Please give careful consideration to renaming the **Resource Center** as the ***Prevention Initiative*** which it now truly represents, in order to dispel the misconception for families and agencies that it is singularly place-based. The proposer may be a HUB for a geographically and culturally diverse array of organizations which are accessible to families. The Contractor would serve as Leader, not Center of the community system of services.

9. Primary prevention, which is family- and community-defined, is not supported in the SOW. While present in the description, primary prevention is "tossed aside" for more classical intervention strategies in the operational elements of the SOW.

10. Secondary prevention is broader than the definition in page 4. The strategies to address risk factors exist for at-risk family circumstances to prevent child maltreatment are delineated on page 5 and are embodied in the ***Prevention Initiative.***

11. The Clinical Director staff position is a remnant of the previous SOW and not necessary, or considered a prevention best practice for Prevention and Aftercare activities.

12. We support the ***Prevention Initiative*** as SPA based and recommend that dollar allocations be based on need and not fixed amounts evenly divided among 8-10 SPAs.

13. There was insufficient funding in the initial SCSF RFP release to support the required full time staffing for professional and paraprofessional and case aide staff, yet alone administrative support staff. We urge DCFS to work in partnership with community-based organizations to develop realistic funding levels for prevention services.

14. There needs to be geographic and culturally accessible prevention activities for families. The Coalitions (collaborative HUBs) need to be the planning/allocation mechanisms for determining the spread of resources in the SPA areas. Listing the Resource Center as one geographic center moves away from the establishment of neighborhood-based resource hub across SPAs and is again more of an intervention strategy than a prevention practice

15. PIDP was limited to 2-3 zip codes in certain SPAs (i.e. SPA 4). Rolling out the PIDP approach to the entire SPA communities will take more resources.

16. We support maintaining, or raising the minimum of 35 percent to be subcontracted to community partners for locally-directed family activities to prevent social isolation, depressed economic hope and barriers to supportive services that address child abuse risks.

17. We oppose the required development of a program plan for Differential Response services without any funding yet available. While the budget derives from the program design; the program design absolutely requires the budget as a structure within which to create the staffing, contracting and service delivery/activity planning designs.

18. Page 9 absolutely requires that 10% of referrals (4 families) be family reunification families. This is another instance where the community organizations are dependent on the DCFS regional offices for referrals, and thereby become an integral component of the community Coalitions. For FR cases, we are supportive of this helpful, specialized focus on providing community-based support for biological parents seeking to regain responsibility for their children.

19. Family reunification services should be designed or conceptualized as a continuum between Family Preservation, PIDP and the Resource Center.

20. The functions, resources and activities of the **DCFS Kinship Centers** currently centralized in 2-4 localities need to be incorporated into all Service Planning Area ***Prevention Initiative*** (Resource Center) proposals. This will provide kinship families, both DCFS funded and informal kinship families, with geographically accessible support groups and education.

21. Standards and timeframes throughout the 5 program categories for actions and documentation should be collaboratively developed among DCFS and community stakeholders during the implementation phase and not necessarily dictated unilaterally through this RFP.

22. On page 11, the requirement of one (1) community outreach a year is unreasonable. A plan for a dozen outreach activities over the year may be more reasonable an expectation.

23. Please reword the title on page 12 from “Contractor directed” to “Community directed” to reflect the intended service integration.

24. We ask for consideration that Community-directed discretionary funds should be flexible and be family/community driven and not limited to making “one choice among 3-5 options” for each outcome area. This runs counter to the stated intent for grassroots decision-making, responsibility and accountability.

25. Pre-approval by a County manager for “use …for the implementation of every activity/service/ program” (see page 16) is not necessary. Perhaps the DCFS regional offices could play a role by active participation in the decision-making process as it is actualized in several service areas for PIDP.

26. Use of “Community-defined practices” (to be added on pages 13 and 17) is what the Prevention Initiative has successfully placed into our service delivery systems across the County. Community-defined practice” has been defined by DMH to serve as starting point to reframe and to address our collaborative Prevention and Aftercare approaches and principles in SCSF.

27. Page 7 (SOW 3.7.4.1): 45% total contract amount to contractor discretionary funds but in Sample Contract designates 45% (page 13 SOW 5.4.2) – We prefer the Sample Contract definition.

28. Page 5 (SOW 3.1): Contract will be awarded by SPA but clients shall have adequate access to Prevention and Aftercare services will align with catchment areas of the DCFS regional offices located within in the contracted SPA - Please make sure the funding is allocated appropriately in order to provide services to SPAs that cover large geographical areas and DCFS offices – also, fund more than one Resource Center in SPA 3 due to large geographical area and number of DCFS offices.

29. *We feel that primary prevention has largely been removed from the suite of DCFS strategies proposed for funding in the RFP:* While we applaud the Department's initial focus on the protective factors framework and its address to a strengths-based approach rooted in primary prevention best practice, our overall impression is that this focus quickly disappears from the SOWs and contracts as those documents begin to discuss guidelines for service provision, staffing, and budgeting. Even in the strategy area in which we would expect to find the most pronounced commitment to primary prevention—the resource center—our reading of the SOW and contract has left us to conclude that the service methodology being proposed is overwhelmingly oriented toward intervention and treatment. Some key areas in which this shift of methodological focus is most pronounced, along with our preliminary recommendations for revisions, include:

    a. *Clinical approach:* The requirement of a clinical director, and of a supervision apparatus that has its roots in clinical practice, is out of place as an across-the-board requirement in a non-clinical service category like the Resource Center. While we recognize the need for structured supervision of all staff attached to the program, in many instances the indigenous leadership and community talent appropriate to a

primary prevention program does not require supervision by a licensed clinician, but by senior staff grounded in community prevention. We would request that the RFP language reflect this, with clear indications that clinical supervision shall be required only for staff providing services that are intervention and treatment-based, such as license-track MFT and MSW clinicians providing therapeutic interventions, and shall not be required for prevention-based approaches such as community organizing. Furthermore, we would request that thought be given to funding levels adequate to support a licensed clinician if that requirement is to remain part of the RFP, in whole or in part. If funding levels are to be roughly similar to those presented in the previous iteration of the RFP, support for a Clinical Director will present a serious budgetary challenge.

b. *Required staff qualifications:* While some steps toward greater flexibility in use of paraprofessional and case aide staff have been taken since the first RFP, we believe that more work remains to be done in the Resource Center SOW, and to some extent in PFF and CAPIT as well, in order to align funded practice with best practice for primary prevention. As a family- and community-based approach, primary prevention relies extensively on indigenous leadership and neighborhood capacity. The current PIDP initiative has built a solid foundation on this basis—but this foundation will be rendered almost entirely unusable by the current SOW and contract's requirement of BA and MA-level staff for most core services.

c. *Subcontract budgets:* We would strongly recommend that the 35% of the Resource Center budget currently allowable for use by subcontractors be set at a higher percentage to allow for the formation of effective collaborations. True primary prevention, as a family- and community-defined approach that relies on increasing local capacity, needs to function as a hub with multiple “spokes” leading to referral sites throughout the community. Strong, funded partnerships are critical to achieve this structure.

d. *The requirement of a program plan for Differential Response services prior to notice of funding:* Developing a fully-formed plan for DR services without knowing whether funding will be available presents a severe challenge. Ideally, program design and program budgeting should inform and support each other: deliverables in the form of family and child outcomes are of course paramount, but the reality for our organizations is that getting to those outcomes requires fiscal decisions about staffing levels and qualifications, facilities, and operating expenses, all of which need to be informed by accurate budgeting.

e. *Intrusive intake and monitoring:* At present, the SOW for both Prevention and Aftercare areas requires an intake process during which families consent to make their data available to DCFS. While this may be appropriate for certain targeted populations (the 10% required Family Reunification services, or a Differential Response population), primary prevention functions largely on the basis of self- and/or community-referred families who may be hesitant to share certain data with DCFS and the broader child welfare system.

f. *More appropriate outcomes measures:* We applaud the department for including an outcomes form rooted in the protective factors framework as part of the Resource Center SOW. However, in the absence of clear metrics or indications of how these outcomes are to weighted against the standard (across all SOWs) measures of

involvement or reinvolvement with DCFS, it is difficult to determine how much they will actually be allowed to guide practice and program design.

30. *As currently structured, the RFP does not lay out a pathway toward a seamless and coordinated continuum of care:* The issue of five separate SOWs leads us to anticipate that, as was the case with the previous iteration of the RFP, applicants will apply separately for contracts in each of the 5 service areas. While certain changes since that first RFP have moved the Department's approach closer to a “continuum of care” (e.g., the shift to a SPA-based collaboration in the Resource Center), the overall approach still leads toward a series of disconnected providers of individual services that will only accidentally or after the fact create mechanisms of coordination and collaboration. Certain key populations, in particular (e.g., families receiving Family Reunification services), will be best served by collaboration between providers in several of the service categories. (In this case, CAPIT, PFF, and the Resource Center).

31. *Absence of anticipated allocation or budget amounts:* We are aware of the need to begin the public comments process in a timely fashion, and the difficulty of incorporating budget discussion when the disposition of key funding streams has not yet been determined. However, the ability to adequately plan for service provision in any of the service categories—and thus to provide meaningful, helpful commentary to the Department on the draft documents—is severely limited by the absence of any financial information. Suggested percentage allocations in the various contracts, for example, may be feasible and reasonable given a certain anticipated contract size, but become impractical at smaller total amounts. We also have some concern that the separation of the public comment process on the narrative/program design portions of the RFP from the financial portions, may be an indication that that Department intends to replicate one of the most serious flaws of the previous iteration of the RFP: the completely separate submission and evaluation of program proposals and financial proposals. As was indicated in many of the public comments at that time, this process will lead to a “race to the bottom” in bidding on the financial portion of the application, and this consideration of cost separately from program quality will distort the entire field of proposed services.

32. *Collaboration with CBOs:* Finally, we would strongly recommend that the Department design a process for further development and review of the new RFP that relies on the extensive network of partnerships with provider organizations. We see ourselves as collaborators and resources for the Department, and would welcome the opportunity to engage in a more fully collaborative design process in which discussion between public- and nonprofit sector partners drives development of the RFP. The current approach, in which draft documents are assembled for the most part without extra-Departmental input, and then released for public comment in settings where discussion cannot take place, artificially creates an adversarial environment that we do not believe accurately, characterizes the relationship between our organizations and the Department. We stand ready to support you in this work.

33. Section 8.0: The description of services appropriate for professional, paraprofessional, and case aide positions is unclear, and needs greater specificity.

34. Section B—Project Foundation, Target Populations 2.0 Page 4-5 details the Target Populations to receive services, but it does not adequately reflect the Primary Prevention population, which includes the general public. True Primary Prevention strategies target the general community and neighborhoods, not just those who are “in need of services to

prevent future child maltreatment and/or DCFS involvement." The population described in this section should include those who would qualify under Primary Prevention as the general population.

35. Section C—Service Description 3.0 Scope of Work 3.3 Page 6 states that the Contractor shall be required to subcontract a minimum of 35% of its services. Making subcontracting a requirement of this contract limits a potential Contractor from being able to provide services it may be able to provide internally. It would be more helpful if a Contractor had a choice to EITHER provide the services itself OR subcontract services to partnering agencies. If a Contractor has the ability to provide services, it should not be limited from doing so.

36. Section C—Service Description 7.0 New, Expanded and Specialized Services and Support 7.3 Contractor Directed Discretionary Funds Page 13-14 describes the types of comprehensive, strengths-based, child abuse and neglect prevention programs that are allowable, but this section does not include the Neighborhood Action Councils (NACs) that were a key part of the Prevention Initiative Demonstration Project (PIDP). NACs are ongoing neighborhood/community action groups led by community residents who have no direct affiliation or contact with DCFS and represent the true Primary Prevention population. If this is to be a true Prevention program, there needs to be a specific focus on primary prevention strategies such as the NACs and the activities supported by NACs as reflected in the PIDP program.

37. Section C—Service Description 8.0 Staffing Page 19 discusses the requirement of a Clinical Director for all services provided under the Prevention and Aftercare Program. For activities classified as true Primary Prevention, such as NACs, a provision for non-clinically-based, community organizing-focused supervision should be included. This is because the work of Primary Prevention is less clinical and driven more by a community-based process. To be clear, the recommendation is not to eliminate supervision but to be inclusive of the different types of supervision that the services and activities within this program would require. Some types of supervision may not be relevant for some services and activities (i.e. clinical supervision is not necessarily relevant for community-based organizing prevention strategies).

38. *Clinical approach:* The requirement of a clinical director, and of a supervision apparatus that has its roots in clinical practice, is out of place as an across-the-board requirement in a non-clinical service category like the Resource Center. While we recognize the need for structured supervision of all staff attached to the program, in many instances the indigenous leadership and community talent appropriate to a primary prevention program does not require supervision by a licensed clinician, but by senior staff grounded in community prevention. We would request that the RFP language reflect this, with clear indications that clinical supervision shall be required only for staff providing services that are intervention- and treatment-based, such as license-track MFT and MSW clinicians providing therapeutic interventions, and shall not be required for prevention-based approaches such as community organizing. Furthermore, we would request that thought be given to funding levels adequate to support a licensed clinician if that requirement is to remain part of the RFP, in whole or in part. If funding levels are to be roughly similar to those presented in the previous iteration of the RFP, support for a Clinical Director will present a serious budgetary challenge.

