

DEPARTMENT OF ADMINISTRATION  
GENERAL SERVICES DIVISION  
STATE PROCUREMENT BUREAU

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3/28/2014

STATE OF MONTANA  
REQUEST FOR PROPOSAL ADDENDUM  
RFP NO. 14-2934R  
TO BE OPENED: 4/23/2014

TITLE: Maternal, Infant, and Early Childhood Home Visiting: SafeCare Augmented

ADDENDUM NO. 2

To All Offerors:

Attached are written questions received in response to this RFP. These questions, along with the State's response, become an official amendment to this RFP.

All other terms of the subject "Request for Proposal" are to remain as previously stated.

**Acknowledgment of Addendum:**

The offeror for this solicitation must acknowledge receipt of this addendum. This page must be submitted at the time set for the proposal opening or the proposal may be disqualified from further consideration.

I acknowledge receipt of Addendum No. 2:

Signed: \_\_\_\_\_

Company Name: \_\_\_\_\_

Date: \_\_\_\_\_

Sincerely,

Rhonda R. Grandy  
Contracts Officer

Question Number	Page Number	Section Number	Questions & Answers for RFP14-2934R
1.		General	<p>Q. What are the qualifications for a Safe Care supervisor? For a Safe care direct service worker? We'd like more information on level of education and any specialized training beyond the model training.</p> <p>A. <b>There are no specific qualifications or educational level required for the supervisor. The supervisor is expected to support the home visitor in the competence and quality of the services they provide and meeting model requirements. There are no specific qualifications or educational level required for the SafeCare home visitor. All required training will be provided. This includes the SafeCare orientation, the SafeCare workshop, Motivational Interviewing, Domestic Violence, ASQ-3/ASQ:SE, CANS, and MT MECHV program training.</b></p> <p><b>Recommended characteristics of SafeCare home visitors include:</b></p> <ul style="list-style-type: none"> <li>• good communication and interpersonal skills</li> <li>• comfortable delivering interventions to families in the home setting</li> <li>• open to learning and implementing new curricula or intervention programs</li> <li>• open to or have prior experience delivering a highly structured intervention protocol</li> <li>• able to be both creative and flexible in delivering services to families</li> <li>• open and responsive to coaching and constructive feedback</li> <li>• previous experience working with families</li> <li>• understanding of family circumstances and responsive to family needs, but able to provide structure to visits and maintain fidelity to the model</li> <li>• able to demonstrate compassion, and cultural/linguistic understanding to each individual family</li> <li>• diligent and mindful in meeting reporting requirements</li> </ul>
2.		General	<p>Q. How many Direct service FTE can a Safe Care supervisor oversee?</p> <p>A. <b>Agencies should use their discretion in determining how many direct service FTE a supervisor can oversee. The SafeCare model differs from PAT, NFP, and other home visiting models in that the direct supervisor (who is not the SafeCare coach) does not have model-specific responsibilities, beyond ensuring that the home visitor meets program requirements. When planning supervisory time, programs should consider the level of effort required for the grant management, including program reporting, referral systems development, and continuous quality improvement activities.</b></p>
3.		General	<p>Q. What are the hours of supervisor time are required per FTE for Safe Care?</p> <p>A. <b>SafeCare does not have specific requirements for supervisor time. The SafeCare model differs from PAT, NFP, and other home visiting models in that the direct supervisor (who is not the SafeCare coach) does not have model-specific responsibilities, beyond ensuring that the home visitor meets program requirements. When</b></p>

