

Performance Based Early Recognition Coordination and Screening Questions and Answers

If a clinic is planning on partnering and submitting a joint proposal with one or more agencies, how do we figure out the cost per screen?

As stated in section 5.4 B of the [Request for Proposal](#) (RFP), for those bidders applying in partnership with other clinic provider agencies, average cost per screen must be reported separately for each partner agency.

When the New York State (NYS) Office of Mental Health (OMH) came up with the performance target of 1000 screens annually despite population, was there consideration given to population distribution?

Yes, we considered population when creating this RFP. We allow for Clinic-Plus agencies within OMH regions to partner with each other in order to increase the likelihood of meeting the target.

Can the same children be screened repeatedly?

Yes, screening repeats are acceptable, given reasonable timeframes between screens.

Can the one Full Time Equivalent (FTE) be shared between two or more individuals?

Yes, as long as each individual meets the minimum qualifications as listed in section 5.4 A of the RFP.

What are the Early Recognition Specialist (ERS) education minimum qualifications?

The qualifications are the same as those from Clinic-Plus; as stated in section 5.4 A of the RFP:

Education:

A bachelors degree in one of the below listed fields*, or

A NYS teachers certificate for which a bachelors degree is required;

or NYS licensure and registration as a Registered Nurse and a bachelors degree. And

Experience:

Working knowledge and familiarity with child-serving providers in the local area to be served;

Four years of experience providing direct services to children with emotional disturbance and their families; or

A masters degree in one of the below listed fields* may be substituted for two years of experience.

*Qualifying education includes degrees featuring a major or concentration in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing.

Regarding screening done by community partners, what are the requirements in terms of the format of the screening?

This has not been predetermined. Once the awards are made, discussions between awardees and OMH will take place, and clarification about what is required of screens completed by entities other than clinics will be determined.

In rural areas, agencies often triage over the phone. Can consent for a mental health screen be obtained verbally over the phone, or is written consent needed?

Written consent for screening is required.

If some other child-serving entity, such as a school or probation, has their own consent form and hands out a screening instrument, but the mental health clinic scores and acts upon results, is an additional consent needed?

Yes, the mental health clinic should still obtain their own consent, or should incorporate the details of their screening consent into that of the other entity. Those details should name the mental health clinic, and the clinic should retain a copy of each signed consent.

When you are figuring out cost per screen, what allocation are you looking for?

Use only the screening portion of your Clinic-Plus allocation.

Obtaining parental consent has been difficult. Many parents have refused to sign it. The consent in the schools specify mental health treatment; will we be able to use our own consent or will be mandated to use the OMH consent for the screening function?

As with Clinic-Plus, if you retain the components of the screening consent, you can maintain your own consent form on your own agency letterhead. Consent for treatment alone is not adequate; the parent must be informed that a mental health screen is occurring.

Can an individual age 18 and over sign consent for themselves?

Yes, an individual age 18 or over can consent for themselves.

Will the screeners be tracking the referrals and report the other activities post screening?

Awardees will be required to report the number of screens by age and location. Many of the other current Clinic-Plus reporting requirements will be dropped after 12/31/11.

Satellites in schools have a lot of contact with social workers who have direct contact with children in need; will that contact count as screenings?

Once awards are made, OMH and awardees will have discussions and OMH will provide guidance on how to differentiate traditional referral from early identification. When writing your proposal, consider that the goal of this RFP is to allow children to be accurately identified sooner in their development, not simply to generate more referrals in the traditional sense.

We are the only OMH clinic in the county. What are the specifics you are looking for designated area (how do we define the community)?

The community is open for the bidder to define. Bidders are encouraged to work together with their Local Governmental Unit (LGU) as well as the larger child-serving network to define the community and develop a comprehensive plan for early identification.

Does the Early Recognition Specialist (ERS) have to be a new hire or could they be someone already on staff?

The ERS can be someone already on staff or a new hire.

How much emphasis will be needed on linkages and referral after children are identified through screening?

Engagement, linkage, and referral for children identified are just as important as the early identification and are considered part of the screening process; therefore, these components should be addressed in the bidder's strategic plan for this RFP.