39. *Required staff qualifications:* While some steps toward greater flexibility in use of paraprofessional and case aide staff have been taken since the first RFP, we believe that more work remains to be done in the Resource Center SOW, and to some extent in PFF and CAPIT as well, in order to align funded practice with best practice for primary prevention. As a family- and community-based approach, primary prevention relies extensively on indigenous leadership and neighborhood capacity. The current PIDP initiative has built a solid foundation on this basis—but this foundation will be rendered almost entirely unusable by the current SOW and contract's requirement of BA and MA-level staff for most core services.

40. Section C – 3.0 – what does "P & A services shall be geographically accessible to clients and aligned with catchment areas of the DCFS regional offices located within the contracted SPA" mean? How would this requirement be implemented in a SPA based contract, which this contract is supposed to be?

41. Section 3.3 – the requirement to subcontract a minimum of 35% of P & A Services only makes sense if there is a large enough allocation of funding to feasibly do so. Without knowledge of the funding allocation, this item cannot be evaluated.

42. Section 3.6 – what is the definition of a Community Family Resource Center? Can this be a lead agency coordinating several partners providing a continuum of activities? Can it only be a single center to which it is expected that participants will travel? This is in conflict with best practice for implementation of Prevention activities.

43. Section 3.7 -- The percentages assigned to each type of activity to be included are far too prescriptive and ought to be removed.

44. Section 3.7.4 – How can a prospective contractor be responsive to the requirement of allocating 10% of contracted funds to a County Directed discretionary program without knowledge of available funding? How would an entity be able to determine what the program would cost?

45. The requirement of a program plan for Differential Response services prior to notice of funding: Developing a fully-formed plan for DR services without knowing whether funding will be available presents a severe challenge. Ideally, program design and program budgeting should inform and support each other: deliverables in the form of family and child outcomes are of course paramount, but the reality for our organizations is that getting to those outcomes requires fiscal decisions about staffing levels and qualifications, facilities, and operating expenses, all of which need to be informed by accurate budgeting.

46. Section 4.0 – Why is the "Differential Response Target Population" separated out? This population would naturally be part of the populations included in a comprehensive prevention program. Also, these participants are already targeted in Section 2.2.2.

47. Section 5.0 – Ascribing a specific percentage (25%) to participants for Case Navigation is far too prescriptive to be consistent with a prevention approach. The Case Navigation approach ought to be determined based on the needs of individual families.

48. Section 5.1.5 – Ascribing 10% of the contract to DCFS referred clients receiving FR services is far too prescribed.

49. Section 6.0 – If specific percentages are to be allocated to specific activities, 7½ % to Community Outreach & Capacity Building is far too little. This area is essential if one is to address the "underlying causes for child abuse and neglect". Why is it allocated such a small proportion of funding?

50. Section 6.2 – This section does not describe "capacity building" at all. This section requires going back to the drawing board.

51. Section 7.3.10 – Sentence makes no sense—please clarify

52. Section 7.3.12 – far too unwieldy

53. Section 7.5.1 – recommend this to say "can utilize" rather than "shall utilize" since contractors are supposed to try to utilize alternative aid approaches and only use these County funds if absolutely necessary.

54. Section 8.1 – Why would a Prevention Program require a "Clinical Director"? This is not a clinical program. Contractors might choose to utilize Clinical Staff as appropriate, but this requirement conflicts with best practice in Prevention.

55. Sections 8.1.5, 8.1.6, and 8.1.7 – these prescribed academic credentials are not necessarily indicative of the personnel best equipped to deliver the activities consonant with best prevention practice. Why are these credentials being arbitrarily required?

56. Section 8.4 – Program Manager should have this information for key personnel (Project Director, Project Manager) but going all the way down to line staff is inappropriate.

57. Section 9.2 – Requiring monthly, quarterly and annual reports seems inefficient.

58. Section 9.2.3 – What support will be provided for evaluation?

59. Section 9.3.2 – Individualized Family Service Plans are not necessarily congruent with best practice in Prevention. Why is this a requirement?

60. Section 11.1.4 – These time frames are not realistic.

61. Section 12.1 – Requiring birth dates is not congruent with attracting participants within the "general population" but at risk for child abuse and neglect. Why is this a requirement?

62. Secondary prevention is broader than the definition in page 4. The strategies to address risk factors exist for at-risk family circumstances to prevent child maltreatment are delineated on page 5 and are embodied in the Prevention Initiative.

63. Page 9 absolutely requires that 10% of referrals (4 families) be family reunification families. This is another instance where the community organizations are dependent on the DCFS regional offices for referrals, and thereby become an integral component of the community Coalitions. For FR cases, we are supportive of this helpful, specialized focus on providing community-based support for biological parents seeking to regain responsibility for their children.

64. Family reunification services should be designed or conceptualized as a continuum between Family Preservation, PIDP and the Resource Center.

65. Use of “Community-defined practices” (to be added on pages 13 and 17) is what the Prevention Initiative has successfully placed into our service delivery systems across the County. Community-defined practice” has been defined by DMH to serve as starting point to reframe and to address our collaborative Prevention and Aftercare approaches and principles in SCSF.

66. Page 7 (SOW 3.7.4.1): 45% total contract amount to contractor discretionary Page 5 (SOW 3.1): Contract will be awarded by SPA but clients shall have adequate access to Prevention and Aftercare services will align with catchment areas of the DCFS regional offices located within in the contracted SPA - Please make sure the funding is allocated appropriately in order to provide services to SPAs that cover large geographical areas and DCFS offices – also, fund more than one Resource Center in SPA 3 due to large geographical area and number of DCFS offices.

67. Section B, paragraph 2.4.1, page 5: there is no paragraph number 2.4 after 2.3; but there is paragraph number 2.4.1; then there is paragraph 3.4.1 under paragraph 2.4.1. Make the necessary corrections.\

68. Section C—3.0: what does “Prevention and Aftercare Services shall be geographically accessible to clients (sic) and aligned with catchment areas of the DCFS regional offices located within the contracted SPA” mean? If this is a SPA based contract, how would this requirement be implemented?

69. Section C, paragraphs 3.2.4 and 3.2.5, page 6: these two cannot be sub-paragraphs of 3.2. To be so they have to be outcome statements. Change their numbering to 3.3 and 3.4 respectively. The rest of the numbers should be changed too.

70. Section C, paragraph 3.3, page 6: the requirement to subcontract a minimum of 35% of Prevention Aftercare Services only makes sense if there is a large enough allocation of funding to make economies of scale work. Without knowing what the funding allocation will be, this item cannot be evaluated

71. Section 3.6 – what is the definition of a Community Family Resource Center – can this be a lead agency coordinating a range of partners providing a continuum of activities or is this solely a single center to which it is expected that participants will travel to come to? Again, this is in conflict with best practice for implementation of Prevention activities

72. Section C, paragraph 3.7, page 6 -- The percentages assigned to each type of activity to be included are far too prescriptive to be responsive to capitalize on the existing assets and meeting the challenges of unique areas of the County. These should be removed.

73. Section C paragraph 3.7.4, page 7: It would be quite onerous for a prospective contractor to be responsive to the requirement of allocating 10% of contracted funds to a “County Directed” discretionary program – without knowledge of available funding, how would any entity be able to cost out what that program would cost?

74. Section C paragraph 3.7.4, page 7: the total allocation to the discretionary fund is 57.5% of the total contract amount. In the sample contract, page 13 paragraph 5.14.1 the allocation to the discretionary fund is shown to be 15% of the contract amount. Reconcile the two.

75. Section C, paragraph 4.0, page 7: Why spell out specific attention to the "Differential Response Target Population"? This population would naturally be included in the continuum of populations that would be included in a comprehensive prevention program. Additionally, these participants are already called out as targeted in Section 2.2.

76. Section C, paragraph 5.0, page 9: Ascribing a specific percentage, in this case 25%, allocated to participants for Case Navigation is again far too prescribed to be consistent with a prevention approach. The approach of Case Navigation should be determined based on the family needs and desires.

77. Section C, paragraph 5.1.5, page 9: Prescribing 10% of the contract to DCFS referred clients receiving FR services is again far too prescribed.

78. Section C, paragraphs 5.10 and 5.11, pages 10 and 11: The two paragraphs appear to be the same. Combine.

79. Section C, paragraph 6.0, page 11: If specific percentages are to be prescribed to specific activities, 7 ½% to Community Outreach & Capacity Building is far too little. This is the area that is most essential to address is one is to address the "underlying causes for child abuse and neglect" – why would it be allocated such a paltry proportion of funding?

80. Section C, paragraph 6.2, page 12: In totality, this section does not describe "capacity building" at all – this section requires going back to the drawing board.

81. Section C, paragraph 7.3.6.3.1: page 15: On the first bullet point, the sentence following the topic "Institutional Transformation Activities" seems incomplete and the example given does not go with the topic.

82. Section C, paragraph 7.4.1, page 17: Change "shall" by "that" in the last sentence.

83. Section C, paragraph 7.4.1.2, page 17: The paragraph states in part: "… Contractor shall provide a proposal supporting the efficacy of the program" Why is the Contractor required to provide a proposal for County Directed Discretionary Funds? If contractor proposes it will not be different from the Contractor Directed Discretionary Funds. Clarify.

84. Section C, paragraph, and 7.4.1.5, page 17: The paragraph states in part: "DCFS Regional Managers within each SPA and Contractor shall jointly identify new activities, services and/or programs to be implemented. This contradicts with the statement in paragraph 7.4.1.2 which makes the contractor the sole proposer. Clarify.

85. Section C, paragraph 7.5.1, page 17: It should say "can utilize" rather than "shall utilize" since contractors are supposed to try to utilize alternative aid approaches and only use these County funds if absolutely necessary

86. Section C, paragraph 8.1, page 19: Why would a Prevention Program require a “Clinical Director”? This is not a clinical program. Contractors might choose to utilize Clinical Staff as appropriate but this requirement conflicts with best practice in Prevention.

87. Section C, paragraphs 8.1.5, 8.1.6, and 8.1.7, page 19: these prescribed academic credentials are not necessarily indicative of the personnel best equipped to deliver the activities consonant with best prevention practice. Why are these credentials being arbitrarily required?

88. Section C, paragraph 8.4, page 20: This is quite unwieldy; Program Manager should have this information for key personnel (Project Director; Project Manager) but going all the way down to line staff is inappropriate

89. Section C, paragraph 9.2, page 21: What is the efficiency of requiring both monthly, quarterly and annual reports?

90. Section C, paragraph 9.2.3, page 21: What is the support that will be provided for evaluation?

91. Section C, paragraph 9.3.2, page 21: Individualized Family Service Plans are not necessarily congruent with best practice in Prevention; why are you requiring this?

92. Section C, paragraph 11.1.4, page 22: These time frames are not realistic

93. Section C, paragraph 12.1, page 23: Requiring birth dates is not congruent with attracting participants within the “general population” but at risk for child abuse and neglect; why would this be needed?

94. Section C, paragraph 12.3, page 23: Delete “and” after Safe.

95. Section D, page 24: What is the purpose of including the chart on page 24? If the outcomes to be proposed are to be within those listed on the chart on page 25, the inclusion of the DCFS outcomes chart is confusing. Remove.

96. Section D, page 25: The first row in the first two columns should not be there because the statements in there are not services, activities or outcomes.

97. Section D, page 24 – 27: The absence of clear metrics or indications of how these outcomes are to be weighted against the standard measures of involvement or re-involvement with DCFS, it is difficult to determine how much they will actually be allowed to guide practice and program design.

PREVENTION and AFTERCARE – CAPIT (Exhibit B)

1. Section 1.0 Purpose Adequate funds need to be provided to support the array of Prevention and Aftercare Services

2. Section 4.5 Parenting Education Services: Include evidence-based programs that empower families to strengthen families and prevent child maltreatment.

3. We support the new language within CAPIT which attempts to integrate into the continuum of care by virtue of its restored connection to the Community Family Resource Center.

4. CAPIT currently contributes to both (a) integration of counseling and psychotherapy within the mental health system for indigent families and (b) extension of parenting education and extension of family support/family preservation case management and in-home services. We urge that funding for CAPIT be expanded in order to ensure that these two essential program elements be sustained throughout the SPAs.

5. Outcomes could be extended beyond the narrowly-focused DCFS interests to community-defined outcomes

6. Staffing should be flexible in terms of part-time, full-time and contracted staff requirements and shared resources across organizations.

7. With current CAPIT funding being an average of $69,000, we cannot hire even one full-time mental health professional. We urge DCFS to work to bring AB2994 funds into the funding matrix in order to ensure CAPIT's viability

8. Make the CAPIT budgets more flexible. Currently, you get a fixed budget of professional services and a fixed budget for paraprofessional services. It would help if we got the total amount with the ability to bill either without the fixed limits in each category. Now if you spend down one category you can't bill anymore of those services, even if you have money in the other category left

9. Regarding section 3.1., as a program designed for prevention and aftercare, aren't families with a current open DCFS case ineligible as they are at that point neither in the prevention or aftercare phase. It may be better to read: "Families who have recently had their cases closed with DCFS".

10. Page 21 Sample Contract Project Manager to be available 24 hours a day 7 days a week which is inconsistent with SOW page 4—2.4 - CAPIT is not an emergency program and does not have the funding to support a 24 hour program. Provide more funding or simplify language to be available to respond during the traditional business hours of Monday through Friday from 9 am to 5 pm as stated in the SOW page 4—SOW 2.4.

11. Page 7 (SOW 4.3.5) Travel time for in home services - In order to meet the protective factors (social connections), reimbursement for travel time should include services provided at school and other community locations as necessitated by the goals listed in the treatment plan

12. Contract amount will not allow for reimbursement rates that are comparable to DMH/Medi-Cal rates which places agencies at risk for losing their DMH contracts. - Review rate structures

    a. Please consider reviewing the rate structure that DMH maintains for similar services and ensure the funding amount is adequate enough to allow contractors to hold to rates for DCFS programs/services that are comparable to DMH rates for the same/similar services.

