Connecticut MATCH Learning Collaborative
Request for Qualifications Question and Answer Conference Call
April 29, 2015 10:30 - 11:30 AM

***Please Note:** The original due date of May 25th is Memorial Day. The revised RFQ due date is Tuesday, May 26th by 4:00 pm.

If you have any questions, please contact Jack Lu at jacklu@uchc.edu.

Important due dates: April 30, 2015 - Email of Intent
May 5, 2015 @ 5:00 pm - Deadline for Submission of Questions
May 26, 2015 @ 4:00 pm - Deadline for Receipt of Proposals

RFQ Q & A Conference Call Attendance:

- CHDI: Jack Lu, Kim Campbell, & Jason Lang
- Harvard University (HU): Lauren Santucci, Jackie Hersh, Caroline Cooke, John Weisz
- DCF Central Office: Paul Shanley, Karen Mahoney
- Nine (9) Connecticut agencies in attendance

Question	Answer
RFQ references outpatient clinics and community-based clinics, is an Extended Day Treatment (EDT) able to apply for MATCH? Population at EDT: Clients who are not appropriate for outpatient treatment, do have individual treatment sessions, average length of stay is 6 months.	Lauren Santucci (HU): MATCH was developed and tested with an outpatient population so we can't definitively say it would be effective in higher levels of care. MATCH is typically delivered individually for 45-60 minutes (which can be done in day treatment if it fits with the program). Keeping in mind MATCH is not the treatment of choice for children with primary eating disorders, psychosis, autism, etc. Karen Mahoney (DCF) - Supports this idea. If children meet criteria for anything MATCH addresses, go forward.
How did you come up with the clinic stipend amount? What kinds of costs would be acceptable to use this $12,000? Has any thought been given to recommendations as to whether an agency can be involved in more than one LC at a time? We are also participating in another LC and questioning whether individuals involved with TF-CBT can also be trained in MATCH.	Jack Lu (CHDI): CHDI is sensitive to Learning Collaborative days, planning to do 6 days clinical training and 2.5 days of learning sessions to reduce amount of productivity loss for clinicians and clinics. The clinic stipend of $12,000 provided is based on available funding to help offset the lost revenue associated with participating in a learning collaborative. Jason Lang (CHDI): A limiting factor is financial situation and amount of money available. The 12K does not offset every lost hour of time staff will spend, but all training and consultation is provided at no cost. Jason Lang (CHDI): An agency could participate in two LCs at the same time if different staff are identified. We do have clinicians trained in TF-CBT and MATCH - some agencies have been successful in doing this. Takes some effort on the agency's part to figure out how to juggle. MATCH does include trauma as well. Jack Lu (CHDI): CHDI is considering how this will impact the clinics. We welcome feedback and questions as people gain experience with LCs.

Connecticut MATCH Learning Collaborative
Request for Qualifications Question and Answer Conference Call
April 29, 2015 10:30 - 11:30 AM

We used CBT and found that in community cases, school clinicians have been the most successful, but there's only going to be so many children with trauma in a given population, MATCH may be a better match for school therapy? Has it been used successfully in schools? We have masters level clinicians (most licensed) delivering the service in the school like an outpatient clinic. Depending on the structure of the school, they may have 35 min to one hour sessions. Once get to upper level, may be limited to 40 min sessions because this is class length. Schools may have some different levels of freedom to incorporate MATCH. With use of TF CBT, we have higher parent involvement in school setting.	John Weisz (HU): We have used MATCH in schools.The biggest MATCH randomized controlled trial (RCT) in Hawaii and California had about one-third of the included children were seen in school-based programs. So we have used MATCH in school settings and it seemed to work well there. We are also using MATCH now in schools in the Boston area. In Boston, we are finding school-based care tends to be with guidance counselors or other staff and meetings are much briefer than typical outpatient sessions, sometimes only 15 min long, so we have had to adjust how to do MATCH for short sessions. Our sense is that it can work under those circumstances, but does require some thought about how to adjust the descriptions in the manual that tend to be geared to 50 min sessions. If school clinicians are comfortable making these adjustments on their own, this may be fine. Karen Mahoney (DCF) - MATCH also involves the parent or caregiver, especially for disruptive behavior like Oppositional Defiant Disorder. There are some sessions that parents would need to attend. If child demonstrating conduct issues specifically, may not be best for school setting unless caregiver can be involved. John Weisz (HU): Clinicians may decide on a case by case basis whether to use MATCH if caregiver is unable to come in.
1.We have 3 outpatient offices in different locations; is there a preference for applying for 1 site vs more than 1 site? 2.Is there any feedback from current clinics doing MATCH on any of the challenges/struggles faced to guide future clinics?	Jack (CHDI): 1) Consider which site has the best capacity to implement MATCH. If each site has the same capacity, you can prioritize. 2) Feedback/struggles:CHDI, DCF, and Harvard have worked to get feedback from the current agencies and incorporate this feedback into planning for the LC. Example, feedback - time between end of MATCH trainings and start of seeing MATCH clients was too long in MATCH RCT - in LC, we will encourage agencies to start seeing clients right after training in model. People seem to like using MATCH and are even using it outside of the study. We also heard that clinicians like the electronic format of MATCH manual (Practicewise). Clinics stated that having an organized way to use these forms helps to reduce prep-work (e.g., binders of MATCH handouts). Also, how to integrate MATCH into intake system and forms they use - important to integrate into organizational structure. Lauren (HU): Anytime you implement a new EBP, it can take more of the clinician's time, so having a system in place to support clinicians as they learn a new model, give time to prep for sessions, etc. is important. Karen (DCF): Based on input from clinicians in RCT, they really like the model, and they are using it with other non-study clients, including using MATCH skills for most of their caseload.
Based on question from Children and Family Aid, we have different sites that provide services (e.g., alternative school, couple of pediatric practices), as well as main clinic. But central staff travels - do we present as one vs different sites? Clarification: Do we have to submit separate applications for multiple sites within a provider?	Jack (CHDI)- You can submit one application for your agency, but just make clear if multiple sites will be used. If you get the sense that you have, for example, 3 clinicians and 1 who will see clients at central and satellite offices, please communicate that this is reasonable and feasible for clinicians to do so. We don't want to add extra burden to clinicians who have to travel between sites.

