

CITY OF PHILADELPHIA
DEPARTMENT OF BEHAVIORAL HEALTH
AND MENTAL RETARDATION SERVICES
COMMUNITY BEHAVIORAL HEALTH

REQUEST FOR PROPOSALS (RFP)

BEHAVIORAL HEALTH LABORATORY SERVICES (SOLE SOURCE)

Community Behavioral Health (CBH) under the auspices of the City of Philadelphia's Department of Behavioral Health/Mental Retardation Services (DBH/MRS) is seeking to combine all existing contracted laboratory services into a sole source laboratory contract that will operate under a capitated plan model. Through this Request For Proposals, all Philadelphia County Medicaid enrolled members, capitated through the HealthChoices program to CBH, will be eligible for behavioral health related laboratory services excluding hospital-based services. It is the intent of this RFP to solicit proposals from interested laboratories possessing the professional expertise to develop and provide these services within the guidelines established in this RFP. CBH will consider joint proposal submissions from more than one laboratory that build upon each laboratory's unique expertise and experience to effectively serve CBH consumers.

In order to submit a proposal, prospective bidders must send a **Letter of Intent by Friday, June 29, 2007**, indicating a plan to bid. No proposals will be accepted unless the Letter of Intent is received by 3:00 PM on June 29th. A **Bidders' Conference will be held on Tuesday, July 17, 2007 at 2:00 PM** at the CBH Conference Room, 801 Market Street, 7th Floor, Philadelphia, PA 19107. All prospective bidders are invited to attend but attendance is not mandatory for proposal submission. **Responses to the RFP must be received no later than 3:00 PM Local Time on Friday, August 31, 2007.** Any response(s) received after that date and time would be returned, unopened, to the applicant.

Full RFP is available on the CBH website at: <http://www.phila-bhs.org/>

EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER
MINORITIES, WOMEN AND PERSONS WITH DISABILITIES SHOULD APPLY

TABLE OF CONTENTS

I General Information for Prospective Contractors

II Proposal Content and Format Requirements

III Budget

IV Evaluation Plan

V Criteria for Selection

Appendices

A) Resource Listing

B) CBH Provider Agreement

C) Minority Business Enterprise Council Language

D) Socially/Economically Restricted Businesses

E) Proposal Cover Sheet

F) Training and Education Requirements

G) Capitation Plan Data

H) Provider List

I) Listing of Lab Tests

SECTION 1: GENERAL INFORMATION FOR PROSPECTIVE CONTRACTORS

I.1 PURPOSE

Community Behavioral Health (CBH) under the auspices of the Philadelphia Department of Behavioral Health/Mental Retardation Services (DBH/MRS) is seeking to contract with a sole source laboratory, in keeping with the industry standards for Behavioral Health Managed Care Organizations. Sole source laboratory contracts have been proven to be effective, at a national level, providing opportunities for improved quality of care, greater range of services, advanced reporting technology and lower costs. It is the intent of this Request For Proposals (RFP) to solicit proposals from interested laboratories possessing the professional expertise to develop and provide the laboratory services specified within the guidelines in this RFP.

I.2 BACKGROUND

The creation of the Department of Behavioral Health/Mental Retardation Services (DBH/MRS) within Philadelphia city government in October 2003 signaled an important step in the evolution of service integration. The new office officially combines the three elements of Philadelphia's behavioral health system – the Office of Mental Health (OMH), the Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP) and Community Behavioral Health (CBH) – along with the Office of Mental Retardation Services (MRS) into its own separate administrative entity. The present structure of this department represents the culmination of years of hard work to recognize Philadelphia's behavioral health system in an official way. Previously, three of the four components, OMH, CODAAP and MRS were components of the Philadelphia Department of Public Health. CBH, Philadelphia's not-for-profit managed care entity, was established by the city to manage behavioral health care for the city's approximately 400,000 Medicaid recipients.

The three public governmental organizations, OMH, CODAAP and MRS, have been administering county operated behavioral health and mental retardation programs for more than 30 years. The not-for-profit organization, CBH, began operation in 1997. The creation of CBH served as the catalyst for the development of Philadelphia's behavioral health system. Currently, in its present structure DBH/MRS employs more than 600 people and provides funding of almost one billion dollars to a vast array of services to citizens of Philadelphia who need supports to manage their behavioral healthcare needs and mental retardation.