13. Several CAPIT services require a paraprofessional level staff member at minimum; however, the CAPIT SOW does not define paraprofessional level staff. Please indicate if it is consistent with the definitions noted in other components of the RFP (i.e. in Assessment and Intervention Services) or if it is defined differently in CAPIT. Paraprofessional level staff historically have been classified as those with a minimum educational level equivalent to a Bachelors Degree or those with commensurate experience in a field related to the services being provided. It would be helpful to know exactly what the classification is for this program.

14. CAPIT funds remain the only flexible funds available to agencies to provide essential prevention and aftercare services to families in the community. Funding for this program element needs to be increased in order for this service to remain viable in the SCSF continuum. AB2994 funds need to be returned to the funding matrix in order to sustain CAPIT and make it a viable program for agencies and families.

15. In the SOW it is unclear if CAPIT will remain SPA-based as it currently is provided or if DCFS is recommending that it change to a Regional Office funding base. We urge DCFS to maintain CAPIT as a SPA-based program in order to sustain the flexibility of the program.

16. In the SOW, Section B, 1.0 Purpose on Page 2, Attachment Q is referenced for the Five Protective Factors. Attachment Q was not included with the SOW.

17. In the SOW, Section B, 2.1 on Page 3 lists the Core Services of Intake and Assessment, Psychotherapy, Counseling, In-Home services, Case Management and Linkage services, Referral and Parenting Education services. These are County-directed services and not aligned with the Strengthening Families approach and Protective Factors framework.

18. In the SOW, Section B, 2.5 on Page 4 states that the CONTRACTOR will have a physical location in the service area they are contracted to serve within 30-60 days from the contract award. We urge that DCFS change this condition and require that a CONTRACTOR have an already existing physical location in the service area and a history of relationships in the service area as a threshold condition for applying for CAPIT funds.

19. In the SOW, Section C, 4.0 Scope of Work, page 4, the services listed under Paragraph 4 should be restated and aligned to the Protective Factors Framework.

20. In the SOW, Section C, 4.1 Intake and Assessment Services, page 5, Paragraph 2 refers to Attachment Q. This Attachment is not in the SOW.

21. In the SOW, Section C, 4.1 Intake and Assessment Services, page 5, Paragraph 2 states that the Contracted Agency is responsible for developing an appropriate intake. There is already a Protective Factors Survey that is evidence-based. Rather than have agencies compete to develop their own intake, DCFS should use the Protective Factors Survey as part of the intake. Additionally, DCFS has discussed using the Family Assessment Form (FAF) in other program components of the SCSF continuum. DCFS could use the FAF as the core intake for all continuum programs including CAPIT. This would be an evidence-based approach and remove the competition between agencies to develop their own intake.

22. In the SOW, Section C, 4.1 Intake and Assessment Services, page 5, 4.1.5 indicates that the case plan should at minimum include the following: Identify client therapeutic needs; Identify client's basic needs; and Include the client's signature indicating that they are in agreement with the case plan. This section needs to restated as a "Family Strengths Plan" in terms of the Strengthening Families approach and Protective Factors framework. Areas to be identified for further action should be aligned to the 5 Protective Factors and not overly prescribed therapeutic interventions.

23. In the SOW, Section C, page 6, 4.25 Family Case Records, 4.2.5.3 states that the case plan shall address the protective factor(s) which were assessed to need strengthening. We recommend that DCFS include the Protective Factors survey in this section as the vehicle/process for determining and developing the plan to strengthen the Protective Factors.

24. In the SOW, Section C, page 8, 4.5 Parenting Education Services, 4.5.1 states that Parenting groups shall meet for a minimum of twenty (20) sessions conducted over a period of not less than twenty (20) consecutive weeks. CONTRACTOR has the ability to submit a request for CPM approval to waive the (20) session requirement based on the agency's curriculum and/or training. We recommend that DCFS work in partnership with its existing network of agencies to determine a listing of evidence-based and community-defined practices for parent education that are aligned with the Strengthening Families approach and Protective Factors framework prior to the RFP release.

25. In the SOW, Section C, page 9, 5.1 Quality Assurance Plan, paragraph 2 states that the CONTRACTOR'S QAP shall include a description of its service delivery model components and detail how those components align with the Protective Factors Framework. 5.1.3 states that the CONTRACTOR'S QAP should identify its plan to meet or exceed the CAPIT contract's Performance Outcome Measures, Section D of the SOW. In the CAPIT Sample Contract, pages 36 and 37, Section 24.2 reiterates SOW 5.1.3 and Section 24.4 states that CONTRACTOR'S QAP shall include strengthening families protective factors to ensure compliance with the CAPIT contract. Yet, in the SOW, Section D, pages 11 and 12, Performance Outcome Measures for Prevention Services, the only outcomes listed are CWS/CMS data outcomes related to child abuse/neglect referrals, substantiated referrals, cases opened and children removed and placed in out of home care. There is no measurement framework for increases in the Protective Factors listed in Section D – Performance Outcomes Measure. We recommend that DCFS work in partnership with its existing network of CAPIT and PIDP providers to

develop appropriate outcome measurements documenting increases in the Protective Factors.

26. In the SOW, Section D, pages 11 and 12, Performance Outcome Measures for Prevention Services, the only outcomes listed are CWS/CMS data outcomes related to child abuse/neglect referrals, substantiated referrals, cases opened and children removed and placed in out of home care. None of the outcomes are aligned with the Strengthening Families/Protective Factors approach as there is no measurement framework for increases in the Protective Factors listed in Section D – Performance Outcomes Measure. We recommend that DCFS work in partnership with its existing network of CAPIT and PIDP providers to develop appropriate outcome measurements documenting increases in the Protective Factors.

27. In the CAPIT Sample Contract, page 21, Part II, Section 1.0 Administration of Contract – Contractor, 1.1 describes the Contractor's Program Director and 1.3 describes the Contractor's Program Manager. For a contract with the limited funds of CAPIT, it is redundant and fiscally ineffective for an agency to assign a Program Director and Program Manager to the contract.

28. CAPIT currently contributes to both (a) integration of counseling and psychotherapy within the mental health system for indigent families and (b) extension of parenting education and extension of family support/family preservation case management and in-home services. We urge that funding for CAPIT be expanded in order to ensure that these two essential program elements be sustained throughout the SPAs.

29. Staffing should be flexible in terms of part-time, full-time and contracted staff requirements and shared resources across organizations.

30. With current CAPIT funding levels, agencies cannot hire even one full-time mental health professional. We urge DCFS to work to bring AB2994 funds into the funding matrix in order to ensure CAPIT's viability.

31. Make the CAPIT budgets more flexible. Currently, you get a fixed budget of professional services and a fixed budget for paraprofessional services. It would help if we got the total amount with the ability to bill either without the fixed limits in each category. Now if you spend down one category you can't bill anymore of those services, even if you have money in the other category left.

32. Regarding section 3.1, as a program designed for prevention and aftercare, aren't families with a current open DCFS case ineligible as they are at that point neither in the prevention or aftercare phase. It may be better to read: "Families who have recently had their cases closed with DCFS."

33. Page 21 Sample Contract Project Manager to be available 24 hours a day 7 days a week which is inconsistent with SOW page 4—2.4 - CAPIT is not an emergency program and does not have the funding to support a 24 hour program. Provide more funding or simplify language to be available to respond during the traditional business hours of Monday through Friday from 9 am to 5 pm as stated in the SOW page 4—SOW 2.4.

34. Page 7 (SOW 4.3.5) Travel time for in home services - In order to meet the protective factors (social connections), reimbursement for travel time should include services

provided at school and other community locations as necessitated by the goals listed in the treatment plan.

35. Contract amount will not allow for reimbursement rates that are comparable to DMH/Medi-Cal rates which places agencies at risk for losing their DMH contracts. Review rate structures.

ASSESSMENT and INTERVENTION (Exhibit C)

1. Can the Bill of Rights be reviewed - #4 enrolling in Independent Living Program (ILP). How do we do this? Unable to find description of Discretionary funds (Aux Funds Pg 93A is new?). If this is the case Page 94A #8 asks for Executive Director signature – why not P.M. or DC?

2. Aux Funds Page 95 B #2 C – The Return of Security and Rental Deposit Agreement does not help when we are asking for 1 months rent – landlords don't want to sign. MCPS's for Probation cases need to be clear on who signs and who must be at IH visits.

3. 7.2.3 – Referral date may be different than start date. When its faxed may differ from when we agree to start

4. Section 7.2.19.3 Supplemental Services including but not limited to:

   7. Parenting Training Services/Fatherhood Programs

   Since the inception of Family Preservation Programs 19 years ago by DCFS, "Parenting Training: has been defined as "interactive groups which caregivers with mutual support, training and enhancement of parenting skills and child development education, which includes alternative discipline and impulse control. Groups are designed to raise self-awareness and understanding, develop insight into personal issues and problem solving towards creating a healthy and safe home environment." Parents Anonymous Inc. groups are an evidenced-based program (see California Evidenced-Based Clearinghouse)to accomplish all these goals and has been doing so for the past 11 years in Family Preservation in Long Beach as a sub-contractor with the City Health Department. Groups should not be excluded since there are evidence-based models to prevent and intervene in child abuse and neglect.

5. Restore the name ***Family Preservation Program*** to reflect the accomplishments the County and community has achieved together over the past 20 years to protect children in their families and homes, minimizing the need for costly (personally and financially) removal from their beds and familiar home environment. There are nearly 30,000 fewer children traumatized by removal from their homes and placement with foster homes by implementation of the family preservation approach.

6. Child and Family Team Decision Making should replace TDMs. The best practice regarding multidisciplinary family-centered case planning teams (generic term) should be applied to all 5 programs including replacing the language, MCPCs. This is a hybrid of Family Group Conferencing and TDMs.

7. There needs to be collective agreement to define a standard for an IHOC caseload standard (or range) where quality is not compromised?

8. The Learning Collaborative needs to develop a fee matrix that increases the flat Base Rate fees to encompass supplemental services.

9. The Base rate needs to be annually revised along with the cost of living adjustments for Southern California.

10. Fee rates should be based on collaborative rate studies and be updated from the 1990s.

11. Supplemental services rates should be reassessed to be for each child in some circumstances, i.e. SARM, and family-based in others

12. Requirements for any future use of EBPs must be paid for by the County for training, curriculum, evaluation and other costs.

13. Doesn't allow registered interns and master level students to provide "counseling" services (SOW page 36—counselor qualification) - not consistent with workforce development concept and not financially feasible. Also, please raise standards for non-master level waiver IHOC and provide funding stream.

14. SOW 7.1.1 Receive ARS referrals via both fax and telephone contract receipt. - Must document that they call us but do they send a form? Can county clarify procedure for the telephone referral and what documentation will be needed?

15. Clinical director must make initial contact when referral is received to discuss family plan—not financially feasible; it is also not efficient for work (SOW page13; 7.1.2) - Quality Assurance plan includes auditing of notes, family plans and provision of weekly supervision. Also, ongoing training is emphasized.

16. Clinical Director or Supervisor must cosign all progress notes as noted on Exhibit C-17 page 88.

17. There are inconsistencies in the designated facilitator between the ARS (page 14) and FP MCPC (page 20).

18. Are agencies expected to prevent all subsequent referrals, allegations etc., when sometimes we are in the position of making calls to the hotline based on concerns observed during the visits? How realistic are these expectations on the agencies as mandated reporters and can this be further explored through discussion with service providing agencies. SOW page 6. 5.0.

19. Concern regarding the requirement to contact workers (especially Regional Workers) when assessment may be conducted days later based on the availability of the adult to be assessed. May not be feasible to call twice to confirm that we received the assessment within an hour and later before we complete assessment. Please clarify? SOW page 11 6.2.3.

20. Will agencies need to submit C-11 after each attempt to reach the adult to be assessed? Especially with Regional Assessments, agencies try several times before reaching the CSW. Pg 9. 6.1.6.

21. Are agencies to provide linkages to the family regardless if we get a hold of CSW or SCSW, and document in our records? Need to clarify this and the amount of time allowed before agencies can proceed with the linkages after attempting to reach the CSW.

22. The ability to conduct an initial assessment of needs when the information provided on the referral is so limited and often incorrect (based on past referrals) will be extremely difficult, especially without having any contact with the family? Pg 13 7.1.2.

23. Will the FAF (Family Functioning Assessment tool) be completed manually or electronically? Pg 14 7.1.6

24. Is Exhibit C13 is the only document that agencies need to sign in addition to the MCPC itself or would agencies be expected to sign another 802 each time we conduct a MCPC? This is confusing. Pg 14 7.1.8.2

25. Also, it appears the only signature requested for Exhibit C13 is the Clinical Supervisor. Need clarification as to whether the approved designee for the agency that conducts the MCPC rather than the Clinical Supervisor is also able to sign or perhaps the agency representative's signature is printed in the "other" space provided? Pg 15

26. Please clarify if making DMH referrals is part of ARS services since in the past it was not part of the services for which program participants qualified. In the past resources were provided, not referrals. Please clarify.