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			<p>planning supervisory time, programs should consider the level of effort required for the grant management, including program reporting, referral systems development, and continuous quality improvement activities.</p>
4.		General	<p>Q. Is there a target caseload for Safe Care in each community? If so, what is it?</p> <p>A. There is not a specific caseload target for each community. The program estimated an average of 2 full-time (2.0 FTE) home visitors per community, recognizing that some communities may propose more home visitor time and some less. The caseload recommendation for a full-time home visitor (1.0 FTE) is 8 clients. Where less travel time is required, a full-time home visitor (1.0 FTE) may have a caseload of up to 12 clients. Offerors are encouraged to use the Maternal, Infant, and Early Childhood Home Visiting County Profiles (available at: <a href="http://www.dphhs.mt.gov/publichealth/homevisiting/countyprofiles.shtml">http://www.dphhs.mt.gov/publichealth/homevisiting/countyprofiles.shtml</a>) and coordinate with their Best Beginnings coalition and early childhood partners to estimate eligible families and to determine their proposed caseload for SafeCare.</p>
5.		General	<p>Q. It appears that the State will pay for the training for Safe Care, but the costs associated with the staff hours fit training and travel are borne by the applicant agencies. What are the number of hours and total days for training for both direct service training and for the Safe Care supervisor training. Are the locations listed in the RFP finalized and can trainees pick the location? If the location is assigned or not yet finalized, what is the estimate for time and travel expenses?</p> <p>A. Offerors should estimate the travel costs. Required trainings include:</p> <ul style="list-style-type: none"> <li>• The SafeCare Orientation: supervisors (program manager) and home visitors are required to attend: June 4 in Helena (afternoon training).</li> <li>• The Motivational Interviewing training: June 2 or 3 (SafeCare participants are encouraged to attend the June 3<sup>rd</sup> 4-hour Motivational Interviewing training) in Helena, as a part of the Great Beginnings, Great Families Conference.</li> <li>• The 4-day SafeCare Workshop (home visitor attendance required, supervisors will not attend) in Helena.</li> <li>• The ASQ-3/ASQ:SE training is 2-3 days in length (depending on whether the trainee attends the Training of Trainers Seminar). A training is scheduled for Billings in May.</li> <li>• Domestic Violence: 1 day in Helena or Butte.</li> <li>• MTmechv data system training: 1 day in Helena.</li> <li>• Offerors should also plan travel for 2 in person quarterly meetings annually.</li> </ul> <p>The MT MECHV program training is anticipated to take place by WebEx as much as possible or be combined with other on-site trainings such as Domestic Violence. However, offerors are encouraged to plan for at least 5 days of training throughout the year in addition to the trainings above to be sure the budget accounts for all possible training costs.</p>

Question Number	Page Number	Section Number	Questions & Answers for RFP14-2934R
6.	16	3.2.6Q	<p>Q. Can CQI activities be the same for the Expansion Project and the SafeCare Project?</p> <p>A. <b>Home visiting sites can select the same Continuous Quality Improvement (CQI) activities for all home visiting models they are implementing, if appropriate. Please note that the SafeCare funding provided under this RFP is MIECHV Expansion funding.</b></p>
7.	17	3.2.11	<p>Q. The example timeline for hiring after grant award is tight, will there be other SafeCare and Domestic Violence training opportunities available after the June 2014 training or can we use local resources for domestic violence and motivational interview training?</p> <p>A. <b>Sites are encouraged to make every effort to have staff attend the trainings that are already scheduled. If staff are not able to participate in the planned trainings, the state SafeCare coordinator will work with sites to ensure staff receive all training to meet the model and state requirements. Certain trainings are required before home visitors can provide services, and the state must ensure that required trainings (including the motivational interviewing and domestic violence trainings) are consistent and meet appropriate standards. The document titled “Requirements for motivational interviewing and domestic violence training for SafeCare Augmented” provides more information about the components of these required trainings.</b></p>
8.	13	3.2.3	<p>Q. We have agencies who are interested but are unwilling to commit without more specifics about the content of modules and how they are used in the 7- step process detailed on the SafeCare website and more specifics about the recording requirements. Can DPHHS provide more specifics about the content of modules and recording of home visits?</p> <p>A. <b>The document titled “The SafeCare Model” provides information about the content of the modules. The recording of home visits is a requirement of the model. Recorded visits are used by the SafeCare coach to provide coaching and support to the home visitor. The recorded visits are the basis for helping home visitors develop competency in the SafeCare approach, with support and feedback from the SafeCare coach. More detailed training on the recording and competency will be provided at the SafeCare Orientation and Workshop.</b></p>
9.			<p>Q. Will our staffs time be covered when they attend trainings for this Grant? Though it is great that Trainings will be provided to us for free, our agency still has to cover the cost of that employee's day, and they are not reaching any form of productivity for the days at training. This can be costly, when the staff is attending several trainings. If it is covered, how would that look?</p> <p>A. <b>Staff time for participation in required trainings can be included in the proposed budget. This should be reflected in the personnel section (if direct hires) or contract section (if contracted staff) of the budget.</b></p>
10.			<p>Q. Caseload per community? Does this mean that several different agencies, within one community, can only have a max of 2 FTE? Or, does that mean that for an entire community can only have 2 FTE?</p>