DBH/MRS provides a full continuum of medically necessary and clinically appropriate behavioral health and mental retardation services, along with an array of services that meet locally defined "social necessity" criteria. Services for Medicaid recipients are primarily paid for on a capitated basis through a contract between the City of Philadelphia and the Pennsylvania Department of Public Welfare (DPW) through their HealthChoices mandatory managed care initiative. Federal, state, and city funds support additional treatment and other social support services for individuals who receive care from programs administered by DBH/MRS.

By way of background, in February 1997, Philadelphia became the first city in the nation to launch its own non-profit corporation to manage the behavioral health care of the city's Medicaid recipients. The opening of CBH followed years of planning and impassioned advocacy by consumers, advocates, mental health and addiction treatment providers and government officials. By creating this new organization, the city was able to realize a long-standing vision: the creation of a comprehensive behavioral health system that would integrate mental health and substance abuse services for its neediest citizens in ways that had not been possible before.

At the same time, Philadelphia had long operated mental health, mental retardation and substance abuse programs for citizens who were uninsured or underinsured. Until 1997, however, there was no ability to coordinate those programs with the funds and services for Medicaid recipients. The goal of providing behavioral health care for individuals consistent with their needs, regardless of the funding stream that paid for that care, was not attainable in the system that existed.

DBH/MRS has actively involved consumers of mental health services, family members, and people in recovery in every aspect of its operation: policy and program development, oversight, and ongoing quality assurance activities. It has established and worked closely for years with the Consumer and Family Task Force and with mental health, drug and alcohol as well as mental retardation advocacy groups. It contracts with the Consumer Satisfaction Team, an organization staffed entirely by mental health consumers, people in recovery, and family members who make both announced and unannounced visits to service sites year round, document concerns in writing which go to the community providers and meet regularly with staff from DBH/MRS to resolve consumer issues. Furthermore, DBH/MRS receives an annual grade from the Consumer Satisfaction Team rating its effectiveness in remediating consumer/client satisfaction concerns. Accountability to the persons served is thus built directly and effectively into the system.

DBH/MRS has significantly improved public performance by creating a citywide culture based on expectations for high quality, consumer responsive services. DBH/MRS has provided extensive ongoing training to the staff of its provider network as well as consultation to agencies whose clinical standards have needed strengthening.

Coordination of funding streams has allowed DBH/MRS to use non-Medicaid dollars to create less costly services (such as new residential options) as alternatives to higher cost care (such as inpatient care). As a result, CBH, the Medicaid managed care component, has realized significant savings, which can now be reinvested into the development of new public sector services. It is these savings that have been the source of "reinvestment" funding for the programs in the community that support a recovery-focused system.

I.3 GOALS, VALUES AND PRINCIPLES

As part of the process to develop new and expanded services, DBH/MRS is committed to supporting system-wide goals, values and principles that all respondents to this RFP will need to acknowledge and to which they must adhere. The following goals of the system were used to guide the development and implementation of DBH/MRS efforts:

- Ensure a comprehensive, seamless system for all publicly funded behavioral health care in which continuity of care is prioritized and sustained recovery is promoted.
- Facilitate care so that each consumer and recovering person is able to attain the best quality of life that he or she can achieve.
- Serve people recovering from addictions and mental illness with the most appropriate and cost effective services.
- Empower people with serious mental illness and addiction issues with opportunities that allow them to exert control over their lives and exercise the maximum level of self-determination.
- Expand the choice of services for people recovering from addictions and mental illness.
- Expand participation of people recovering from addictions and mental illness in both the delivery and the evaluation of services.
- Promote community health as a welcoming and safe environment that fosters recovery.
- Ensure accountability for the provision of publicly funded mental health and addiction services.