Will this new program have the same program code and funding code as Clinic-Plus?

No, there will be new codes, which will be announced at a later date.

Are community partner letters of support allowable in the proposal?

Yes. They are not required, but may be included if desired.

I understand there are qualifications for the ERS; are there qualifications for the community partners if they will be doing the screening?

No, if a partner child-serving agency is doing the screening, that agency determines the necessary qualifications for their screener(s).

For those bidders who apply for the grant in partnership with other clinic providers, will there just be one award for one FTE?

Yes. If awarded, the partnership will get one award for one FTE.

If we encourage a community child-serving agency to conduct the screening by using a screening instrument which we have already been using, is it okay that they conduct the screening and we score it? Can that be counted as a screening?

Yes, that is fine, and it can be counted.

Is there a specific age range for early identification?

No, OMH has not predetermined the age range except for the broad age range served by children's clinics, which is now 0 to 21 years. It is up to the bidder to define the target population and the community in the proposal.

Who pays for the actual screening instrument?

Some screening instruments are in the public domain, which are free. If you use an instrument that has an associated cost, the awarded agency must pay for the instrument.

In terms of service scope, is OMH more interested in depth of target population, or in serving a wider geographic area?

OMH does not have a preference.

Clinic-Plus focused on expansion of clinic to allow for faster, improved access to clinic services. This RFP does not accentuate access. Why is that? Does this mean that access doesn't matter?

Statewide, we did not see expansion happen via Clinic-Plus funding, so we did not allocate funding for expansion with this funding opportunity. This RFP allows for early identification, engagement, linkage and referral. Access to services identified by screening is very important, and it is expected that bidders' plans will address engagement, linkage and referral in their proposals.

Can we target a specific population focus?

It is up to the bidder to decide which population(s) to focus on. Bidders are expected to coordinate with their LGU and the larger child-serving network in their community to continually evaluate for the need to target and screen particular populations.

In the RFP, there is mention of cultivating relationships with primary care practices as well as working with schools. Can the bidders determine for themselves where the screening will occur?

Bidders should work together with their Local Government Unit (LGU) and the larger child-serving network to continually evaluate the need to target particular populations and to screen in particular settings. NYC providers interested in working with schools should be in touch with Scott Bloom. Primary care physicians should be considered an essential part of the community's larger child-serving network, and OMH is particularly interested in encouraging clinics to cultivate effective relationships with primary care in order to promote early identification and to facilitate referrals.

If a parent calls and wants to have their child screened, can the verbal discussion be considered parental consent to screen?

No, written consent for screening must be obtained.

If in fact we were working with an Article 28 in a school where they get a comprehensive consent, does that cover as consent for screening?

The mental health clinic should still obtain their own consent, or should incorporate the details of their screening consent into that of the other entity. Those details should name the mental health clinic, and the clinic should retain a copy of each signed consent.

If an Article 28 has identified a child, how do we tell the difference between a referral and early identification?

Once awards are made, OMH and awardees will have discussions and OMH will provide guidance on how to differentiate traditional referral from early identification. When writing your proposal, consider that the goal of this RFP is to allow children to be accurately identified sooner in their development, not simply to generate more referrals in the traditional sense.

With this funding opportunity, can we broaden our traditional reach by serving other counties?

Bidders are encouraged to work with the LGU's in the proposed community, and should cooperate and coordinate with other clinic providers when defining their community as it relates to this RFP.

Can a clinic propose to develop partnerships with services operated by their own parent agency? Can children screened by those other partners be counted?

Yes, provided these children are indeed identified sooner than normal and are not just traditional referrals which would occur normally without this program.

If a Clinic-Plus provider has been successful and has met and exceeded your target, do you have to change what you are doing?

This program provides an opportunity for Clinic-Plus providers to maximize the success that they may have had, and OMH also wants these providers to continue to strengthen and improve their capacity to identify and serve children earlier. With this proposal, clinics should look to broaden their reach within the local network of child serving agencies.

What if your agency is very small and needs a partner, but you can't find a partner?