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			<p><b>A. There is not a specific caseload target for each community. The program estimated an average of 2 full-time (2.0 FTE) home visitors per community (not agency), recognizing that some communities may propose more home visitor time and some less. The caseload recommendation for a full-time home visitor (1.0 FTE) is 8 clients. Where less travel time is required, a full-time home visitor (1.0 FTE) may have a caseload of up to 12 clients. Offerors are encouraged to use the Maternal, Infant, and Early Childhood Home Visiting County Profiles (available at: <a href="http://www.dphhs.mt.gov/publichealth/homevisiting/countyprofiles.shtml">http://www.dphhs.mt.gov/publichealth/homevisiting/countyprofiles.shtml</a>) and coordinate with their Best Beginnings coalition and early childhood partners to estimate eligible families and to determine their proposed caseload for SafeCare.</b></p>
11.			<p><b>Q. Will the Grant cover the cost of the Audio-Recording devices?</b></p> <p><b>A. Yes. You may include the cost of the recording devices in your budget. SafeCare recommends an audio recording device with a USB port.</b></p>
12.			<p><b>Q. If a family does not have more than one child, can they still participate in dual services, i.e. Parent As Teachers and Safe Care Model? Most families could really benefit from all the different services.</b></p> <p><b>A. MIECHV clients can only be enrolled in one model at a time. They cannot be simultaneously enrolled in two models (i.e. Parents as Teachers and SafeCare).</b></p>
13.			<p><b>Q. Will the Grant pay for advertisement for the Safe Care Model being used within the community? And if so, what will that look like?</b></p> <p><b>A. The State is developing outreach and awareness materials that sites can use to educate partners and potential clients about the services in their community. Any site-specific materials and outreach that an implementing agency is planning in addition to the statewide efforts should be included in the offeror's budget.</b></p>
14.			<p><b>Q. Will the State assist communities in developing an effective referral system?</b></p> <p><b>A. Yes.</b></p>
15.			<p><b>Q. Will the State allow someone to facilitate the application process as it did with the MIECHV ID Expansion and Service Delivery funding?</b></p> <p><b>A. A list of facilitators available to communities was released as an addendum to the RFP.</b></p>
16.			<p><b>Q. Where can we find exact model specific costs, training, materials etc. as we develop our budget?</b></p> <p><b>A. A model budget with estimated costs (such as is available for PAT and NFP) is not available for SafeCare. Sites should use the Key Costs Table on page 17 of the RFP to develop a budget for SafeCare. A list of SafeCare home visitor recommended supplies was included with the RFP as Appendix D.</b></p>

