

State of Hawaii
Department of Health
Family Health Services Division
Maternal and Child Health Branch

Addendum 1

January 10, 2007

To

Request for Proposals

RFP No. HTH 550-18

**Baby S.A.F.E. (Substance Abuse Free Environment)
Program**

ISSUED: December 7, 2007

January 10, 2007

ADDENDUM NO. 1

To

REQUEST FOR PROPOSALS
Baby S.A.F.E. (Substance Abuse Free Environment) Program
RFP No. HTH 550-18

The Department of Health, Family Health Services Division, Maternal and Child Health Branch is issuing this addendum to RFP Number HTH 550-18, Baby S.A.F.E. (Substance Abuse Free Environment) Program for the purposes of:

- Responding to questions that arose at the orientation meeting of 12/19/06 and written questions subsequently submitted in accordance with Section 1-V, of the RFP.
- Amending the RFP.
- Final Revised Proposals

The proposal submittal deadline:

- is amended to <new date>.
- is not amended. **Deadline 1/26/2007**
- for Final Revised Proposals is <date>.

Attached is (are):

- A summary of the questions raised and responses for purposes of clarification of the RFP requirements.
- Amendments to the RFP.
- Details of the request for final revised proposals.

If you have any questions, contact:

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Responses to Question Raised by Applicants
For RFP No. HTH 550-18
Baby S.A.F.E. (Substance Abuse Free Environment) Program

1. **Question:** On page 2-6 number 4 the statement is unclear, is there a requirement for a MSW or RN to “sign off” on a risk assessment or when screening is completed by another professional or para-professional?
Response: Yes this was included for quality assurance. This does not mean that the MSW or RN would be required to be the staff delivering services and providing the risk assessments and screening. They would be the staffing providing some oversight to support quality assurance and this would include the “sign off” on a risk assessment or screening by another professional or para-professional. This would include this “sign off” for a staff such as a certified substance abuse counselor.
2. **Question:** On page 2-7 number 6, what is the data collection form?
Response: See Section 5 C.3. Baby S.A.F.E. Data Forms. There is one form when a participant is admitted and one when participants are discharged. The heading of this form will be changed to specify that it is a data form. There may also be additional data collected such as that related to outreach which is community-based and part of a quarterly report data collection form to be developed. This form will be developed by the Maternal and Child Health Branch with input from the Provider(s).
3. **Question:** On page 2-8 number 8, is this additional or updated training? For example, some staff already attended Motivational Interviewing Training. Will all staff proposed for this grant attend this training?
Response: This would be additional training for any staff that may have engaged in training for Motivational Enhancement Services in the past. This is a new cycle of contracts and there may be providers and staffing who have not been introduced to this training. All staff engaged in service delivery would attend this training. Airline travel costs would be covered for neighbor island travel as required. It is important to continue training and technical assistance for quality assurance purposes as research indicates conducting training for providers is just the first step in delivering a truly motivational intervention. There may also be onsite related technical assistance and follow-up after this training.
4. **Question:** What is the payment mechanism?
Response: The payment mechanism is cost reimbursement. See Section 2. Service Specifications (page 2-12), 8. Pricing structure or pricing methodology to be used. More specifically this reads “A cost reimbursement pricing structure for all services will be used. The cost reimbursement pricing structure reflects a purchase arrangement in which the purchasing agency pays the Contractor(s) for budgeted

agreed-upon costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation.”

5. **Question:** On (page 2-9, Section 2 # 1) what are “outreach activities”? Are these the # of services, # of events participated within, # of encounters, or # of women who were provided outreach?

Response: There will be two types of outreach activities. See Section 2, Service Specifications, A. Services Activities (page 2-6) and 4. Output and performance/outcome measurements (page 2-9). In A. Service Activities this is defined as: 1. Delivering outreach services which would increase overall awareness of program services and target pregnant women, their families and the community. 2. Delivering outreach services with an emphasis on identifying and recruiting the target population of substance using pregnant women into Baby SAFE services during their first trimester.

For #1 this would be both the number of events or community based activities and for #2 this would typically be actual encounters with potential participants during the trimester of entry they enter the program. There will be included in the quarterly reporting more detailed information that the provider would collect. For example, for number 1 this would allow for an explanation of the number and type of events or community-based activity provided and the target number reached. Applicants should provide their ideas in the proposal of how this would occur.

6. **Question:** On page 2-9, Section 2, #2, is this the number of pregnant women provided Baby S.A.F.E. risk assessment(s) in the 1st trimester, 2nd trimester, and 3rd trimester? Is this expected to be an unduplicated count?

Response: Yes, this would be an unduplicated count based on the entry into care and information documented on the Baby S.A.F.E. data form. However, it is assumed that the Provider(s) would continue risk assessment screening as part of any case management/care coordination plan throughout service delivery. A risk assessment would also be completed and documented on the discharge form. Risk assessment documentation should also be included in progress notes in the Care Plan.