Connecticut MATCH Learning Collaborative
Request for Qualifications Question and Answer Conference Call
April 29, 2015 10:30 - 11:30 AM

In terms of feedback from current clinics doing MATCH, what are costs of doing data collection and data entry; what is ongoing cost of maintenance? We're trying to get a sense of the up front cost of time for training & ongoing LC commitment.	Jack (CHDI): We are collecting data differently in LC than RCT - CHDI will use a web-based data service called EBP Tracker for the MATCH LC. Part of LC clinical training will include a half day on how to use this EBP tracker. We're currently using the EBP tracker with TF-CBT. Clinics have found different ways to input this data for LC cases: a) designated person who enters from paper forms, or b) clinicians enter themselves, etc. It is formatted so that clinicians can do the measures with clients in the room if they have technical resources to do so. Long-term goal of data service is to provide real-time outcome reporting, so clinicians can monitor changes throughout treatment and SR leaders can see how the MATCH model and other EBPs are working in their clinics.
In terms of continuing EBPs over time, onboarding of new clinicians who aren't trained is an issue. Once core group trained, can we have them train subsequent people in the agency moving forward? Some EBPs require fee paid for ongoing training & consultation. Is that case for MATCH?	Jack (CHDI): MATCH is a complex model and takes some time to develop expertise, but we want to sustain it past the LC. We want to support agencies providing MATCH, especially down the road. We will consider whether it is possible to have Associate Trainers. Yet to be determined - have to think through what is most feasible to clinics and what will help maintain model fidelity.
You mentioned 5 yr plan of rolling out MATCH. If there is a decision to not proceed with the MATCH LC this year, will there be future opportunities to participate?	Jack (CHDI): Yes, we will have 2 future LCs - with same approximate timeline as this year (e.g., tentative future RFQ release dates: April 2016, April 2017).
Because we have trainees and eventually they may move on to other clinics, will they be able to transfer those skills to another agency/group model? Trainees may include intern or non-licensed clinician who might move to other clinical settings. In their documentation, they can say that MATCH is the model they're using, even if leave agency?	Jack (CHDI): For this LC, we want to focus on clinicians who are employed by the agency. We understand trained clinicians might move on and practice in other agencies.They can say they're trained in MATCH and take the skills with them as long as they meet the requirements of the training. John (HU): Clinicians can use the skills wherever they are practicing; does not have to be solely at the clinic that is part of the LC. Karen (DCF): There is a difference between a MATCH agency versus a MATCH clinician. The training stays with the clinicians, not the agency. If a clinician moves to another agency with a MATCH supervisor and participates in a weekly consultation meeting that is a MATCH agency. But it's the clinician who is trained in MATCH.
If part of our LC has one or two clinicians leave and we hire new ones, would those new clinicians be able to join the LC 3 or 6 months in?	Jack (CHDI): With regards to attrition, since we do only have one clinical training upfront, we ask clinics to be thoughtful about the time frame and select a number of clinicians who can remain the duration of the LC. You may want to have clinicians attend the trainings as "back-ups" providing that space is available (e.g., if clinics send 5 clinicians to the training, but identify only 3 are active members of the MATCH core team. The 2 non-active clinicians that received the training may serve as substitutes down the road). Please note that at this time, agencies are asked to identify at least 3 and no more than 7 clinicians for the MATCH LC and clinical training. Lauren (HU): It is possible that more clinicians can join provided that the training space and resources (e.g., MATCH manuals) can accommodate more people.