The system values and principles, as described below, are interrelated in such a way that they must be viewed and addressed collectively in order to maximize the benefits envisioned by DBH/MRS for individuals served by the system. These system-wide values and principles include:

Promotion of a recovery-oriented service system for people with substance abuse and psychiatric disorders

A recovery oriented system is a system filled with the hope that some people can and do fully recover from serious mental illness or addiction. It recognizes that each person's recovery journey is individual and that the journey is the process of developing new meaning, purpose, values, roles and relationship following the development of an illness, addiction or other traumatic life event. It is a person-centered approach, which recognizes that what is recovery to one person is different from what is recovery to another. A recovery-oriented system focuses on supporting the person's wellness, not just stabilization or treating the illness. It may include returning to a healthy state evidenced by improving one's mood and outlook on life following an episode of depression; managing one's illness such that the person can live independently and have meaningful employment and healthy social relationships; reducing the painful effects of trauma through a process of healing; attaining or restoring a desired state such as achieving sustained sobriety; or building on personal strengths to offset the adverse effects of a disability. There are many steps that a laboratory could take to foster an environment that promotes recovery. Successful bidders must articulate a plan that demonstrates a real understanding of recovery and describe the steps necessary to achieve the incorporation of a recovery model into their program design. This would include the hiring of individuals in recovery. Demonstration of or commitment to such hiring practices would result in additional points awarded in the proposal review stage.

Evidenced Based Practices

Evidenced based practices are interventions that have shown consistent scientific evidence of being related to preferred consumer/client outcomes or interventions for which there is significant supporting evidence suggesting they are effective. The use of evidence based practices holds the potential to improve quality of care, particularly for individuals who present with complex issues, within the constraints of limited resources; to offer support for providers who are under pressure to improve performance; and to address the need for increased accountability on the part of agencies and service systems. In instances where no evidence based practices exist for the population being targeted and the program being proposed, model programs or promising programs that suggest effectiveness may also be used. Contractors responding to this RFP will need to share information that demonstrates awareness of practices that are supported by some level of evidence for the population being targeted. Providers should also identify next steps that may increase the evidence base of those services that appear to be effective. Demonstration of or commitment to the utilization of evidenced based practices would result in additional points awarded in the proposal review stage.

Cultural Competency

Cultural competence is a set of congruent practice skills, attitudes, policies and structures which come together in a system, agency or among professionals and enable that system or those professionals to work effectively in cross cultural situations. Cultural competency is the acceptance and respect for difference, continuing self assessment regarding one's own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations. For DBH/MRS, the expectation is that providers will respond effectively to the needs and differences of all individuals, irrespective of their race, gender, age, physical or mental status, sexual orientation, and ethnic or cultural heritage. Cultural competency is also one medium through which behavioral health disparities are addressed. Demonstration of or commitment to culturally affirming practices would result in additional points awarded in the proposal review stage.

Behavioral Health Disparities

Behavioral health disparities are defined as systematic differences in healthcare practices and service utilization patterns related to race, culture or gender and not due to a health condition. The causes of behavioral health disparities can range from discrimination, stereotyping, racism and cultural mistrust to socioeconomic differences, language barriers, differences in help seeking norms, payor status and the intercultural divide between service systems and people's community norms. The manifestation of these disparities is a reduced access to and availability of high quality behavioral health services. This means increased distress for some individuals who may be misdiagnosed, who do not receive the treatment they require, who fail to get the medications or testing they need and who, as a result, may experience a greater burden of disability. All respondents must discuss how these disparities will be addressed in the proposed program.

There are also other person-centered values and principles that DBH/MRS supports in addition to those for the overall system. These values and principles focus on services that can meet the specific needs of some individuals in treatment and have a positive impact on the quality of care that each individual receives. They include:

Trauma Informed Services

Trauma informed services are services that occur within a culture where there is an understanding of the relationship between human behavioral pathology and exposure to abuse of power, disabling losses and disrupted attachment. Individuals who have been abused or have otherwise suffered significant losses often lack the basic skills required for healthy living. Addressing these individuals' needs requires an environment where staff has been trained and are sensitive to the issues that adversely impact upon the people with whom they are working. Successful bidders will need to demonstrate an understanding of these issues and describe how they will be incorporated into the proposed laboratory service delivery model.

** In an effort to assist in the preparation and development of your response to this RFP, a listing of resources has been included in Appendix A that provides further elaboration of the above values and principles. We encourage you to make extensive use of these resources.