7. **Question:** On page 2-9, Section 2, #3, is it considered that those who screen positive for current substance use to be automatically counted as Baby S.A.F.E. participants?

Response: No, they would not automatically be counted as Baby S.A.F.E. participants. This would depend on the circumstance and if it would then be documented on the admission form. It is however anticipated that some education and related service delivery would be provided if there is a positive screen. The following information “3. The total number of pregnant women who become program participants (to be defined as those who screen positive for substance

- abuse)” was included to define that a participant should be a women who is a one that screens positive for substance abuse.
8. **Question:** Is a pregnant participant who uses substances inclusive of tobacco, alcohol and illicit drug use?
Response: Yes the use of any of these substances would mean that this is a pregnant women who is using a substance or in regards to poly use of substance(s).
9. **Question:** On page 2-10, Section 2, #6. if a woman is counted as a Baby S.A.F.E. participant, is it not an expectation that case management and care coordination are provided, as indicated under A. Service Activities?
Response: That is correct. This output measure 6. “The total number of Baby S.A.F.E. participants (unduplicated count) who receive case management/care coordination through a Care Plan” was added to provide specific information that a “Care Plan” will be expected for each participant. This output measure will be included as part of the data collection and monitoring process. This has been included as an output measure in Section 5.within C. 2. Table B – Output Measures, F.
10. **Question:** On page 2-10 Outcomes: Decrease infant mortality rate. “Are there any other specifics, for example, by how much or compared to what – our current baseline rate”?
Response: The overarching goals of these services are to improve the State’s performance measures in maternal and child health. See Section 2. Service Specifications, (page 2-3) C. Description of the goals of the service, number 3. Decrease infant mortality rates (Healthy People 2010 Target is as follows: 4.5 fetal and infant deaths during perinatal period, 28 weeks of gestation to 7 days or more after birth). This performance measure will not be measured by program data. See Section 5 C. 1. Table A – Performance Measures 3. Decrease mortality which reads, “infant mortality will be based on the State data as it becomes available.” This includes rates for the baseline of 2006 and the fiscal year 2007.
11. **Question:** When the report related to infant mortality is submitted is this to be blank?
Response: Yes this report area within Table A – Performance Measure 3. “Decrease mortality” will be left blank. The Maternal and Child Health Branch (MCHB) will provide the infant mortality state data when it becomes available. In addition all data collection forms sent to MCHB will be analyzed and sent to provider(s) on a schedule to be determined by MCHB.

12. **Question:** If in fiscal year 2006, we did not have the data for one of the goals, such as low birth weight, how should this be addressed in the baseline column of the Table A. Attachment?
Response: Low birth weight although not a Table A. Performance Measure for the Baby S.A.F.E. contract period from July 1, 2003 through June 30, 2007 was a measure collected on the Baby S.A.F.E. data collection through discharge information. This information should be provided as available.
13. **Question:** On page 2-11 5. Experience: Why is the applicant required to have “experience in managing substance abuse treatment programs serving pregnant/parenting women”? As Baby S.A.F.E. is not a treatment program, why is this a requirement?
Response: There will be a change made to this requirement in the Addendum for, Section 2. Service Specifications, III. Scope of Work, B. Management Requirements, 5. Experience. The first sentence will be removed and written as follows: The Applicant(s) should have experience in working with substance using pregnant/parenting women.
14. **Question:** We have included a woman as a participant if she reported to have used substances since her last menstrual period, can this be a criteria for admittance?
Response: At this time a program participant would be defined as those pregnant women who screen positive for substance use. During 2007 to 2008 and possibly during 2009 there will be an evaluation of the Baby S.A.F.E. program. This evaluation would include discussions with Baby S.A.F.E. Providers on the most effective strategies for service delivery. There could potentially be a contract modification during the first year to expand the criteria for Baby S.A.F.E. as a result of discussions with Awardee(s).
15. **Question:** This has to do with the Perinatal Services on Maui. It is currently at one clinic on this island, how are other candidates for these services to be serviced? Most medical centers take care of their participants and do not refer to this clinic. It is anticipated that there will be a change in the current staffing at this clinic which makes referrals. Are there other providers who may be our referral source for perinatal support services? Who would we refer those women to needing support services for family, partner and past use, as the RFP suggests these referrals be made to a Perinatal support provider?
Response: Applicants should respond to this request for proposal with details on coordination of service. See Section II. (page 2-11) 6. Coordination of Services, Section III. (pages 3-2 to 3-3), and Section 4. Proposal Evaluation (pages 4-3 to 4-4) D. Coordination of Services. During 2007 to 2008 and possibly during 2009 there will be an evaluation of the Baby S.A.F.E. program and in addition discussions with Baby S.A.F.E. Providers on the most effective strategies for service delivery. There could potentially be a contract modification during the first year to expand the criteria for Baby S.A.F.E. as a result of discussions with Awardee(s).