You need to find a partner within your OMH region. You may utilize the Clinic-Plus Listserv to reach out and communicate with other providers. Also, you may contact your regional OMH Field Office if you don't know how to contact other Clinic-Plus providers.

If you want to partner with an agency do both partners need to be at the bidder's conference?

No, as long as at least one of the partners was represented at the bidder's conference.

If you partner, you will only get one award? Who will the money go to?

The partnership will get one award. The money will go to the lead agency as defined in the proposal.

Do you have to have one full time person as the ERS?

One full time individual who is dedicated to early identification would be ideal, but it is acceptable to split the position among two or more individuals if your proposal explains how that will work.

In the current Clinic-Plus model, only screenings can be conducted in pre-approved or licensed sites. Do sites need to be approved by OMH?

With this RFP, the bidder is free to propose screening sites as the bidder wishes. Bidders are encouraged to work together with their LGU as well as the larger child-serving network to define the community and develop a comprehensive plan for early identification, and, if you are a NYC provider and are interested in screening in schools, contact Scott Bloom.

How do you calculate cost per screen?

As stated in section 5.4 B, divide your clinic's average annual screening allocation by the average annual number of screens your clinic conducted.

When writing the screening performance history section of our proposal, can we include extra information about trends of screening?

Yes, you can include more information in the proposal if you wish, provided you do not exceed the page limit of 15 pages, as described in section 2.4.

When computing average annual cost per screen, should we pro-rate the screening numbers for 2011?

Yes, since this year is not yet complete, include your figures from the 1st and 2nd quarters of this year.

When we compute our average cost per screen, should we use only the state screening allocation and not any other funding?

Use only the screening allocation and do not include any other funding your agency may have allocated toward the screening activity.

Do you have any idea what the average cost per screen should be?

No, there is wide variation between providers on their average cost per screen.

What is going to happen to the Clinic-Plus funding?

This RFP is one component of the reprogramming of Clinic-Plus funding. Another RFP is planned for release in December 2011, which will provide start-up funding for clinic satellites located in primary care.

How is the budget scored?

Please note Section 4.1 incorrectly states "The Cost scores will be computed separately based on a weighted formula. Points associated with cost are "calculated by dividing the total 5-year budget submission by the total amount of the lowest budget submission received, then multiplying the result by the maximum points (20) achievable."

Section 4.1 should state: "The cost scores will be computed separately based on a weighted formula. Points associated with costs are calculated by dividing the total 5-year budget submission of the lowest bid by the total 5-year budget of the bid being evaluated, and then multiplying the result by the maximum points (20) achievable."

Regarding Other Than Personal Services (OTPS), could money be used toward start up for 2011 as part of an outreach component?

Yes, start-up for outreach is an acceptable OTPS expense.

What are acceptable OTPS expenses?

See [Section 13.6](#) (8) of the [Consolidated Budget Manual](#)

Can we use funding for subcontractors and/or consultants?

Yes, the use of subcontractor/consultants would be acceptable OTPS.

Cost section: It is our understanding that points for cost will be calculated as follows: they will take the lowest budget submission received from all applicants and weight all others against that budget? Is this correct? Will cost be weighted to consider the higher cost of personnel and other services in different communities?

You are correct about the formula. The weight is applied to the final overall cost. It is 20 points of the total score of 100.

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The formula used to determine cost scores is not weighted to address geographic or other cost considerations. Bidders should use the budget narrative to provide details explaining how the costs were derived

Are printed brochures and advertising allowable as OTPS?

Yes, this is an OTPS expense.

Question about the scoring of the budget seem to be weighted unfairly towards the bidder with the least costly proposal, even if that proposal is ridiculous. How does this work?

As stated in the RFP in Section 3.1, *Method of Award*, "Awards will be made to the vendors proposing the Best Value. Best value means the basis for awarding contracts for services to the proposal which optimizes quality, cost and efficiency, among responsive and responsible proposers. The proposal with the best value will be deemed to be the proposal with the highest final evaluation score".