I.4 SUSTAINABILITY OF PROGRAMS

The laboratory awarded the contract by this RFP will be required to participate in a shared-risk capitation plan where contracted laboratory services will be provided to CBH members. The successful bidder must be credentialed by CBH in order to complete the contracting process. More information on the CBH credentialing process is available on the CBH website, located at <http://www.phila-bhs.org>. The successful bidder must demonstrate extensive experience in providing lab services to a behavioral health population and demonstration of the operational infrastructure to serve over 20,000 persons per year.

Prospective bidders should consider that individuals who meet or ultimately will meet the criteria for Medicaid eligibility are the primary recipients of the services provided by this RFP. Bidders should also be aware that an evaluation process would be established that would identify specific and concrete outcomes. The continuation of the contract will be based, among other things, on the successful achievement of the specified outcomes.

I.5 ISSUING OFFICE

This RFP is issued by Community Behavioral Health (CBH) under the City of Philadelphia's Department of Behavioral Health/Mental Retardation Services (DBH/MRS). CBH will be the sole point of contact in the City of Philadelphia with regard to this RFP.

I.6 TYPE OF CONTRACT

The contract entered into with CBH as a result of this RFP will be designated as a Provider Agreement. Negotiations will be undertaken only with the bidder whose proposal, including all appropriate documentation (e.g., audits, letters of credit, past performance evaluations, etc.) shows them to be qualified, responsible and capable of performing the work required in the RFP.

I.7 INCURRING COSTS

Neither CBH nor the DBH/MRS is liable for any costs incurred by applicants for work performed in preparation of a response to this RFP.

I.8 RESERVATION OF RIGHTS AND CONFIDENTIALITY

By applying for a notice of contract opportunity, the bidder understands and agrees to this reservation of rights.

A. CBH's Reservation of Rights in Connection with the Notice of Contract Opportunity Process

CBH reserves and may exercise any one or more of the following rights and options with respect to its notice of contract opportunity process:

- 1) to reject any and all proposals and to reissue a notice of contract opportunity at any time prior to execution of a final contract;
- 2) to issue a new notice of contract opportunity in terms and conditions substantially different from those set forth in a previous notice of contract opportunity;
- 3) to issue a new notice of contract opportunity with terms and conditions that are the same or similar as those set forth in a previous notice of contract opportunity in order to obtain additional proposals;
- 4) to extend a notice of contract opportunity in order to allow for time to obtain additional proposals prior to notice of contract opportunity application deadline; or,
- 5) to cancel a notice of contract opportunity with or without issuing another notice of contract opportunity.

B. Proposal Selection Process and CBH's Reservation of Rights in Connection with Selection of Proposal(s) for Review

CBH reserves and may exercise any one or more of the following rights and options with respect to its selection process:

- 1) to reject any proposal if, in CBH's sole discretion, the proposal is incomplete, the proposal is not responsive to the requirements of a notice of contract opportunity or it is otherwise in the best interest of CBH to reject the proposal;

- 2) to supplement, amend, substitute or otherwise modify a notice of contract opportunity at any time prior to the award of one or more respondents for negotiation;
- 3) to reject the proposal of any respondent that, in CBH's sole judgment, has been delinquent or unfaithful in the performance of any contract with CBH or the City of Philadelphia, is financially, or technically incapable, has had founded state and/or federal investigations of improper business practices, or is otherwise not a responsible respondent;
- 4) to reject as informal or non-responsive, any proposal which, in CBH's sole judgment, is incomplete, is not in conformity with applicable law, is conditioned in any way, deviates from the notice of contract opportunity or contains erasures, ambiguities, alterations or items of work not called for by the notice of contract opportunity;
- 5) to waive any informality, defect, non-responsiveness and/or deviation from the notice of contract opportunity that is not, in CBH's sole judgment, material to the proposal;
- 6) to permit or reject, at CBH's sole discretion, amendments (including information inadvertently omitted), modifications, clarifying information, alterations and/or corrections to proposals by some or all of the respondents following proposal submission and before contract award and/or contract execution.