27. Concern about listing the frequency of services in the initial MCPC given that agencies do not always know the extent of the need of the family at this point. pg. 16 7.1.8.4

28. Statement regarding MCPC reports to be provided to all pertinent individuals including the family on the same day however MCPC's are conducted outside of the office at times making it very difficult to provide MCPC reports at the conclusion of each meeting. An exception should be provided to allow for this circumstance. pg 16 7.1.8.6

29. Concern regarding the implementation of IFP services and the provision that visits can not be conducted on the same day such as T & D and IHOC visits . Families may not be available every day because of work or other responsibilities. Is DCFS willing to consider modifying this on a case to case basis and/or revising their position? Pg 22 7.2.10

30. Doesn't allow registered interns and master level students to provide "counseling" services (SOW page 36—counselor qualification)

    a. not consistent with workforce development concept and not financially feasible

    b. Raise standards for non-master level waiver IHOC and provide funding stream

31. SOW 7.1.1 Receive ARS referrals via both fax and telephone contract receipt.

    a. Must document that they call us but do they send a form? Can county clarify procedure for the telephone referral and what documentation will be needed?

32. Clinical director must make initial contact when referral is received to discuss family plan—not financially feasible; it is also not efficient for work (SOW page13; 7.1.2)

a. Quality Assurance plan includes auditing of notes, family plans and provision of weekly supervision

b. Ongoing training is emphasized

33. There are inconsistencies in the designated facilitator between the ARS (page 14) and FP MCPC (page 20).

34. Section 7.2 FP Intervention: Open DCFS/Probation FP Cases Page 17-18 discusses the criteria for Intensive Family Preservation (IFP) Families to include 1) families with children ages 0-5; 2) a child with demonstrated mental health needs; or 3) any child determined to necessitate intensive services as identified by the TDM/CFT meeting. It is unclear if for the last two criteria if this could include any child ages 0-17 with demonstrated mental health needs or any child ages 0-17 determined to necessitate intensive services. Please clarify whether this is correct, or if the last two criteria only apply to children of a certain age (i.e. ages 0-5).

35. Section 7.2 FP Intervention: Open DCFS/Probation FP Cases Identification of IFP (FP) Families for Service Priority Page 17 discusses the provisions for Intensive Family Preservation, but it does not specify certain terms or limits regarding this part of the program. For example, there is no information as to how many sessions are permissible per week under Intensive Family Preservation, if the sessions must be 1 hour or if sessions can be extended beyond 1 hour, what type of service can be included, etc. Given the fact that there has not been any specific training for IFP services to date, it will be important to have a clear understanding of what the County expects. The County may need to set some parameters and structure for this component of the program in order to adequately guide and direct the agencies responsible for providing the service.

36. Child and Family Team Decision Making should replace TDMs. The best practice regarding multidisciplinary family-centered case planning teams (generic term) should be applied to all 5 programs including replacing the language, MCPCs. This is a hybrid of Family Group Conferencing and TDMs.

37. There needs to be collective agreement to define a standard for an IHOC caseload standard (or range) where quality is not compromised?

38. The Learning Collaborative needs to develop a fee matrix that increases the flat Base Rate fees to encompass supplemental services. The Base Rate needs to be annually revised along with the cost of living adjustments for Southern California.

39. Supplemental services rates should be reassessed to be for each child in some circumstances, i.e. SARM, and family-based in others.

40. Requirements for any future use of EBPs must be paid for by the County for training, curriculum, evaluation and other costs.

41. Doesn't allow registered interns and master level students to provide "counseling" services (SOW page 36—counselor qualification) - not consistent with workforce development concept and not financially feasible. Also, please raise standards for non-master level waiver IHOC and provide funding stream

42. SOW 7.1.1 Receive ARS referrals via both fax and telephone contract receipt. - Must document that they call us but do they send a form? Can county clarify procedure for the telephone referral and what documentation will be needed?

43. Clinical director must make initial contact when referral is received to discuss family plan—not financially feasible; it is also not efficient for work (SOW page13; 7.1.2) - Quality Assurance plan includes auditing of notes, family plans and provision of weekly supervision. Also, ongoing training is emphasized.

44. Clinical Director or Supervisor must cosign all progress notes as noted on Exhibit C-17 page 88. This is unclear as to who must be actual co-signor.

45. There are inconsistencies in the designated facilitator between the ARS (page 14) and FP MCPC (page 20).

46. Section 7.0, 13: A capitated base of $_____ per month will be paid for each family participating in FP services through the Assessment and Intervention Services Program.

    Recommendation: Clarify what the capitated base rate per month will be for each family participating in FP services through the Assessment and Intervention Services Program.

47. Section 12.0, 6: CONTRACTOR shall be available to provide the services defined through Exhibit C, Assessment and Intervention SOW, twenty-four (24) hours a day, seven (7) days per week, to meet the needs of the families served. […] CONTRACTOR shall adhere to the following hours of operations:

    - FP Assessment Services
        - Monday through Friday, 8:00 a.m. to 8:00 p.m.
        - Saturday OR Sunday, 9:00 a.m. to 1:00 p.m.
    - FP Assessment Services – Command Post
        - Monday through Friday, 5:00 p.m. to 9:00 a.m.
        - Saturday, Sunday, and COUNTY approved holidays, 24 hours
    - FP Intervention Services
        - Monday through Friday, 8:00 a.m. to 8:00 p.m.
        - Saturday OR Sunday, 9:00 a.m. to 1:00 p.m.

    Question: Are CONTRACTORS required to be in the field working with families on Saturday or Sunday and/or have open office hours for a half-day on Saturday or Sunday?

    Recommendation: Due to logistical challenges and limitations in staffing resources, CONTRACTORs should not be mandated to provide FP Assessment or Intervention Services on Saturdays or Sundays, with the exception of FP Assessment Services for the Command Post.

48. Section 6.1.5, 8: CONTRACTOR shall ensure that the clinician or registered intern arrives at the parent(s)/caregiver(s) home/location within one hour of the CONTRACTOR's receipt of the referral form or telephone contact, unless otherwise specified by the COUNTY designee, to complete the screening consistent with DCFS Core Practice Model, Exhibit C-9.

Question: Can DCFS retain the current requirement for the FP assessor to arrive at the home within three hours, particularly when documented reasonable logistical challenges (such as difficulty coordinating with staff after hours or lengthy travel times in larger SPAs) arise?

Recommendation: Please revise the language to clarify that the FP assessor may contact ERCP for approval of arrival times that exceed one hour when documented reasonable logistical challenges arise [as stated in the Attachment to Addendum 2].

49. Section 6.1.7, 9: CONTRACTOR shall ensure that within one-hour of completing the FP Assessment, the clinician or registered intern will communicate with the CSW and provide a verbal summary of the findings.

Question: What should the provider do if the CSW cannot be reached by telephone within the required timeframe?

Recommendation: Clarify that when the CSW is unavailable, CONTRACTOR shall contact the ERCP Trouble Shooter (or COUNTY designee) at 213-639-4500 to convey the results to the appropriate supervisor and/or manager [as stated in the Attachment to Addendum 2].

50. Section 6.1.10, 9: CONTRACTOR shall ensure that all services conducted for this family because of an ERCP referral, be assigned to the same agency for continued services by In-Home Outreach Counseling (IHOC) Services, and Teaching and Demonstrating Homemaking Services (T&D) staff members, unless otherwise clinically indicated or directed by the COUNTY designee. When a referral is re-assigned to another agency, it must be documented and such documentation must be provided to the COUNTY designee. The maximum billable amount for IHOC or T&D Services is three hours per assessment.

Recommendation: Clarify that the maximum billable amount for IHOC and T&D Services is three (3) hours each per assessment [as stated in Addendum 3].

51. Section 6.2.2, 10: CONTRACTOR shall ensure that referrals are assigned within one hour of receipt, to a licensed clinician or registered intern that is under the supervision of a LCSW or LMFT or Licensed Psychologist to conduct an assessment. The CONTRACTOR's designee must contact the COUNTY designee within the same hour of receipt of the referral form.

Question: Can DCFS retain the current accepted practice of allowing the provider more than one hour to assign a referral and contact the County designee when documented reasonable logistical challenges arise (given that the one-hour timeframe would require a staff person to remain at the fax machine at all times)?

Recommendation: Clarify that, if the CONTRACTOR determines that the agency will be unable to meet the mandated assignment timeframe in response to a particular referral, the CONTRACTOR can request approval from ERCP for an arrival time beyond one hour [as stated in Addendum 3].

52. Section 6.2.5, 11: CONTRACTOR shall ensure that the clinician or registered intern arrives at the parent(s)/caregiver(s) home/location within 24 hours of the

CONTRACTOR's receipt of the referral form, unless otherwise specified by the COUNTY designee to complete the screening consistent with DCFS Core Practice Model, Exhibit C-9.

Question: Does "24 hours" refer to one business day?

Recommendations: Clarify that 24 hours indicates that the CONTRACTOR has one business day to complete the assessment [as stated in the Attachment to Addendum 2].

53. Section 7.1.8.6, 16: Note: If an assessment was conducted for this family through the FP Assessment services component, as indicated in Sections 6.1 - Emergency Response Referrals - Command Post, and 6.2 – Emergency Response Referrals - Regional Office, the Regional Office shall assign, for continued services, the CONTRACTOR that conducted the FP Assessment, unless otherwise clinically indicated. Reasons for assigning another IHOC from the CONTRACTOR needs to be documented. If the CONTRACTOR is not available to take the case, this needs to be documented on the ARS referral form (Intervention Services Intake Form, Exhibit C-3).

    Question: Who determines whether it is clinically appropriate for the family to receive ARS from the FP provider that completed the assessment of the family?

    Recommendation: Clarify that if after an agency has completed as assessment, the ag ecy's Clinical Director determines that it is not clinically appropriate to provide ARS services to a referred family, the Clinical Director should inform the County Designee as soon as practically possible so that an alternate plan for the family can be formulated [as stated in the Attachment to Addendum 2].

54. Section 7.2, 17: The provision of IFP services will be contingent on the availability of CONTRACTOR's resources to provide the service and is <u>NOT</u> a mandatory requirement. The determination as to whether a CONTRACTOR has resources available to provide IFP services will be made on a case by case basis by the COUNTY designee. Once CONTRACTOR has accepted an IFP referral, CONTRACTOR is required to adhere to <u>ALL</u> IFP service requirements as outlined in Exhibit C.

    Question: Why is the COUNTY designee responsible for determining whether the CONTRACTOR has the necessary and sufficient resources available to provide IFP services?

    Recommendation: Revise the language as follows: "The CONTRACTOR, after consultation with the COUNTY designee, will make the final decision as to whether the CONTRACTOR has the staffing and resources available to accept an IFP referral."

55. Section 7.2.6, 19: In any one of these cases, the CONTRACTOR may invoice for the supplemental IHOC visit that is in excess of the base rate visit for the assessment, at the hourly rate of the educational level of the staff providing the assessment, which shall not exceed one hour.

    Question: Can DCFS retain the current accepted practice of compensating the FP provider at a daily pro-rata rate for supplemental services provided up to the point at which it is determined that the family will no longer receive ARS, especially given that the assessment may exceed one hour?

Recommendation: Revise the language, as follows, "In any one of these cases, the CONTRACTOR may invoice for the supplemental IHOC visit that is in excess of the base rate visit for the assessment, at the hourly rate of the educational level of the staff providing the assessment ~~which shall not exceed one hour~~" [as stated in Addendum 2].

56. Section 7.2.9.3, 21: In the event mental health issues are identified in adult family members, CONTRACTOR must complete the necessary forms and/or processes, including Exhibits C-29, C-30, and C-31, to refer the family member to a DMH provider.

    Question: What is the expectation of the FP provider in the event the adult family is ineligible to receive mental health services through DMH (e.g., family member does not meet medical necessity or has Other Health Insurance)?

    Recommendation: Clarify that, in the event that an adult family member is identified as having mental health issues, the CONTRACTOR should refer the family member to a COUNTY's DMH provider or to another similarly qualified, affordable mental health provider [as stated in the Attachment to Addendum 2].

57. Section 7.2.16.1, 23: CONTRACTOR shall provide TDT services for Probation Youth as approved by the MCPC.

    Question: Can TDT services be subcontracted?

    Recommendation: CONTRACTORS should be allowed to subcontract TDT services [as stated in the Attachment to Addendum 2].

58. Section 7.2.19.2, 26: CONTRACTOR shall ensure all Supplemental Services are delivered within 72 hours or less after the services have been deemed necessary by the MCPC or prior to the MCPC for IFP services.

    Questions: 1) Will the FP provider be allowed more than 72 hours to deliver Supplemental Services when documented reasonable logistical challenges (such as the family is unavailable or the provider is at capacity) arise? 2) Does "72 hours" refer to three business days?

    Recommendations: 1) Revise the language, as follows: "CONTRACTOR shall ensure all Supplemental Services are referred ~~delivered~~ within 72 hours or less after the services have been deemed necessary by the MCPC for IFP services" [as stated in Addendum 2]. 2) Clarify that "72 hours" refers to three business days [as stated in the Attachment to Addendum 2].

59. Section 8.4.3.1, 32: CONTRACTOR shall ensure that the completed, approved, and signed assessment report be submitted to the COUNTY designee no later than 72 hours (three business days) after the assessment has been completed. CONTRACTOR shall not email the report due to confidentiality guidelines. The report must clearly provide the clinician or registered intern assessment of parental capacity/incapacity, and must include recommended services and resources to address any identified service needs consistent with DCFS Core Practice Model, Exhibit C-9. The report must clearly document assessor's RFP for SCSF – Part D: Statement of Work for 152 Assessment and Intervention (Exhibit C) arrival and departure time in the heading of the report. The

report is due on the 10th day of every month. CONTRACTOR shall maintain documentation of submission to DCFS.