The formula, which was developed by the New York State Comptroller's Office and the New York State Procurement Council, is weighted to give the highest possible cost points (in this case it is 20 possible points) to the bidder with the lowest overall budgeted cost. The remaining 80 points will be scored by determining the reasonableness and merits of the scope of work proposed against the budget that is submitted. If a budget appears "ridiculously low", for example, the remaining technical evaluation will likely reflect this by awarding low points.

Will there be more details about what is allowable in the budget?

Not other than answers to the specific questions in the Q's and A's.

Aside from Memorandums of Understanding and Budget Worksheets, are any other documents allowed as attachments to the program narrative and thus excluded from the 15 page limit?

Other supporting documents which are in and of themselves not direct responses to the requirements of the RFP, but rather are supporting documents are allowed. Letters of support from potential community partners would be an example.

Section 4.2.2 of the RFP states: "Points = (Lowest bid received divided by the bid being evaluated) x 20 points." Is the lowest bid taken from all bids submitted or from the lowest bid in each respective region?

It is taken from all the bids submitted.

Can an applicant propose to designate a specific target population or must the proposed program serve all children under age 18?

OMH has no preference for target population.

Will current Clinic-Plus funding end on 12/31/11?

Yes. This has already been announced to Clinic-Plus providers as well as LGU's.

The financing under restructuring will include funds for assessments and home visits. Given the pending implementation of Ambulatory Patient Groups (APGs), will any transitional funding be made available?

This question is not directly related to the RFP and will not be addressed here.

Can a program designate a target population for screening but also propose to provide community outreach and education to the entire population of children under age 18 and their families?

Yes.

Are Digital Video Disks (DVDs) acceptable materials to include with the grant proposal to show an example of community outreach and promotion of the early recognition program?

Yes.

Can support staff time for such things as telephone, outreach and letter composition be included in addition to the 1 FTE Early Recognition Specialist?

Yes, in addition to the 1 FTE Early Recognition Specialist, you may include other staff costs that relate directly to the performance based early recognition coordination and screening activities.

If we conduct a screening through a community partner (Primary Care Practice PCP office, community center, etc) and that screening results in the identification of a need for treatment, but the identified child does not attend one of our Clinic-Plus schools, can they be seen for treatment at our main clinic location?

Yes.

Will the PowerPoint presentation from the bidders' conference be made available?

Yes. The Power Point is available on the [OMH website](#).

If we receive this grant does it have any impact on OMH's consideration of us for the other RFP's coming out from Clinic-Plus, specifically the co-location of health and mental health?

No. If you receive this grant, you will still be eligible to apply for the co-location grant.

It is our understanding that points for cost will be calculated as follows: they will take the lowest budget submission received from all applicants and weight all others against that budget? Is this correct? Will cost be weighted to consider the higher cost of personnel and other services in different communities and the need for bi-lingual/bicultural services in some communities?

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The formula used to determine cost scores is not weighted to address geographic or other cost considerations. Bidders should use the budget narrative to provide details explaining how the costs were derived.

Is an OMH licensed outpatient clinic, Tier I status, who is not a current Clinic Plus provider, eligible to apply for this RFP?

No. As stated in section 1.3: Eligible bidders are children's outpatient mental health clinics currently licensed by OMH and having a current designation as a Child and Family Clinic-Plus provider.

Will the Local Government Unit identify the target population to be served through the Clinic Plus initiative?

Providers are encouraged to defer to their LGU for guidance and input about target populations. It is assumed that the LGU will be represented in the networks referred to in section 5.2: Early Recognition Specialists will participate in existing child-serving agency networks, or facilitate the creation of new or stronger networks, and utilize those networks to continually evaluate for the need to target and screen particular populations.

If the clinic plus provider does not achieve the performance outcomes within the year will there be another RFP issued?

As stated in section 4.4: OMH will review each agency's data, as submitted via the Clinic-Plus Quarterly Report, to determine if the performance targets have been met. A review of performance targets will take place each June. The first annual performance target of a minimum of 1000 screens will be expected to be met by June of 2013. Any awardee who does not meet the performance target will be subject to corrective action plans. Failure to meet the minimum of 1000 screens annually could result in a pro-rated reduction in the contract amount based upon a percentage of screens achieved. Consistently poor performance for two consecutive years could result in termination of contract. Screens counted may include those screens conducted by community partners as part of a coordinated, comprehensive, community-wide plan for early recognition which the Early Recognition Specialist oversees.