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17.			<p>Q. Will Safe Care data be tracked through the current MECHV data system?</p> <p>A. <b>Data on SafeCare clients served with MIECHV funds will be entered into and managed in the MTmechv data system. Client data is required to be entered within 5 working days of the client encounter.</b></p>
18.			<p>Q. How will this funding come to communities? Will it have to flow through Health Departments or can it flow through other agencies?</p> <p>A. <b>Funding for SafeCare services under this RFP will be provided through task orders (for health departments) or contracts. Offerors and contractors for this funding do not have to be health departments.</b></p>
19.			<p>Q. Are agencies interested in Safe Care required to become an affiliate as with PAT? What are the costs involved? What type of providers are eligible?</p> <p>A. <b>SafeCare does not have an affiliation fee. SafeCare sites are required to participate in the coaching and support provided by the SafeCare model developers in order to maintain their status as an approved site. There are no specific qualifications for the types of agency that can provide SafeCare services. There are no specific qualifications or educational level required for the SafeCare home visitor.</b></p> <p><b>Recommended characteristics of SafeCare home visitors include:</b></p> <ul style="list-style-type: none"> <li>• good communication and interpersonal skills</li> <li>• comfortable delivering interventions to families in the home setting</li> <li>• open to learning and implementing new curricula or intervention programs</li> <li>• open to or have prior experience delivering a highly structured intervention protocol</li> <li>• able to be both creative and flexible in delivering services to families</li> <li>• open and responsive to coaching and constructive feedback</li> <li>• previous experience working with families</li> <li>• understanding of family circumstances and responsive to family needs, but able to provide structure to visits and maintain fidelity to the model</li> <li>• able to demonstrate compassion, and cultural/linguistic understanding to each individual family</li> <li>• diligent and mindful in meeting reporting requirements</li> </ul>



## **The SafeCare® Model**

SafeCare is an evidence-based, parent-training curriculum for parents of children ages 0-5 who are at-risk or have been reported for child maltreatment. SafeCare providers work with at-risk families in their homes to improve parents' skills in three primary domains. Parents are taught (1) how to interact in a positive manner with their children, to plan activities, and respond appropriately to child behaviors, (2) to improve home safety, and (3) to recognize and respond to symptoms of illness and injury. SafeCare is generally conducted in weekly home visits lasting from 1-2 hours. The program typically lasts 18-20 weeks for each family.

## **SafeCare® Modules**

### **Health**

The goals of this module are to train parents to use health reference materials, prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment by following the steps of a task analysis. To assess actual health-related behavior, parents role-play health scenarios and decide whether to treat the child at home, call a medical provider, or seek emergency treatment. Parents are provided with a medically validated health manual that includes a symptom guide, information about planning and prevention, caring for a child at home, calling a physician or nurse, and emergency care. Parents are also supplied with health recording charts and basic health supplies (e.g., thermometer). After successfully completing this module, parents are able to identify symptoms of illnesses and injuries, as well as determine and seek the most appropriate health treatment for their child.

### **Home Safety**

This module involves the identification and elimination of safety and health hazards by making them inaccessible to children. The Home Accident Prevention Inventory- Revised (HAPI-R) is a validated and reliable assessment checklist designed to help a provider measure the number of environmental and health hazards accessible to children in their homes. Rooms are evaluated using this assessment tool and then training takes place to assist parents in identifying and reducing the number of hazards and making them inaccessible to their children. Safety latches are supplied to families. This protocol is effective in significantly reducing hazards in the home and these reductions have been found to be maintained over time.

## **Parent-Child/Parent-Infant Interactions Module**

This module consists of training on parent-infant interactions (birth to 8-10 months) and parent-child interactions (8-10 months to 5 years). The purpose of this module is to teach parents to provide engaging and stimulating activities, increase positive interactions, and prevent troublesome child behavior. The primary method for teaching this module is Planned Activities Training (PAT) Checklist. Providers observe parent-child play and/or daily routines and code for specific parenting behaviors. Positive behaviors are reinforced and problematic behaviors are addressed and modified during the in-home sessions. Providers teach parents to use PAT checklists to help structure their everyday activities. Parents also receive activity cards that have prompts for engaging in planned activities.

## **Problem Solving and Counseling**

Two additional focal points of the SafeCare model are problem-solving and counseling skills. Problem-solving is used by SafeCare providers to help parents work through the many problems they may face that are not addressed by the SafeCare model. Structured problem-solving involves correctly framing the problem, generating potential solutions, identifying pros and cons of those solutions, choosing a solution, and acting. SafeCare also teaches providers to use good counseling skills including: how to frame a session, building rapport, how to ask questions to elicit more information, how to provide positive and corrective feedback, and how to close a session. Problem-solving and counseling are used across the SafeCare modules as needed.