C. Proposal Evaluation Process and CBH's Reservation of Rights in Connection with Proposal Evaluation and Contract Negotiations

Proposals, which CBH determines in its sole discretion, are responsive to a notice of contract opportunity, will be reviewed and evaluated by CBH. CBH reserves the right to request respondents to make one or more presentations to CBH at CBH's offices at respondents' sole cost and expense, addressing respondents' ability to achieve the objectives of the notice of contract opportunity. CBH further reserves the right to conduct on-site investigations of the respondents' facilities or of those facilities where the respondent performs its services. Proposals will be evaluated, in part, according to whether the respondent meets the minimum qualifications and submits a proposal complying with all of the requirements of the notice of contract opportunity.

CBH reserves the right to enter into negotiations with any or all respondents regarding price, scope of services, or any other term of their proposals, and such other contractual terms as CBH may require, at any time prior to execution of a final contract. CBH may, at its sole election, enter into simultaneous, competitive negotiations with multiple respondents or negotiate with individual respondents either together or in a sequence. Negotiations with respondent(s) may result in the expansion or reduction in the scope of services, or changes in other terms and submitted proposals. In such event, CBH shall not be obligated to inform other respondents of the changes, or to permit them to revise their proposals in light thereof unless CBH, in its sole discretion determines that doing so is in CBH's best interest. CBH may accept or reject any or all of the items in

any proposal and award the contract in whole or part if it is deemed in CBH's best interest to do so.

In the event negotiations with any respondent(s) are not satisfactory to CBH, CBH reserves the right to discontinue such negotiations at any time; to enter into or continue negotiations with other respondents; to reissue the notice of contract opportunity in order to solicit new respondents. CBH reserves the right not to enter into any contract with any respondent, with or without the re-issuance of a notice of contract opportunity, if CBH determines that such is in CBH's best interest.

D. Confidentiality and Public Disclosure

The successful respondent shall treat all information obtained from CBH, which is not generally available to the public as confidential and proprietary to CBH. The successful respondent shall exercise all reasonable precautions to prevent any information derived from such sources from being disclosed to any other person. The successful respondent agrees to indemnify and hold harmless CBH, its officials and its employees, from and against all liability, demands, claims, suits, losses, damages, causes of action, fines and judgments (including attorney's fees) resulting from any use or disclosure of such confidential and/or proprietary information by the successful respondent or any person acquiring such information, directly or indirectly, from the successful respondent.

By submission of a proposal, respondents acknowledge and agree that CBH, as a municipal corporation, is subject to state and local disclosure laws and, as such, is legally obligated to disclose public documents, including proposals, to the extent required thereunder. Without limiting the foregoing sentence, CBH's legal obligations shall not be limited or expanded in any way by a respondent's assertion of confidentiality and/or proprietary data.

I.9 QUESTIONS / CONTACT PERSONS

Any general or programmatic questions that you may have as a result of reading this RFP should be directed to Sean Gallagher, Director of Network Development at CBH. He will be the sole point of contact for answering these questions and will be available to respond to questions via email. His email address is sean.gallagher@phila.gov. All questions will be posted and answered on the CBH website for all prospective bidders to view. Contact with other CBH and DBH/MRS staff regarding the RFP is not permitted.

I.10 PROPOSALS AND RESPONSE DATE

A Letter of Intent must be submitted by 3:00 PM on Friday June, 29, 2007, indicating a plan to bid. The letter should include the name of the bidding laboratory and the name of the person who ultimately will sign the proposal when it is submitted. A laboratory may decide not to submit a proposal after sending a Letter of Intent without any adverse effect.

All Letters of Intent are to be sent via certified mail to:

Nancy Lucas
Chief Executive Officer
Community Behavioral Health
801 Market Street, 7th floor
Philadelphia, PA 19107

A Bidders Conference will be held on Tuesday, July 17, 2007 at 2:00 P.M to provide clarification on the RFP and answer questions about the RFP submission. All questions for the bidders conference must be submitted to Sean Gallagher by e-mail at sean.gallagher@phila.gov. Questions will be accepted up to 24 hours in advance of the Bidders Conference.