Other questions/comments with responses which were asked during the electronic Request for Information November 20, 2006 include:

- 16. Question:** Is the total number who become program participants defined as those who screen positive for positive substance abuse? In the past participants were defined as those who had a history of use, parents use, currently used or participants used and they CONSENTED to Baby S.A.F.E. Is the program no longer looking to serve “at risk” clients and consent is not needed?
Response: Program participants are defined as those pregnant women who screen positive for substance use. All Baby S.A.F.E. participants would consent to service delivery. See Section 2, Service Specifications (page 2-4) D. Description of the target population to be served as “Substance using pregnant women”. Also see III. Scope of Work (page 2-6) “Note”: and that referral for women screened who is part of other categories of risk would be referred for services to the State Perinatal Services Program for the islands of Oahu and Maui; and the Big Island Disparities Program in Hawaii County.
- 17. Question:** Please explain what is an “unduplicated count”. Is this per pregnancy? What if a pregnancy occurs twice in the same funding year?
Response: See Section 2, Service Specifications, 4. Output and performance/outcome measurements (pages 2-9 to 2-10) with “Note” on page 2-10 which defines that the description for measurements in numbers 4, 5, and 6 are unduplicated counts for an annual program participant. In cases where a program participant becomes pregnant again within the annual timeframe they would be counted again as a program participant for these services.
- 18. Question:** Our Baby S.A.F.E. group has noticed and hoped that in the new grant period there would be an expansion of services to include a 3 month cut off for newborns. We have found that women want to continue in the program beyond their child’s 3 month birthday and we will keep them as part of our ongoing groups. We find they provide strength and continuity for newer members. The goal of reaching pregnant women in their first trimester is definitely what we aim for, often it is in the second and even third trimester that our engagement shows more consistent success. This is another reason that by the 3rd month of the newborn, the mother is not wanting to sever ties.
Response: For this proposal services are being sought to serve pregnant women who are substance abusers. There will be discussions with Awardee(s) and the community during this first contract year to evaluate potential changes for a future (2008-2009) request for proposal.
- 19. Question:** It was hoped that in the next grant period there would be a cost of living increase in funding available.
Response: The State funds appropriated for Baby S.A.F.E. have not increased, therefore the Department of Health is not able to appropriate additional funding

for cost of living increases. In addition, a portion of the appropriation for Baby S.A.F.E. will be used to initiate and complete training, needs assessment and evaluation of current services.

RFP No. HTH 550-18
Baby S.A.F.E. (Substance Abuse Free Environment) Program
is amended as follows:

Subsection Page

Section 1, Administrative Overview

No Changes

Section 2, Service Specifications

III. B. 5. 2-11

Experience:

Deletion – “The Applicants should have experience in managing substance abuse treatment programs serving pregnant/parenting women.”

Addition – “**The Applicant(s) should have experience in working with substance using pregnant/parenting women.**”

Section 3, Proposal Application Instructions

V. A. 1) 3-6

The first bullet under unallowable costs is deleted. In the second bullet, the word “of” is amended to read “**or.**”

Section 4, Proposal Evaluation

II. 4-1

Proposal Application -- Experience and Capability changes from 20 points to **25** points.

Project Organization and Staffing changes from 15 points to **10** points.

III. B. 1. 4-3

Points assignments are revised **as shown below.**

1. Experience and Capability (25 Points)

The State will evaluate the Applicant’s experience and capability relevant to the proposal contract, which shall include:

- A. Necessary Skills**
 - Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.
 - Demonstrated ability to incorporate cultural competency in the service delivery requirements. 5

- B. Experience**
 - Demonstrates experience working with the target population.
 - Demonstrates experience in improving the outcomes of substance using women and their families; working with various cultural groups and ethnicities; and working with hard-to-reach populations. 5

- C. Quality Assurance and Evaluation**
 - Sufficiency of quality assurance and evaluation plans for the proposed services, including methodology. Quality assurance plans shall be in the proposal, but are not limited to assuring:
 - Adherence to scope of services, program supervision, staffing, and accounting practices.
 - Activities are being implemented to meet output measures in the scope of services.
 - Accurate invoices are submitted to the MCHB. 5

- D. Coordination of Services**
 - Demonstrated capability to coordinate services with other agencies and resources in the community.
 - Demonstrated ability to coordinate with multiple services, agencies, PCPs, and DOH managed programs such as Perinatal Support Programs, Big Island Disparities Project, Family Planning and Healthy Start. 5

- E. Facilities**
 - Adequacy of facilities relative to the proposed services. 5

2. Project Organization and Staffing (10 Points)

The State will evaluate the Applicant's overall staffing approach to the service that shall include:

A. Staffing

- Proposed Staffing: That the proposed staffing pattern, participant/staff ratio, and proposed caseload capacity is reasonable to insure viability of the services.
- Staff Qualifications: Minimum qualifications (including experience) for staff assigned to the program.