## **Common Elements of All Modules**

All modules involve baseline assessment, intervention (training) and follow-up assessments to monitor change. SafeCare providers conduct observations of parent skills for each module with structured checklists. The SafeCare training format is based on well-established social learning theory and evidence from previous research. Service providers and parents are trained using a general seven step format:

1. Describe desired target behaviors
2. Explain the rationale or reason for each behavior
3. Model each behavior (demonstrate desired behavior)
4. Ask parent to practice behavior
5. Provide positive feedback (point out positive aspects of performance)
6. Provide constructive feedback (point out aspects of performance needing improvement)
7. Review parent's performance, have them practice areas that need improvement, and set goals for the week.

Using this format, parents are trained so that skills are generalized across time, behaviors, and settings. Each module is implemented in approximately one assessment session and five training sessions and is followed by a social validation questionnaire to assess parent satisfaction with training. Home visitors work with parents until they meet a set of skill-based criteria that are established for each module.

## Requirements for motivational interviewing and domestic violence training for SafeCare Augmented

Sites wishing to implement SafeCare Augmented must receive SafeCare training from the National SafeCare Training and Research Center (NSTRC) or a certified SafeCare trainer at their site (or authorized by NSTRC). Sites must also be trained in Motivational Interviewing and Domestic Violence awareness. The NSTRC will have record of SafeCare training received. Sites must obtain and document for NSTRC their compliance with the following requirements for MI and DV training.

### Motivational Interviewing training must consist of the following:

- For Motivational Interviewing (MI) training, NSTRC will require SafeCare Augmented sites to provide a plan for being trained in MI either online or through an in-person workshop or consultation. Training should be conducted by a MINT certified training. To learn more about costs and scheduling of MI training, please see [http://www.motivationalinterview.org/quick\\_links/mitraining.html](http://www.motivationalinterview.org/quick_links/mitraining.html). NSTRC will assist sites in developing a plan for MI training as part of a readiness plan to implement SafeCare Augmented.
- In line with best practices in implementation science, SafeCare Augmented sites are strongly encouraged to participate in ongoing consultation or supervision with a MI trainer to become most proficient in using MI skills with families participating in home visiting. Ongoing consultation, training, and supervision should include role-playing and practicing MI skills on important, related topics for the families (e.g., implementing parenting skills, safety planning, substance abuse, accessing resources/jobs). We also encourage sites to consult with MI trainers that have some experience with in-home work focused on parenting or early childhood. A list of recommended MI trainers is available from NSTRC.

### Domestic Violence (DV) Training

- The goals of the DV training are:
  - Raise providers' awareness of domestic violence as an issue that affects families of children 0-5.
  - Increase provider's ability to detect partner violence, to ensure client safety, and to make appropriate referrals.

- The initial DV and safety planning training is likely to take 4-8 hours. DV training should include a discussion of the following topics:
  - What is domestic violence?
  - Recognizing signs of domestic violence
  - How to broach and discuss domestic violence with your clients
  - How to assess for danger and lethality
  - Impacts on the children and how to assess impact
  - How to make referrals, including specific agencies that can be called based on danger assessments
  - How to create a safety plan with the victim
  - Understanding of the challenges of leaving for the victim, and understanding the dangerousness for the victim when leaving
  - What is a restraining order and how one is requested?
- Training should combine both didactic and role-play/skill practicing. Providers should practice: recognizing domestic violence, assessing safety, utilizing standardized tools (e.g., Danger Assessment/Lethality Index), safety planning, and establishing a protective order.
- It is recommended that the DV training is conducted by a local DV agency. If a local DV shelter staff is not part of the intensive training, training should include a visit to the local shelter to discuss the processes for contact, referral, assessment, and support of transition to the shelter.
- An annual refresher training is strongly recommended. The refresher training should emphasize topics current providers express a need for based on the population served (see above).
- In addition to the annual training, local DV experts should be available for regular consultation on concerning cases. Timely support and consultation for concerning cases is important to integrate.

For more information about SafeCare Augmented, please contact

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