Question: Will FP workers be allowed flexibility to refrain from making determinations of parental capacity in cases where they are not able to collect enough information to do so? [FP workers who complete these assessments typically have limited interaction with the parent/caregiver (generally, 2 to 3 hours on only one occasion). The information obtained through the assessment is based mostly on the self-report of the parent/caregiver, and the agency has a limited 72-hour turnaround time to complete the report and submit it to the CSW. The assessor does not observe any interaction of the parent/caregiver with the child. The Behavioral Severity Assessment Program (BSAP) was designed to assess for mental health, substance abuse, and domestic violence. However, the instrument was not designed to assess for caregiver capacity in any manner. The assessment was intended to be a screening – one of many components of the ER investigation that would deepen the CSW's understanding of the clinical needs of the parent/caregiver. The general concern is that the FP assessor who completes the assessment is not equipped to make determinations regarding parent/caregiver capacity due to the limited scope of the assessment.]

Recommendations: FP assessors should be allowed flexibility to refrain from making determinations of parent/caregiver capacity in cases where they are not able to collect enough information to do so.

60. Section 11.0, 40: CONTRACTOR shall adhere to the measures established in Sections D and E of this SOW.

Question: Is DCFS willing to collaborate with FP providers on an ongoing basis to review and discuss FP performance outcomes data and determine whether any outcome indicators or performance targets should be modified (similar to the Performance Measures Task Groups for out-of-home care providers)?

Recommendation: Clarify that DCFS will collaborate with FP providers on an ongoing basis following the first year of implementation to review and discuss FP performance outcomes data and determine whether any outcome indicators or performance targets should be modified (similar to the Performance Measures Task Groups for out-of-home care providers) [as stated in Addendum 3].

ADOPTION PROMOTION and SUPPORT SERVICES (Exhibit D)

1. Section 6.7 Add evidence-based support groups that strengthen families using the protective factors is preferred.

2. The pricing/reimbursement sheet for APSS is overly complicated with reimbursement split among four different pay points. The rates vary from families per month for case management; individual youth per month for mentoring; completed group meetings for support groups; and completed training sessions. APSS would better be a cost reimbursement, or capitated rate per month reimbursement system

3. SOW 3.6 (page 3): Weekly supervision reviews with all professional staff, paraprofessional staff, interns, and all other staff that provide program services under this contract, with the exception of mentors and volunteers who may be supervised on a monthly basis. It is suggested that the amount of supervision be deleted since all staff are expected to possess the expertise and experience necessary to provide direct client services. Supervision will be provided as needed depending on knowledge and experience of staff, hours worked, and needs of the clients. If amount of supervision remains in the SOW, individuals providing clerical work shall be excluded from weekly supervision requirements. This point appears redundant since on page 4 section 5.1.2 states supervision and training requirements for staff.

4. SOW 4.0 (page 3): Target Population: It is suggested that provisions be implemented to work with non-minor dependents created by the Fostering Connections legislation, as well as continuing APSS with youth after the age of 18.

5. SOW 5.2.1 (page 6): CONTRACTOR shall ensure all professionals, paraprofessional, intern staff, volunteers, and Subcontractors' staff providing program services receives regular, ongoing in-service training and supervision. CONTRACTOR's staff shall receive a minimum of eight (8) hours of training each quarter of the Contract term. APSS professionals who have worked in an adoption agency for two years or more would qualify for a reduction to 16 hours of training per fiscal year. CONTRACTOR shall hold weekly supervision reviews with all professional staff, paraprofessional staff, interns, and volunteers. CONTRACTOR shall hold monthly supervision reviews with all mentors and volunteers." Clerical/Administrative staff would be classified as paraprofessional staff and should be excluded from training requirements, both initial and ongoing. It is suggested that the ongoing training requirement state 8 hours per quarter OR 32 hours per fiscal year, as in year's past some contractors have been able to send staff and mentors to multi-day adoption specific conferences which provide more than the 8 hours a quarter of training. All APSS staff (professional, paraprofessional, mentors, interns, and volunteers) who have worked in an adoption agency for at least 2 years shall qualify for a reduction to 16 hours of training per fiscal year.

6. SOW 6.3.1 (page 8): CONTRACTOR shall accept the referral from the CPM or designee regardless of where the family resides within Los Angeles County. Efforts will be made by the CPM or designee to assign referrals based upon the home address however other considerations may take precedence. CPM, or designee, in collaboration with CONTRACTOR, shall determine the appropriateness of referrals, if the CONTRACTOR, after assessing the child and/or family, regards them as inappropriate for APSS services. The COUNTY reserves the right to make the final decision. As a current provider of APSS, contractors on a regular basis work with clients outside of the designated SPA, as long as it does not impact the ability to provide services to clients in their contracted SPA and the services being requested are feasible, since in-home services are at times impossible to provide due to the distance. Making this a requirement creates an inability to meet performance standards

7. SOW 6.3.3 (page 8): CONTRACTOR must receive written approval from CPM or designee prior to establishing a wait list. Once approved, continuance of a wait list beyond one month is at the discretion of the CPM or designee. In the event a wait list is approved, CPM will consider re-assigning the wait-listed referral(s) to a provider outside the service area. The extension of priority to a family is at the discretion of the CPM." It is suggested the County work with current providers now to develop guidelines in approving a waitlist.

8. SOW 6.3.3.1 (page 8): Clients with critical needs wait-listed in excess of ten business days shall be referred to and linked with other COUNTY APSS contractors who do not have a wait list - …Procedures outlining who is responsible for linking wait-listed referrals, who holds the referrals when an agency has a waitlist and does not have capacity to serve the family, and who/what determines 'critical needs' needs to be developed with contractors that will serve the needs of the clients

9. SOW 6.3.3.2 (page 8): CONTRACTOR shall make weekly telephone contact with families on the wait list and consult with APSS CPM or designee on an as-needed basis if the family requests immediate services or if the family's situation destabilizes. It seems that if the contractor has a waitlist, they would not have the staffing capacity to contact families weekly. Also, since the County is the "hub" for all providers, they know which providers have waitlists and who have openings in order to reassign. It is suggested that the County (especially if the referral is a non-finalized adoption and has active CSWs on the case) maintain control and possession of the referral and determine reassignment. The contractor should not be responsible for care, support, or treatment of referred individuals as they are not official clients of the agency. They are waiting to become clients.

10. SOW 6.3.3.3 (page 8): Within 30 days of a family's placement on a wait list, CONTRACTOR shall either provide services or refer the family to another APSS provider that does not have a wait list. Such referral shall not be made prior to approvals by the CPM, the CSW, the PAS Worker, and the family; and receipt of the CPM's confirming e-mail." This outlines how to refer a family to another agency after being on a waitlist for over 30 days and requires permission of CPM. It is suggested the County keep possession of waitlisted referrals and assign to other providers they know that don't have a waitlist would be more seamless for the clients.

11. SOW 6.3.9 (page 10): APSS services of case management, support groups, mentoring and therapy shall be made available in the location which best serves the needs of the

child and/or family, including within a Probation Camp or a Group Home. The APSS Contractor will meet with and/or contact the DPO of Record prior to visiting with the probation child, and the DPO of Record will facilitate entry into the Probation Camp or Group Home and communication with the contact person at the facility. It is suggested that the following language be included "if there are sufficient number of referred children within the Probation Camp or Group Home to warrant a support group."

12. SOW 6.4.2 (page 11): CONTRACTOR shall complete the initial service plan within 30 days of the effective date on the referral form. All involved parties shall sign and date the ISP. Changes to the plan shall be agreed upon by the client and the provider. It is suggested "all involved parties" be defined. If this includes DCFS/Probation workers within the same timeframe, a "back out code" for rating the performance outcomes needs to be developed if those parties do not return the document on time.

13. SOW 6.5 Therapy (page 12): Therapy APSS does not provide additional funding for therapy and requires contractors use Medi-Cal as the reimbursement for therapy. The SOW does not focus enough on "medical necessity" as the driver of service delivery and that Medi-Cal service delivery needs to remain focused on elimination/recovery from whatever condition the child presents with. For instance, 6.5.1 "maximum amount" as with all Medi-Cal should be the "Maximum medically necessary service amount" and 6.5.2.1. All service decisions must be based on medical necessity (clinically indicated) including modalities of treatment.

14. SOW 6.6.4 (page 14): CONTRACTOR shall dedicate a telephone line for the APSS Mentor Program. This is a current requirement of the APSS Program and has not been utilized by clients. Hence, this requirement should be removed or its' purpose further clarified.

15. SOW 6.6.6.4 (page 14): Meet with clients at least once monthly. If mentor is unable to meet with client once monthly, mentor shall have weekly telephone contact with the client for the month without face to face contact. The month following the month without a contact meeting shall include a face to face meeting between the mentor and the client. It is suggested that the requirement be changed to "Meet/communicate with the clients in accordance with the needs of the clients." As a current provider of APSS, clients have not accessed or requested to a significant degree their desire to have monthly face to face meetings with their mentors. In general, clients do not want another appointment mandated to them. They enjoy communicating by phone, email, and other electron means to have their SUPPRT needs met. It seems the client should dictate the type and frequency of contact that best meet their needs with as little requirements imposed as possible.

16. SOW 6.6.6.5 (page 14): Present a monthly promotion in the community, such as dissemination of information and presentations at community agencies, religious institutions and other organizations with whom the mentor is involved. CONTRACTOR shall inform CPM in writing at least six business days prior to the date of monthly promotion. This requirement should be eliminated. Currently, our mentors would not be able to complete this requirement as stated as all clients must be referred through a CSW or PAS worker and be an LA County DCFS client. If the requirement remains, it is suggested that the contractor will coordinate an ongoing promotion plan with the county and collaborate in implementing the plans, such as presentation at various DCFS offices, Foster Family Agencies, etc. It would be helpful if the purpose of this requirement was

clarified to include, what is to be promoted, the purpose of the promotion, and if every mentor or just one mentor from every contracted area must engage in promotion.

17. SOW 6.7 (page 14): CONTRACTOR shall provide Support Groups in English. Groups shall be provided in Spanish whenever there are at least four clients who state their preference for a Spanish-speaking group. Support groups shall be provided for: (1) prospective and adoptive parents (including kin-adopt parents); (2) birthparents; and (3) children (including children who have an alternate permanent plan of adoption) to discuss concerns, issues, frustrations, experiences, and successes related to adoption as well as everyday family life and child rearing.

    a. As current providers of APSS, there have not been enough birth parents involved to warrant a support groups unless it was opened to the community. Birth parents are not mentioned in any of the referrals we received from the county as a client to pursue for APSS or listed as a target population. If referrals were to be needed for a birth parent support group, procedures on files and reports would need to be developed, i.e., service plans, quarterly reports, types of services

18. SOW 6.8 (page 15): Training Workshops: APSS CONTRACTORS shall offer on a quarterly basis every year, a minimum of one adoption-focused training workshop to community health professionals.

    a. Should this state “community professionals”?

19. SOW 7.0 (page 16): Transfer of Records: Prior to contract termination or non-renewal of contract, contractors shall cooperate in transitioning cases which are not ready to close to new contractors, including providing all original case files and electronic records. The transitional plan shall be made in consultation with the County Program Manager at least one month in advance of the contract termination or as soon as possible in the event of non-renewal. If original records are transferred in the event of contract termination or non-renewal, what recourse does the contractor have in the event of a future complaint from a former client?

20. SOW Performance Outcomes (page 18 and 19) –

    a. 100% rating for performance outcomes appear unrealistic, as it does not account for any unforeseen or extenuating circumstances.

    b. #3 CONTRACTOR shall contact the family within two business days and complete initial home visit within five business days of effective date of referral. (90%) - This is repetitive to #1 and #2. Contractors should not be held responsible for client’s schedule.

    c. #4 CONTRACTOR shall complete an individualized service plan that is inclusive of the strengths and needs assessment and protective factors framework with signature of all participants. Contractors should not be held accountable at a 100% level if signatures of professional parties are not returned despite reasonable follow-up on Contractor’s part.

d. #5 CONTRACTOR shall complete individualized service plan within 30 days of the effective date of the referral. This repeats #4 but is more reasonable since it does not require the signature piece from all involved parties.

e. #10 CONTRACTOR shall complete the required face to face mentor visits on a monthly basis or have weekly telephone contracts as required by the SOW. It has been our experience as current providers of APSS that many clients do not desire to have face to face contacts with their mentors. The requirement should be changed to be directed by the client's needs/desires and a new performance measure developed.

f. #12 CONTRACTOR shall present a mentor's monthly promotion in the community in which they service per the SOW. This requirement should be deleted from SOW. Community promotion is inappropriate under the current terms of the SOW due to the referrals for mentoring needing to come from County referral only.

g. #18 Of the families that have received APSS services, the percentage of dissolution of adoptive placement or finalized adoptive home: shall not exceed a maximum of 10%. This performance measure is inappropriate as the APSS contractor has no control over, after providing appropriate services, whether an adoptive placement or finalized adoptive home will dissolve. In addition, APSS contractors do not have access to these statistics to measure. APSS Contractors receive referrals at all points along the adoption journey and have no way of tracking future dissolutions or whether they eventually finalize their adoptions. Many times APSS Contractors do not receive the referrals until it is too late to save the placement and therefore should not be held responsible for this measure.

21. SAMPLE CONTRACT 9.1 (Page 16): CONTRACTOR shall be available twenty-four hours per day, seven (7) days per week to meet the needs of families served. CONTRACTOR shall provide the name and phone number of contact person(s) for services after normal business hours.

    a. APSS is a support program not designed to provide high level of care/support such as Wraparound and FSP. If clients are in need of this level of support/treatment, APSS appropriateness should be re-examined.