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B. Project Organization

- Supervision and Training: Demonstrated ability to supervise, train and provide administrative direction to staff relative to the delivery of the proposed services.
- Organization Chart: Approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks.

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3. Service Delivery (55 Points)

Evaluation criteria for this section will assess the Applicant's approach to the service activities and management requirements outlined in the Proposal Application.

The evaluation criteria may also include an assessment of the logic of the work plan for the major service activities and tasks as written in Section 3, IV, including clarity in work assignments and responsibilities, and realism of timelines and schedules as applicable.

- Delivering outreach services with an emphasis on increasing awareness of Baby S.A.F.E. Program services targeting pregnant women, their families and the community.
- Delivering outreach services with an emphasis on identifying and recruiting the target population of substance using pregnant women into Baby S.A.F.E. services during their first trimester.

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- Conducting initial risk assessment(s), screening and ongoing assessment(s) of participants for substance use, health and psycho-social behaviors. Risk assessments shall include but not be limited to: screening for substance use (e.g. cigarette smoking, alcohol, illicit drug use), domestic violence, depression and other mental health problems, nutrition and physical activity, oral health, and family planning (birth control and reproductive health needs). 5
- Providing documentation and review of participant risk assessment(s), screening by a professional defined as either a Registered Nurse or a Master of Social Work when completed by another professional or para-professional. 5

The following bullet is rated on the five (5) point rating scale and is weighted; maximum point assignment is 10.

- Providing case management and service coordination to participants through a Care Plan including documentation of comprehensive and continuous service including birth outcomes. A Care Plan is defined as written information in a participant chart/file which will include participant risk assessment(s) (and screening information for substance abuse, depression and domestic violence) with progress notes on established goals, objectives and activities planned or completed to meet participant needs based on risk assessment(s), screening. This will include but not limited to: health education one-to-one or group sessions, counseling sessions, support services attended, and completed referrals or services received made on behalf of the participant. In all cases women should be linked with community resources and services whenever appropriate and indicated. 10
- Providing through the program Care Plan and Baby S.A.F.E. data collection form documentation that Baby S.A.F.E. participants are receiving health education through one-to-one or group sessions

which at a minimum promotes information on: 1) abstinence from substance abuse not limited to alcohol, cigarette smoking and illicit drugs; readiness for substance abuse treatment; 3) signs and symptoms of depression and resources for support; 4) domestic violence and resource support; 5) importance of oral care during pregnancy; 6) nutrition and physical activity education; 7) sexually transmitted diseases and resources for treatment; 8) birth spacing and use of effective contraception following pregnancy; 9) pre-natal care; and, 10) parenting education.

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- Providing through the program Care Plan and Baby S.A.F.E. data collection form documentation that Baby S.A.F.E. participants are receiving health education through one-to-one or group sessions which at a minimum promotes information on: 1) abstinence from substance abuse not limited to alcohol, cigarette smoking and illicit drugs; readiness for substance abuse treatment; 3) signs and symptoms of depression and resources for support; 4) domestic violence and resource support; 5) importance of oral care during pregnancy; 6) nutrition and physical activity education; 7) sexually transmitted diseases and resources for treatment; 8) birth spacing and use of effective contraception following pregnancy; 9) pre-natal care; and, 10) parenting education.

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- Providing Motivational Enhancement Services that seek to evoke from participants their own motivation for change and to consolidate a personal decision and plan for change. Motivational Enhancement is grounded in the clinical approach known as motivational interviewing. This approach identifies the various 'Stages of Change' according to Prochaska and DiClemente.

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- Providing as appropriate support groups to participants partners.
- Applicant(s) approach for achieving the following performance measures:

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- a) 90% of pregnant women will receive prenatal care within the first trimester of pregnancy (excluding those who arrive in the state of Hawaii after the first trimester).
- b) Reduce LBW to an incidence of no more than 5% of live births and VLBW to no more than 0.9%.
- c) Decrease infant mortality rate.
- d) 100% of pregnant women will receive screening for DV.
- e) 100% of all pregnant women who screen positive for DV will receive appropriate intervention from the Applicant(s) or referral source.
- f) 100% of all pregnant women who screen positive for depression during pregnancy will receive services/referral.

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4. Financial (10 Points)

- Pricing structure based on cost reimbursement
Personnel costs are reasonable and comparable to positions in the community.
Non-personnel costs are reasonable and adequately justified. The budget fully supports the scope of service and requirements of the Request for Proposal.
- Adequacy of accounting system.

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Section 5, Attachments

No changes