The goal is to have providers perform well. Any specific plan for money saved if contracts are terminated is yet to be determined.

The organization that I work for has been providing culturally competent mental health services in NYC for nearly 30 years. It is licensed by OMH and designated as an Article 31 Clinic (in good standing), not a Clinic-Plus. However, we are working with the school system through Title I to provide school-based counseling, and have made significant inroads into a hard to reach population. We would use these funds in order to vastly expand the program. Would our current designation be sufficient?

No, as stated in section 1.3, Eligible bidders are children's outpatient mental health clinics currently licensed by OMH and having a current designation as a Child and Family Clinic-Plus provider.

What age children is OMH seeking to target for screenings?

OMH has no specific age target; it is up to the bidder to engage in a decision-making process together with local stakeholders to determine which children should be targeted for early identification, as well as how that process should proceed over time. As stated in section 5.2: Early Recognition Specialists will participate in existing child-serving agency networks, or facilitate the creation of new or stronger networks, and utilize those networks to continually evaluate for the need to target and screen particular populations.

As an agency I have been screening kids through the Clinic-Plus programs in New York City Public Schools and would like to continue at our current schools and possibly add new ones. Can I do that? Is there any coordination or contact I need to make?

Yes. For New York City Public Schools you can continue screening at the schools you are currently in. If you want to add new schools as well as continue in old schools, you need to coordinate with Scott Bloom, Director of School Mental Health Services at the NYC DOE. He should be kept apprised of which schools you want to continue and which ones you would like to add on. OMH wants to make sure that there is continuity to on-going enhanced services in the New York City Schools.

Should we partner with other agencies in service to our defined community, do all partners need to be current Clinic-Plus contractors, or just the lead agency?

This question is unclear, so it will be answered two ways. If this question is referring to submission of a joint proposal, then, yes, all partners need to be Clinic-Plus providers. If this question is referring to community partners who are other child-serving entities who participate in one way or another in early recognition activity, community engagement, outreach, and/or stigma reduction, then, no, not all those agencies need to be Clinic-Plus; the intention is for these agencies to be other than mental health agencies, such as primary care practices, probation departments, schools, etc.

Does the screener need to be an employee of the clinic and/or agency or can the clinic/agency contract out for the position?

The Early Recognition Specialist may be an employee of the awarded clinic, or can be a contract employee.

What are the criteria for other agencies' screenings? Are there certain screenings such as the Child and Adolescent Needs and Strengths CANS, or Youth Assessment and Screening Instrument (YASI) or Connors that are universally accepted for Clinic Plus?

This has not been predetermined. Once the awards are made, discussions between awardees and OMH will take place, and clarification about what is required of screens completed by entities other than clinics will be determined.

Is there a specific screening tool that you want to have used? We have been using the Pediatric Symptom Checklist. Is it ok to continue using that?

You should use a reliable and valid screening tool which is developmentally appropriate for the population you are screening. It is okay to continue using screening instruments that you have already been using for Clinic-Plus.

If our agency is awarded via this RFP, I am assuming that screenings we may accomplish at this point will not count toward the new initiative? We are currently continuing to send out screenings from schools, so if it doesn't count, it is a large population that will already be covered when the new program begins.

Screenings done now through 12/31/11 will *not* count toward your performance target of 1000 screens.

Several counties have questioned, what role, if any, counties will have in selection process, recommendations or planning process.

Providers are encouraged to defer to their LGU for guidance and input about target populations. It is assumed that the LGU will be represented in the networks referred to

in section 5.2: Early Recognition Specialists will participate in existing child-serving agency networks, or facilitate the creation of new or stronger networks, and utilize those networks to continually evaluate for the need to target and screen particular populations.

I would like to know if there is any way to be able to apply for the current grant without being a Clinic-Plus Provider.

No. As stated in section 1.3: Eligible bidders are children's outpatient mental health clinics currently licensed by OMH and having a current designation as a Child and Family Clinic-Plus provider.