22. SAMPLE CONTRACT 9.6 (page 17): CONTRACTOR Program Manager or alternate shall be available 24 hours a day, 7 days a week to respond to COUNTY inquiries and to discuss problem areas and shall have full authority to act for CONTRACTOR on all matters relating to the daily operation of this Contract. CONTRACTOR shall not be required to work on the following COUNTY Holidays, with the exception of those services by CONTRACTOR that are provided to the Emergency Response Command Post:

    a. This requirement should be eliminated as we are a support program not designed to provide high level of care/support

23. Section 6.3.1 CONTRACTOR shall accept the referral from the CPM or designee regardless of where the family resides within Los Angeles County. Efforts will be made by the CPM or designee to assign referrals based upon the home address however other considerations may take precedence. CPM, or designee, in collaboration with CONTRACTOR, shall determine the appropriateness of referrals, if the CONTRACTOR,

after assessing the child and/or family, regards them as inappropriate for APSS services. The COUNTY reserves the right to make the final decision. (Statement of Work page 8)

Serving families outside of SPA will likely impact the family's ability to attend support groups and will impact mileage that contractor must pay for case managers to occasionally visit clients in the home. The preference would be that there be a discussion between the county and the contractor with contractor being able to communicate whether there was an ability to serve this family living outside of the SPA.

24. Section 6.6.4 CONTRACTOR shall dedicate a telephone line for the APSS Mentor Program; (Statement of Work page 14)

    In the 7 years since the inception of the APSS program, a dedicated mentor line has not seemed necessary as long as there is a dedicated contact person to accept mentor inquiries. With other lines and cell phone communication, mentors have not had any issues with contacting the mentor coordinator.

25. Section 6.6.6.4 Meet with clients at least once monthly. If mentor is unable to meet with client once monthly, mentor shall have weekly telephone contact with the client for the month without face to face contact. The month following the month without a contact meeting shall include a face to face meeting between the mentor and the client. (Statement of Work page 14)

    Mentor and mentee contact seems best to be coordinated with the mentee based on need. A weekly phone call may be too much for mentees certain months and based on the experience of the last 7 years, relationships between the two parties seems to work best when led by the relationship needs.

26. Section 6.7 Support Groups CONTRACTOR shall provide Support Groups in English. Groups shall be provided in Spanish whenever there are at least four clients who state their preference for a Spanish-speaking group. Support groups shall be provided for: (1) prospective and adoptive parents (including kin-adopt parents); (2) birthparents; and (3) children (including children who have an alternate permanent plan of adoption) to discuss concerns, issues, frustrations, experiences, and successes related to adoption as well as everyday family life and child rearing. (Statement of Work page 14)

    Serving birth parents in the context of group has not been a focus of APSS in the last 7 years, nor has it appeared to be a need. When birth parent relationships have best been served appears to be in therapy. If inclusion of birth parents folds into the APSS program, referrals, consent and files need to altered to match this service.

27. SECTION D – Performance Outcome Summary (Statement of Work page 18-19)

    Some of the categories requiring 100% compliance, while ideal, may not be a realistic goal. For example: 4. CONTRACTOR shall complete an individualized service plan that is inclusive of the strengths and needs assessment and protective factors framework with signatures of all participants.

    It is very difficult to get signatures from all participants 100% of the time. Showing due diligence and attempts to obtain signatures would seem to be appropriate.

28. SECTION D – Performance Outcome Summary (Statement of Work page 18-19)

18. Of the families that have received APSS services, the percentage of dissolutions of adoptive placement or finalized adoptive home. Shall not exceed 10%.

It is the goal of APSS to prevent dissolutions and disruptions from occurring, but there are factors often beyond the control of the contractor to prevent this. For example, the contractor occasionally receives a referral when the placement is already in process of disrupting and the contractor does not determine when this referral was made. In addition, there is not a system set up to track families after receiving services from the APSS program.

29. Section 9.1 CONTRACTOR shall be available twenty-four hours per day, seven (7) days per week to meet the needs of families served. CONTRACTOR shall provide the name and phone number of contact person(s) for services after normal business hours. (Sample Contract page 16)

APSS is not designed as a 24 hour/7 day per week service. This type of service delivery is more appropriate for Wraparound or TBS services, which APSS often partners with in stabilizing a family. There is also a plan for contact when there is a therapist in place on a case, but 24 hour/7 day per week availability is not appropriate for a case management driven service. A family or client that would require this level of support would be better referred to a more intensive program.

PARTNERSHIPS for FAMILIES (Exhibit E)

1. Section 2, Paragraph 2.1, Pg 4: Target Population:

   There is no age limit specified for the DCFS referred cases. Does this mean that the full age range from 0-18 years old is included?

2. Section 3, Paragraph 3.3 , Pg 5: Scope of Work:

   This paragraph lists all of the DCFS services for all programs. Is the PFF Contractor has to provide all of these services, whether they are specific to PFF or not? This paragraph makes the case that the applying agency needs to be a "super agency." Or is the expectation that through partnerships all of these services should be available in the service area? Or is it a mistake to list the full continuum for open cases, substantiated cases rather than just services for the PFF target populations?

3. Section 5, Paragraph 5.6, Pg 8:

   Case Management Services - General Counseling Services: It seems that identifying mental health issues and refer for appropriate treatment is missing. Since mental health issues are a specified risk factor (2.2.4), perhaps a paragraph numbered 5.6.7 could be added that states "Identify mental health problems and provide or refer to treatment." The word "provide" would indicate that some psychotherapy can be directly provided by the PFF program if there is no other funding available for treatment.

4. Section 5, Paragraph 5.7.5, Pg 8: Case Management Services – PFF Service Planning:

   This paragraph indicates that children over the age of 10 must sign the service plan. In the California W&I Code, children ages 12 and above can sign for treatment under specific circumstances. However, children under age 12 years cannot sign for treatment under any circumstances. It would seem that requiring children over the age of 10 to sign the service plan agreement is not consistent with Californian law.

5. Section 5, Paragraph 5.8.3, Pg 9: Case Management Services – Linkage Services:

   This paragraph states that the Contractor needs to follow up to see if a family actually received services within 5 days. Is it acceptable if the family has successfully completed the application for, or made the necessary appointment within 5 days? It is a well known fact in LA County that subsidized childcare slots have waitlists. Other services, like appointments at Legal Aid will not always happen in 5 days.

6. Section 11, Paragraph 11.1, Pg 13: Capacity Building:

Is there a performance standard for the "preapproval" timeframe for Capacity Building Activities – both to make the requests to DCFS and for DCFS to respond? There could be a log-jam at specific times, e.g., holiday or back to school events.

7. Section 12, Paragraph 12.1.3, Pg 14: Reports and Record Keeping:

   By Corrective Action Plans (CAP), is this referring to a CAP from DCFS to the Contractor?

8. Section 5.2 – Change in SOW that case managers now need to be "professional level staff". Typically case managers are BA level. I would suggest this change.

9. Section 4.5 – We do not wish to give up engaging the family after 2 business day attempts. It takes time, phones get disconnected, etc. To terminate after 2 days is premature.

10. Partnerships for Families, Section E – Performance Outcome Measures, page 22, #1:

    Percentage of families identified as the subject of subsequent child abuse and/or neglect referrals to the Child Protection Hotline. Has the Department decided on a timeframe for these referrals? That is, during the program? After program completion or termination? Within 12 months?

    Perhaps this requirement is one that can be discussed further once the programs are under DCFS' purview. In addition, the USC evaluators completed a very comprehensive outcome analysis of PFF that might be helpful in analyzing the re-referrals and the outcomes of those referrals. For further details, see the report released in November 2011 http://www.first5la.org/files/PFF_USC_F5FinalReport_11302011.pdf). I actually believe that USC used a rolling timeframe, in which any case was tracked from its opening until the end of the study – some cases were tracked over 5 years, and some cases had just closed. It would be better to agree upon a specific post-program timeframe. Or maybe look at a number of timeframes – say 6 months, 12 months, 2 years – to see if the program has "legs."

11. There are some discrepancies between amendments that were made to the original SOW (as per Addendum Three) and the current re-issued SOW for PFF. The wording in the new reissued SOW reverts back to the initial wording, not the revision indicated in Addendum 3. Please clarify which wording is accurate:

    Addendum 3, Question 4: "Given the difficulty of engaging families, will DCFS allow the provider to determine whether or not a referral should be terminated."

    Answer: "Yes. The following language will be included in Section 4.0 referrals: CONTRACTOR may request approval from COUNTY PROGRAM Manger to keep a referral open beyond the prescribed timelines on a case by case basis"

    However, the Reissued SOW (Section 4.5 and 4.9) does not reflect this change and reverts back to the original wording.

12. There are some discrepancies between amendments that were made to the original SOW (as per Addendum Three) and the current re-issued SOW for PFF. The wording in

the new reissued SOW reverts back to the initial wording, not the revision indicated in Addendum 3. Please clarify which wording is accurate:

Addendum 3 question 6: Re: the criteria for Clinical Director asks if DCFS is requiring supervisory criteria different from the criteria required by the BBS

Answer: "Section 16.2.4 shall be modified as follows: "....The clinical Director must also have a minimum of two years experience during the last five years providing direct client services or direct supervision of an intern or trainee providing direct series similar to the services listed in this Exhibit C"

However, here again, the Reissued SOW reverts to the original language

For each of the questions above the wording in the new reissued SOW reverts back to the initial wording, not the revision indicated in Addendum 3. Please clarify which wording is accurate.

13. Section 11.2.1 (reissued SOW) states, "CONTRACTOR shall engage in internal capacity building efforts to increase the capacity to recruit and retain at-risk families, and achieve positive child and family outcomes."

    QUESTION: Is there a ratio of DCFS referrals versus Community based referrals for pregnant women that we need to maintain?

14. Section 15.4 (reissued SOW) states, "CONTRACTOR shall document their strengthening families' protective factor outcomes in the CONTRACTOR's annual report.

    QUESTION: What strengthening families' protective factor outcomes are you referring to? Is there an Outcome Measure tool that will be given to us? Or are you referring to a subjective accounting?

15. Section 7.0 Health, Parenting and/or Other Education Programs or Resources

    Add Evidence-Based Weekly Support Groups for Parents, Children and Youth: to provide ongoing emotional support, build a sense of community and increase individual competencies.

16. We support additional funding to be allocated to PFF to sustain and expand the current level of service beyond pre-natal to 5 year old at risk children and their families. If additional funds are not available, then we urge that the pre-natal to 5 year old range be continued in order to ensure that this extremely vulnerable population is able to be effectively served.

17. PFF should be recognized as a better approach toward “alternate response” and replace it altogether.

18. First 5 LA needs to cover the cost of the current program until the DCFS PFF program begins.

19. PFF needs to be funded and the allocation of funds system to SPAs must be based on need.

20. We oppose the required development of a program plan for PFF services without any funding guidance. While the budget derives from the program design; the program design absolutely requires the budget as a structure within which to create the staffing, contracting and service delivery/activity planning designs. Our program proposals and fundamental approach will be different for $500,000 than for $2,000,000

21. Regarding point 3.2, please also include in the evaluation process the increase in family/parental functioning factors in addition to recidivism into the system as a true picture of the work being done

22. Regarding section 3.4.1, Partnerships for Families (PFF) is a 6-12 month program.

23. Regarding section 3.4.1., please include prenatal, postpartum, parenting and child development education and social support/community advocacy and connections as key components

24. Regarding section 5.1., case management should be able to be a subcontracted service to both meet all cultural and linguistic needs of each SPA, and also to allow for a greater depth of available services and linkages through community and agency partnerships

25. Regarding section 5.4., in keeping with the family strengthening framework, it is important that when contracts are written for voluntary programs that the family as expert on themselves and their needs are placed in that position in the framing of a program, so it is my recommendation when writing bout service planning that the plan be agreed on “by the family and case manager”, not by “the case manager and the family”. Order is as important as language in framing our work

26. Regarding section 5.5., should read, “on-going support” not “monitoring” or the family; this is a voluntary program and a preventative one as well.

27. Regarding section 5.9.1., adequate housing and medical care are linkages, not concrete supports.

28. Regarding section 5.9.5., as these are closed cases by DCFS, and the agency has direct contact and closest understanding of family needs, agencies should be able to budget for their own family support and not be dictated by the county as to how best to support the families that they are working with. Agencies however should be asked for justification, accounting and outcomes following the spending of funds. Additionally, prior approval slows down the ability to support families when time could be of the essence

29. Regarding section 5.9.8., amount given should be at the discretion of the agency given the contract as DCFS has already deemed them capable of supporting the family and know what would be best for the family.

30. Regarding section 6.2., as only 10% of the contracted budget, please include a caveat that this service can be subcontracted

31. Regarding section 7.1., with a 0-5 focus (and if not the focus, the agreed upon most vulnerable population by DCFS and in response to the Katy A Lawsuit) and services

available to referrals of at risk pregnant women by the community, there also needs to be a prenatal component and post partum support

32. Regarding section 11.1., true external capacity building requires a willingness to relinquish control to the community that the agency and county is seeking to support. If the community feels that something would be to their benefit and support the community in its growth as facilitated by the contracted agency, it would behoove the County eliminate this language in this section and in the following 11.1.1. This portion should be at the discretion of the community and the agency facilitating and supporting the community's growth. Outcomes should be what the county requests as accountability, not the final decision as to whether they think what the community would like to do is a good idea or not

33. Regarding section 12.2., if the County is moving forward with using the Family Assessment Form (FAF), these should be generated directly to the county's database and all significant data generated by the In-Home Outreach Counselors (IHOC) should be ready available to the county.