Connecticut MATCH Learning Collaborative
Request for Qualifications Question and Answer Conference Call
April 29, 2015 10:30 - 11:30 AM

In the RFQ, pg. 4 (section 4) mentions range of 3-7 clinicians to be trained, then there is a table in section 5 to list staff (pg. 22). Are we restricted by the # of people we enter into the table, and if we submit less than 7 names can we add names, or would you prefer we submit the maximum number that may be trained. Can we submit part time clinicians or clinicians who are full time staff in programs other than outpatient? Max is 7 clinicians? Does this include the supervisor?	Jack (CHDI): Regarding the staff table in the RFQ, first, follow the guidelines of the core team: identify at least 3 clinicians. If you want to add more than 3, that may help to supports our opinion of the number of people who could possibly be on the team. There may be staff changes made between the time you submit the application to when the LC begins, so we understand there may be adaptations to the list. You want to ensure that your agency has an identified: 1 Senior Leader, 1 Supervisor (may or may not also be the designated Site Coordinator), and at least 3 clinicians and capped at 7 (range of 3-7 clinicians does not include supervisor). We strongly encourage supervisors to take on MATCH cases to improve supervisor role. This is not required since supervisors can also be in the site coordinator role. Clinician may also serve in the site coordinator role.
In regards to expectations for clinical staff during action period, it is noted in the RFQ table that there are monthly consultation calls, and then interaction with other teams, etc. Is there more expectation on top of the monthly phone call?	Jack (CHDI): There will be a monthly consultation call with Harvard University for the clinicians to talk about the MATCH model. We also mentioned other components in the RFQ that could be included as potential supports (e.g., interaction with other teams) but are not required. Only the monthly consultation calls are a requirement for the clinicians.
Is there a formal screening process for MATCH, or in the RFQ, are you referring to what the agency uses internally to identify MATCH cases?	Jack (CHDI): There are inclusion criteria regarding age range (6 - 15) and primary diagnoses in any of the following: anxiety, depression, traumatic stress, and/or conduct. Additionally, clinicians may have a sense of cases they currently have that may benefit from MATCH. There's no formal screening tool. Lauren (Harvard): MATCH targets certain areas: anxiety, depression, disruptive behavior, and/or trauma. Hence, we would want to see some clinical elevations in these primary areas. We will include pre-treatment measures in the LC that may inform MATCH appropriateness for a particular client.
In regard to identifying children who we would use this with, any children we would NOT want to apply this model to?	Lauren (HU): MATCH is for children with primary problems in the areas of anxiety, depression, disruptive behavior, and/or trauma. For example, someone with an eating disorder would probably need very specialized treatment. Another example is someone with psychosis may have symptoms that trump other issues and need treatment for that right away. In general, we say MATCH is not clinically appropriate for children with autism spectrum disorders, eating disorders, primary ADHD with attention and overactivity alone and no disruptive behavior, psychosis, and suicidal ideation that results in child not being appropriate for outpatient level of care.
If we come up with additional questions, can we email questions to you over the next week?	Jack (CHDI): Yes, please email additional questions to me by May 5, 5:00 pm. The responses for this Bidder's Conference Call will be found on CHDI's website where the RFQs are located. Tomorrow (4/30/15) is the deadline for the email of intent, so if you are at all interested in applying for the LC, please send an email to Jason Lang (jalang@uchc.edu). The email of intent is non-binding, so you may send the email even if you decide not to apply.

Connecticut MATCH Learning Collaborative
Request for Qualifications Question and Answer Conference Call
April 29, 2015 10:30 - 11:30 AM

Can you clarify the role of a site coordinator vs. clinical supervisor? If you are applying for multiple sites, do you need a site coordinator for each of them? Or do you want a central office coordinator?	Jason (CHDI): You can apply as one team with satellite or multiple offices (with total of 3-7 clinicians and a coordinator), and we will review the application to consider if you can function as a team. It would be preferable to have one coordinator coordinating the whole team. You don't need to have a coordinator at each site unless you are thinking of having two completely independent teams (that meet the requirements otherwise).
You said people can wear 2 hats (site coordinator + supervisor)	Yes, can wear multiple hats, often site coordinator is also a supervisor or a clinician. This person helps manage the team, runs meetings, helps manage data entry, and data reporting.