34. Page 8 (SOW 5.7.5): states clinical director will sign and date the PFF service plan - The way it is written it does not include the person developing the plan.

    a. It would seem to make more sense for the clinical supervisor of the person developing the plan to be the one to sign the service plan. Stating it must be the Clinical Director is restricting and in some agencies may mean that someone removed from the day to day work of the service provider would now be required to sign service plans.

35. Page 8 (SOW 5.7.2): Needs assessment tool of choice - The assessment tool used should be standardized among providers in order to effectively measure outcomes. Currently the FAF is being used and should be implemented

36. Is the expectation to serve the entire SPA, as currently only certain zip codes are being served with the same funding?

37. Page 2 (SOW 2.2) Target Population: Community Referred Pregnant Women - What expectations of DCFS regarding the pregnant women referrals since they are not referred by the Department.

    a. Concerning referral and data information, how will this be provided to DCFS if pregnant women are not necessarily referred by the department. Informing pregnant women that their information will be shared with DCFS will deter them from engaging in the program.

    b. This is not conducive for the pregnant women population, especially since pregnant teens are a target population on page 4. Pregnant women require support particularly after the baby is born and it would be unfair to cut off services during this critical time.

    c. While it is understood that PFF is meant to be short-term intervention, this 6-month standard does not seem conducive for the pregnant women population, especially

pregnant teens who really need support through their pregnancy and in the crucial early months of becoming a parent

d. Length of services for pregnant women should be increased without the necessity of written approval by County Program Manager in order to eliminate barriers to continuous care for this high risk population and to reduce the work it would take to request and follow up on exceptions for each and every pregnant woman served.

38. Page 5 (SOW 3.4.1) PFF is provided for a maximum for 6 months. Point 3.4.1.1 allows extension of services by County Program Manager discretion based on a case by case basis and for extraordinary circumstances - This is not conducive for the pregnant women population, especially since pregnant teens are a target population on page 4. Also, the length of services for pregnant women should be increased without the necessity of written approval by County Program Manager.

39. Section 4.7, contractor shall ensure "that the caregiver signs the Consent to Release and Exchange Information, Exhibit E-2…": Currently, this form is filed by DCFS staff before making a referral to the contractor agency, and is sent to the agency along with the referral. This shift in procedure will necessitate a change in the language on the form.

40. Section 5.1, "contractor shall provide home based case management services. Case management services are not permitted to be subcontracted." What is the rationale for the prohibition on subcontracting? A strong recommendation that emerged from the public comments phase of the previous iteration of the RFP was to allow this subcontracting so as to better leverage partnerships and collaborations that have already been developed for PFF.

41. Section 5.2, "Contractor may request approval for case management services to be provided by a paraprofessional staff." What is the procedure for submitting this request? Does it need to be submitted (and approved or disapproved) as part of the proposal / response to the RFP, or at a later stage in contracting?

42. Section 5.4, "Case management sessions shall include face to face meetings between the case manager and all participants in PFF services." Is this a new requirement imported into PFF from Family Preservation? It will be difficult to meet this requirement with families whose participation is non-mandatory.

43. Section 12.1.2, contractor shall include progress notes, Exhibit E11, with submission of the monthly service report: How does this align with HIPAA compliance requirements?

44. Page 5 (SOW 3.0) Indicates that PFF services are short-term interventions however, most DCFS families referred under the current model require longer term services to address the severity of their needs. DCFS will need to ensure families are appropriately referred to PFF and CSW's should be thoroughly trained as to which families qualify. The sample SOW to be somewhat similar to Family Preservation/A & I and the concern is that if currently CSW's get confused and send inappropriate referrals, the distinction will be even more difficult if there is not proper training on the differences and which families may qualify.

45. Page 5 (SOW 3.2) Indicates the success of PFF services can be determined by subsequent family involvement in DCFS during/and/or after service provision; as well as the level of said involvement with DCFS. It would be advantageous for DCFS to meet with current PFF providers to better understand how PFF participants are currently identified as successful given that often times PFF workers need to make referrals to DCFS and cases will open. PFF families are not opened cases at the onset however they are referred by way of being high to very high risk for child maltreatment thus it is inevitable that referrals to the hotline will be made. Providing families with increased safety measures should also be viewed as a success.

46. Need more information as to the funding of PFF services given the contingency on Title IV E-Waiver dollars. Agencies have invested a lot of resources in the communities served over the last six years which have curtailed child abuse/neglect and saved the County dollars. It would behoove DCFS to meet with current PFF providers to continue to learn about the success of the model and best practices for implementation.

47. Sample Contract 9.1, page 16 defines the hours of operation and 9.2 states a modification can be requested. It would be preferable not to have set hours of operation defined by the county for all providers across the county but rather to allow awarded providers the discretion to keep hours of operation defined by community needs from the beginning.

GENERAL QUESTIONS (Programs)

1. In several Service Planning Areas, leading community-based child welfare organizations have strengthened their local coalitions to respond to the Safe Children Strong Families Redesign. Comprised of those lead organizations across the 6 categorical programs, these "Coalitions" are serving as the "community-based learning collaborative" vehicles for creating the "seamless, accessible continuum of prevention, intervention and aftercare services for families in our communities. We thank the Department for creating this opportunity for a real transformation in the structure of community child welfare service organizations – our intent is for this transformation to move from fragmentation of limited resources towards a more integrated, coherent, efficient and culturally effective services for families, as well as the inclusion of family-directed activities that have been proven to prevent child abuse and neglect

2. We applaud DCFS for the recent focus on a Family Preservation Learning Collaborative and the previous Learning Collaborative which was created for the Prevention Initiative several years ago. We propose that DCFS model its own Redesign and establish one, INTEGRATED Safe Children Strong Families Learning Collaborative for the "Community Child Welfare Service Delivery System". This Learning Community would encompass the continuum from prevention to intervention to aftercare. This Collaborative would partner with DCFS to establish the framework and operational elements to ensure maximum outcomes for the array of SCSF program components (Prevention Initiative (Resource Center), PFF, CAPIT, Assessment and Intervention and APSS). The DCFS "Community Child Welfare System" Learning Collaborative should be formally linked to the SPA-based Learning Collaboratives/Coalitions that have organically emerged in the various SPA areas. As allies we could plan an effective transformation of the child welfare system into a "strengthening families system" and create a public-private partnership with shared values, beliefs and approaches

3. The SCSF Learning Collaborative should replace the redundant Task Force Meetings, Roundtable Meetings, Subcontractor/Network Meetings, and Community Advisory Council Meetings in the Regions (see Assessment and Intervention SOW 8 (8.2.5, 8.2.6, 8.2.8 and 8.3.9).

4. DCFS needs to publish the funding available for all program components as it is extremely difficult for agencies to accurately plan effective programming and scope(s) of service without knowing the level of available funds. For each component, we urge that a partnership between DCFS and community-based organizations work together to establish reasonable and study-based rates for quality (not minimal) services; through this public-community joint cost study, rates based on professional, paraprofessional, case aide (caseload standards) and other staff and administrative costs could be established to ensure success with each respective Statement of Work. This could be a range; for example, IHOC caseloads should fall between 11 and 15 families as caseloads.

5. While keeping the focused perspective on accountability and responsibility, the County needs to prioritize Outcomes that are steeped in the principles of the Strengthening

Families and Protective Factors Framework, a shared Core Practice Model, Services, and Collaborative Efforts. These Outcomes must be based on the promotion of the protective factors and enhanced family functioning, rather than recidivism and time in placement. Further, the Learning Collaborative functions as a coordination of best practice and must not be seen or described as collusion.

6. DCFS should, itself, commit to the "seamless and integrated Continuum of Care and blend its Community-based Support Division administratively and programmatically to avoid programmatic silos (FP v FS v PIDP v PFF v APSS v CAPIT) where we have separate meetings, separate program monitors, separate forms, separate assessments, separate language, separate standards, etc. Different funding sources should not affect the coordination of care in the community.

7. DCFS and the community Learning Collaboratives should establish mutually agreed minimum and maximum workload standards for required staff positions.

8. The Family Assessment Form (FAF) should be implemented across programs and flow into measurement of family functioning outcomes in alignment with the Protective Factors framework

9. There should be a uniform Strength/Outcome based Assessment Form uniformly for all agencies implemented across programs and flow into measurement of family functioning outcomes in alignment with the Protective Factors framework

10. There should be discussion around the reimbursement process across programs

11. The combination of Vermont and WLA DCFS offices and Pomona and El Monte community areas in the last SCSF RFP release should be separated for the purpose of Assessment and Intervention and CAPIT, leaving the "Prevention Initiative"/CFRC, PFF and APSS as SPA-based.

12. Dollar allocations based on the timing of the Waiver approval is critical. Optimally, we need dollar allocations before we approach proposal writing. This is "our" conundrum as DCFS and the coalition of community-based organizations cannot effectively plan a continuum without knowing the scope and level of funds for each program component. Is there more concrete information on the Waiver and its timing? The RFP would best wait for this federal approval.

13. We urge movement (in coordination with the DCFS Strategic Plan) to enhance DCFS specific outcomes from important, yet standard DCFS diversion issues (i.e. diversion, recidivism, and permanency to assessment-based family functioning indicators aligned with the Protective Factors framework.

14. DCFS states throughout the different Statements of Work that the Safe Children and Strong Families continuum is steeped in a strengthening families approach and that the five protective factors are the foundation of this approach. The current Statements of Work and Contracts offered by DCFS for review and public comment are presented in an isolated manner that prevents integration and lacks key ingredients that are essential for meaningful comment and review such as overall and program component funding levels, description of integration between the program elements, scope and level of services, proposal format and evaluation, etc. Rather than collecting comments that focus on the

deficits of each individual program Statement of Work and Contract, we urge DCFS to enter into true partnership with the multiple systems of community organizations throughout the eight Service Planning Areas to plan an effective and true continuum of prevention, intervention and aftercare services. This process will provide DCFS and the provider community with the opportunity to transform the existing fragmented and "siloed" system into a true continuum and assist DCFS to meet many of the objectives listed in its recently adopted Strategic Plan. This model of transforming systems in partnership has been employed by other LA County Departments and other cities, counties and states, resulting in service delivery systems that are responsive.

15. We feel that there remains significant distance between what DCFS is proposing and the core values and capacities of the community of providers—particularly providers with expertise and commitment to primary prevention. The concern in these areas is commonly held by a number of organizations that share a deep commitment to working in a manner that we believe will effectively create a streamlined continuum of care including a solid commitment to primary prevention.

16. *Absence of anticipated allocation or budget amounts:* We are aware of the need to begin the public comments process in a timely fashion, and the difficult of incorporating budget discussion when the disposition of key funding streams has not yet been determined. However, the ability to adequately plan for service provision in any of the service categories—and thus to provide meaningful, helpful commentary to the Department on the draft documents—is severely limited by the absence of any financial information. Suggested percentage allocations in the various contracts, for example, may be feasible and reasonable given a certain anticipated contract size, but become impractical at smaller total amounts. We also have some concern that the separation of the public comment process on the narrative/program design portions of the RFP from the financial portions, may be an indication that that Department intends to replicate one of the most serious flaws of the previous iteration of the RFP: the completely separate submission and evaluation of program proposals and financial proposals. As was indicated in many of the public comments at that time, this process will lead to a "race to the bottom" in bidding on the financial portion of the application, and this consideration of cost separately from program quality will distort the entire field of proposed services.

17. *As currently structured, the RFP does not lay out a pathway toward a seamless and coordinated continuum of care:* The issue of five separate SOWs leads us to anticipate that, as was the case with the previous iteration of the RFP, applicants will apply separately for contracts in each of the five service areas. While certain changes since that first RFP have moved the Department's approach closer to a "continuum of care" (e.g., the shift to a SPA-based collaboration in the Resource Center), the overall approach still leads toward a series of disconnected providers of individual services that will only accidentally or after the fact create mechanisms of coordination and collaboration. Certain key populations, in particular (e.g., families receiving Family Reunification services), will be best served by collaboration between providers in several of the service categories (in this case, CAPIT, PFF, and the Resource Center).

18. We would strongly recommend that the Department design a process for further development and review of the new RFP that relies on the extensive network of partnerships with provider organizations. We see ourselves as collaborators and resources for the Department, and would welcome the opportunity to engage in a more fully collaborative design process in which discussion between public- and nonprofit sector

partners drives development of the RFP. The current approach, in which draft documents are assembled for the most part without extra-Departmental input, and then released for public comment in settings where discussion cannot take place, artificially creates an environment that we do not believe accurately characterizes the relationship between our organizations and the Department. We stand ready to support you in this work.

19. DCFS should, itself, commit to the "seamless and integrated Continuum of Care and blend its Community-based Support Division administratively and programmatically to avoid programmatic silos (FP v FS v PIDP v PFF v APSS v CAPIT) where we have separate meetings, separate program monitors, separate forms, separate assessments, separate language, separate standards, etc. Different funding sources should not affect the coordination of care in the community.

20. If DCFS is unable to develop another model for transformation that is not focused on competitive bidding, then we strongly urge DCFS to stagger the Program Proposal due dates to allow community-based organizations to develop and propose the best possible proposals for each categorical program. We still support the requirement for seamless connections between the five programs from the perspective of family access.

21. The program and budget proposals for each separate program need to be read together, by the same reviewer team to make any connection between creative program design and the way the program needs to be budgeted.

22. DCFS needs to publish the funding available for all program components as it is extremely difficult for agencies to accurately plan effective programming and scope(s) of service without knowing the level of available funds. For each component, we urge that a partnership between DCFS and community-based organizations work together to establish reasonable and study-based rates for quality (not minimal) services; through this public-community joint cost study, rates based on professional, paraprofessional, case aide (caseload standards) and other staff and administrative costs could be established to ensure success with each respective Statement of Work.

23. The effort to secure lowest bidding of rates in the last SCSF RFP release leads to a race to the bottom – no quality standards and opportunity for 'parachuting' into communities for the money or power. We urge DCFS to follow suggestion 8 above and ensure that program and budget proposals are reviewed together with consideration made as to cost-effectiveness based on quality of service.

24. The Family Assessment Form (FAF) should be implemented across programs and flow into measurement of family functioning outcomes in alignment with the Protective Factors framework.

25. There should be discussion around the reimbursement process across programs.

26. We urge DCFS to have the "Prevention Initiative"/CFRC, PFF and APSS as SPA-based with funding levels that are appropriate and adequate to meet maximum outcomes.

27. Dollar allocations based on the timing of the Title IVE Waiver approval is critical. Optimally, we need dollar allocations before we approach proposal writing. This is "our" conundrum as DCFS and the coalition of community-based organizations cannot effectively plan a continuum without knowing the scope and level of funds for each program component. Is

there more concrete information on the Waiver and its timing? The RFP would best wait for this federal approval.

28. It appears that although the Strengthening Families/Protective Factors framework is discussed in the preface to the Prevention & Aftercare Services-Resource Center SOW, the implementation guidelines are not aligned with either the Strengthening Families/Protective Factors framework nor with best practice in the Prevention approach both locally and nationally. The SOW very quickly dispenses with the Protective Factors framework and devolves back to an intervention approach that makes all participants "clients" with the sole objective of preventing DCFS referrals and re-referrals (i.e. there is no measurement framework for increases in the Protective Factors).

29. We feel that primary prevention has largely been removed from the suite of DCFS strategies proposed for funding in the RFP: While we applaud the Department's initial focus on the protective factors framework and its address to a strengths-based approach rooted in primary prevention best practice, our overall impression is that this focus quickly disappears from the SOWs and contracts as those documents begin to discuss guidelines for service provision, staffing, and budgeting. Even in the strategy area in which we would expect to find the most pronounced commitment to primary prevention—the resource center—our reading of the SOW and contract has left us to conclude that the service methodology being proposed is overwhelmingly oriented toward intervention and treatment.

30. At present, the SOW for both Prevention and Aftercare section areas require an intake process during which families consent to make their data available to DCFS. While this may be appropriate for certain targeted populations (the 10% required Family Reunification services, or a Differential Response population), primary prevention functions largely on the basis of self- and/or community-referred families who may be hesitant to share certain data with DCFS and the broader child welfare system.

31. We applaud the department for including an outcomes form rooted in the protective factors framework as part of the Resource Center SOW. However, in the absence of clear metrics or indications of how these outcomes are to weighted against the standard (across all SOWs) measures of involvement or re-involvement with DCFS, it is difficult to determine how much they will actually be allowed to guide practice and program design.

32. In the new DCFS Strategic Plan, Family Visitation Centers are part of the overall department goals - yet there seems to be no reference to them in any of the RFP workplans. This would be the opportunity to have FVCs and the support of those FVCs embedded within the community based programs. However, there must be funding allocated to adequately support their successful implementation. Currently existing community based models should be used as guidelines for this work.

33. Our first comment addresses the Strategic Plan, released in September 2012, which will guide the efforts of the Department of Children and Family Services over the next three to five years. For those of us who are providing direct services to children and their families, this 12 point plan will be the foundation of all our future work - and - it presents us with the underlying premise of our concern for the future of our Native American children who are in the DCFS system. Albeit, Latino children make up the majority of children in the welfare system, recent reports confirm their placement rate aligns with their proportion of the population. DCFS strategy 1.1.4 of *GOAL 1: EMPHASIZE CHILD CENTERED*

PRACTICES: Provide children with both integrated assessments and planning that promote the safety, permanency and wellbeing of children under our supervision, states a *department-wide plan will be implemented by September 2013, to reduce racial disparity and disproportionality for African American children.* The issue of disproportionality cuts across more than one segment of our community. We feel much more is at stake – as cultural brokers we are working to reduce disproportionality every day. Of course there are the numbers; according to NAIC there are 200,000 AIAN (American Indian Alaskan Native) residing in LA County. Many American Indians ended up in Los Angeles as the result of the Bureau of Indian Affairs' Urban Indian Relocation Program.

- ✓ Los Angeles County has the highest population of American Indians of any county in the United States
- ✓ About a seventh of all AIANs reside in California
- ✓ The Los Angeles region is home to about 3 percent of the nation's 3.7 million AIANs
- ✓ AIANs are a relatively young population

SCIC has been serving Native American children and their families for 40 years, with three operating sites two of which are Los Angeles County; thousands of families come to us with multiple challenges from unemployment and homelessness to seeking children's safety and exhibiting normal family functioning.

Thus, our concern is the absence of inclusion of Native American children and their families in the release and subsequently the rerelease of the DCFS Safe Children Strong Families RFP. Southern California Indian Center's American Indian Family Partnership's program is the <u>only 0-5 child abuse/neglect prevention program in LA County</u> [the SPA 9 recipient] funded by First 5 LA, Partnership for Families. SPA 9 was not included in this RFP. Originally the framework for the creation of SPA 9 is American Indians represent the growth development and diversity that make Los Angeles County a great place to work, live and play.

- Historically there were neighborhoods that the 1956 Federal Relocation Program placed American Indians from Reservations
- Support that was offered to the relocated families were sparse and sometimes did not exist; thus American Indians settled across the county
- In the absence of Federal or state Services American Indians found each other and created their own service providers (i.e. Orange County Indian Center) which later became the Southern County Indian Center [SCIC]

Geography

- American Indians can be found in all areas of Los Angeles County but predominantly reside in lower income Black and Latino areas of L. A. County
- Because there is no one "neighborhood" or center to the Native community, people will travel for hours in a car or use public transit to find or use culturally sensitive services and service providers
    - *(It is not uncommon to live in El Monte, get mental health care in Cerritos, cultural family services in Highland park and job services in Korean Town [SCIC])*

Background of the Creation of SPA 9 (2002): The design and purpose of Service Planning Area 9 was to ensure obligations to provide services in compliance with federal law were met and successful partnerships and programs were developed.

- With no geographic center the Native community members advocated for designation for a SPA 9 (American Indian Children's Council). These efforts from both the County and City of Los Angeles resulted in a county-wide approach and decentralized the services to best serve American Indians and Alaska Natives
- There is a special obligation of federally funded agencies including state agencies to provide American Indians with Educational, Health and Housing services. This is based on the fact that being a citizen of an Indian Nation is a Political Status and not a race or ethnic identity

Lack of access to services for our children is a major concern - if we can't identify them we are facing a huge problem. Today most of the forms used by the various departments county-wide to deliver vital social/medical services to LA County residents fail to identify Native American race/ancestry; often individuals with Spanish surnames are inferred to be Hispanic/Latino and - they are not asked if they identify with Native Americans. Additionally, the Native American children face many more challenges a disproportionately high percent face educational barriers and health problems in addition they are: are geographically dispersed; nearly one-in-four live below the poverty ; only about one-half live in two-parent households and AIAN children are more likely to encounter poor housing conditions. 1. We are suggesting a place based or neighborhood approach will limit services to one or no American Indian or Alaska Native families. We are requesting DCFS consider county-wide contracts for providers to Native American families in each of the categories of the Safe Children Strong Families RFP. 2. The emphasis on cost (lowest bidder) versus quality of services is in direct contradiction to DCFS' September 2012 Strategic Plan.

Many of direct service providers have been working in collaboration with the DCFS network of providers to ensure the families have a community-wide safety net to enable families to achieve their goals. Unlike a public works contract we are not dealing with building materials, concrete, bricks and mortar we are concerned with the well-being and safety of children. Some populations are harder to serve, and or have numerous barriers, and because Native Americans are dispersed across the county delivering services will include additional transportation services and or costs. It is clear that there must be measures in place to ensure the County is protecting the public from misuse or waste of public funds and to ensure bidders are responsible and responsive to the community needs; there are in fact other ways to drive costs down-the competitive bidding process does not address this objective and it creates unnecessary acrimony among the network of DCFS providers who share a common goal.

We are looking forward to providing vital services to families in crisis and to working with DCFS in the future, to ensure the safety and well-being of Native American children and with the hopes of alleviating contemporary problems facing indigenous peoples. If you have questions and/or need additional information you may contact me directly or program personnel below.

34. On behalf of the Asian Pacific Policy & Planning Council (A3PCON), an association of forty Asian Pacific community agencies, we commend the Department of Children and Family Services for including a County-wide Asian Pacific Islander Community Family Resource

Center (Prevention and Aftercare Services—Resource Center, Section 2.0, Target Population, Page 5.) in the SCSF RFP re-release.

A3PCON requests that DCFS include County-wide API contracts in the Assessment and Intervention Services (Family Preservation) and the Prevention and Aftercare Services – CAPIT.

The first release of the SCSF RFP (#11-053) contained a provision for an API County-wide contract in the Family Preservation program and this would continue the success of the current County-wide API Family Preservation contract that has served the API communities well since 2002. A3PCON asks that this provision be included in Addenda to the re-release.

Currently 10 API agencies provide CAPIT services, either through direct grants or subcontracts with DCFS. With such an established network of proven providers, it is both critical and feasible to create a county-wide API CAPIT grant that can support a consortium of these API providers, and coordinate the service delivery continuum with the Family Preservation and the Community Family Resource Centers and the DCFS API Specialized Unit. The existing contracting structure in CAPIT has allowed for a collaborative of API agencies in the County to receive funding through one grant and an API lead agency. This has increased the number of diverse API communities who are being served in this program.

A3PCON had expressed concerns with the CAPIT funding structure in the original RFP (#11-053) that we will share again in the possibility that it is being considered by DCFS. Our concerns were based on:

(1) A much smaller size for the new CAPIT grants to be awarded

(2) CAPIT grants apportioned on the basis of three CAPIT grants per each of 14 Regional Office areas

(3) The requirement that CAPIT grantees serve multiple ethnic populations within their Regional Office area

Our concern was that most current API CAPIT grantees serve API ethnic communities well by providing culturally sensitive and linguistically appropriate services, but for the entire county based on language need. Because most of the 30 significant API communities are dispersed, they are often not large enough to be well served through any district based strategy. These requirements could lead to far fewer API-led agencies receiving grants and far fewer APIs receiving CAPIT services.

A3PCON requests a County-wide API CAPIT contract and that the funding for this Countywide API CAPIT (together with any other API CAPIT funding) maintain the current proportionate level of funding for the API community. API agencies are currently receiving about **16%** of the CAPIT funding for API clients, a figure very close to the proportion of APIs in the County. We recognize that all populations will be receiving across-the-board cuts based on the planned reduction of total CAPIT funding, and we also support the suggestions raised at the Public Comment hearing, that the Department seek additional funding for CAPIT.

Of the 1.5 million Asian Pacific Islanders who comprise 15% of Los Angeles County residents, two thirds were born outside the U.S. which points to the necessity for language-appropriate services. API ethnic communities speak the seven API primary threshold languages and additional non-threshold languages. Asian Pacific Islanders live throughout L.A. County with large numbers in SPAs 2, 3, 4, 7 and 8. A3PCON's proposals provide a proven model for serving linguistically diverse and geographically dispersed Asian Americans and Pacific Islanders.

We recognize the difficult challenges DCFS faces and we appreciate the willingness of DCFS to listen and do its best to respond to all the communities' needs.

CONTRACTS ADMINISTRATION

1. If DCFS is unable to develop another model for transformation that is focused on competitive bidding, then we strongly urge DCFS to stagger the Program Proposal due dates to allow community-based organizations to develop and propose the best possible proposals for each categorical program. We still support the requirement for seamless connections between the five programs from the perspective of family access.

2. The program and budget proposals, in each case, need to be read together, by the same reviewer team to make any connection between creative program design and the way the program needs to be budgeted.

3. The effort to secure lowest bidding of rates in the last SCSF RFP release leads to a race to the bottom – no quality standards and opportunity for 'parachuting' into communities for the money or power. We urge DCFS to follow suggestion 2 above and ensure that program and budget proposals are reviewed together with consideration made as to cost-effectiveness based on quality of service.

4. The RFP does not direct us how to do the benefits calculation in regards to health care reform. How do we appropriately calculate on our budgets to cover employees who elect to not take health benefits? As an agency we can pay the benefit into a pool or we can pay a fine for not covering the employee. Of course the fine is the more cost effective way, but we are sure the County will NOT cover this cost, correct.

5. Sample Contract 3.2, page 5 refers to Required Form 4-A Price Sheet and Required Form 4-F Line Item Budget – we did not find these forms in the documents released by DCFS.

6. Sample Contract 8.1, page 15 defines the hours of operation and 8.2 states a modification can be requested. It would be preferable not to have set hours of operation defined by the county for all providers across the county but rather to allow awarded providers the discretion to keep hours of operation defined by community needs from the beginning.

7. Sample Contract 53.0, page 51 Termination for Convenience states that the county will give no less than 10 days notice before termination of contract. This does not seem like adequate time for a contractor to ensure that client needs and ongoing care are planned.

8. Could you please clarify whether DCFS plans to release a new contract that integrates all of the revisions and clarifications made to the contracts? There were quite a few Addendums released after the previous Safe Children Strong Families RFP. This made it very difficult for providers to develop their proposals as the Addendums contained contradicting information with respect to some of the identified issues. We respectfully request that DCFS consolidate any revisions/clarifications made to the contracts so that providers can efficiently work on and submit their proposals.