To submit your proposal:

- ❑ Ten hard copies of the original proposals should be submitted to:
Sean Gallagher, Ph.D.
Director of Network Development
Community Behavioral Health
801 Market Street, 7th floor
Philadelphia, PA 19107
- ❑ Along with the hard copies of the proposal, an electronic version of the proposal (Microsoft Word) is required to be submitted in a portable document format (PDF) as read-only via email to sean.gallagher@phila.gov.
- ❑ Any discrepancy between the hard copy and electronic version may be cause for disqualifying the proposal.
- ❑ All identifying information about the laboratory submitting the proposal **must** be confined to the cover page. This will be a blind review.
- ❑ All proposals must be delivered to CBH at the above address no later than **Friday, August 31, 2007 at 3:00 PM**. Proposals received after this deadline will be returned, unopened to the applicant.
- ❑ An official of the laboratory, authorized to bind the laboratory to all provisions noted in the proposal, must sign the proposal.

I.11 PROPOSAL REQUIREMENTS

Proposals must be prepared simply and economically, providing a straightforward, concise description of the laboratory's ability to meet the requirements of the RFP. The Bidder shall organize the proposal in the same order as presented in the RFP and clearly label each section and subsection with the headings as they appear in the RFP. Include a table of contents. Any attachments called for in the RFP shall be placed at the end of the proposal and clearly labeled. Any additional information or addenda must be referenced in the body of the response and attached to the end of the document after the required attachments. **Bidders are required to**

limit their narrative responses to 25 single spaced pages. This does not include the budget and budget narrative requirements. If you have responded to a requirement in another section of your proposal, please make reference to that section and do not repeat your response.

The narrative portion of the proposal must be presented on standard 8.5"x11" paper, using a font size of 11 or larger. For each section where it is required, the bidder should clearly state it would comply with all CBH requirements and fully answer all of the listed questions in the outline form in which they are presented in the RFP. Answers to each question must be numbered/lettered and correspond to the numbered/lettered questions in the RFP. Failure to number and letter the questions or to respond to all questions may result in the proposal's being considered non-responsive. Each attachment must reference the corresponding section or subsection number to which it corresponds.

I.12 ORAL PRESENTATION

Applicants who submit proposals may be required to make an oral presentation concerning various aspects of their proposal to CBH. Such presentations provide an opportunity for applicants to clarify their proposal to insure a thorough and mutual understanding. CBH will schedule such presentations on an as needed basis.

I.13 PRIME CONTRACTOR RESPONSIBILITY

The selected laboratory will be required to assume responsibility for all services described in their proposals whether or not they provide the services directly. CBH will consider the selected contractor as the sole point of contact with regard to contractual matters.

I.14 DISCLOSURE OF PROPOSAL CONTENTS

Cost and price information provided in proposals will be held in confidence and will not be revealed or discussed with competitors. All material submitted as part of the RFP process becomes the property of CBH and will only be returned at CBH's option. Proposals submitted to CBH may be reviewed and evaluated by any person other than competing bidders. CBH retains the right to use any/all ideas presented in any reply to this RFP. Selection or rejection of a proposal does not affect this right.

I.15 COMMUNITY BEHAVIORAL HEALTH – PROVIDER AGREEMENT

The general provisions and cost principles are enclosed for the information of prospective bidders. Any final contract entered into between CBH and the laboratory will include the CBH Provider Agreement.

I.16 SELECTION / REJECTION PROCEDURES

The laboratory whose proposal is selected by CBH to provide a particular set of services will be notified in writing. Information will be provided in this letter as to any issues within the proposal

that will require further discussion or negotiation with CBH. This letter should not be considered as a letter of award. A formal letter of award will be forthcoming to the laboratory selected at such time when mutual agreement has been reached by the parties on all issues pertaining to the proposal. Bidders whose proposals are not selected will also be notified in writing by CBH.

I.17 RESPONDENTS RESTRICTED

No proposal shall be accepted from, or contract awarded to, any City of Philadelphia or CBH employee or official, or any firm in which a City or CBH employee or official has a direct or indirect financial interest. Any proposal may be rejected that, in CBH's sole judgment, violates these conditions.

I.18 LIFE OF PROPOSALS

CBH expects to select one bidder as a result of this RFP within approximately 90 days of the submission deadline. However, proposals that are submitted may be considered for selection up to February 28, 2008. CBH reserves the right to rescind the RFP at any juncture in the RFP process including through the contract negotiation period, up to the actual signing of a contract with the successful bidder.

I.19 CONTRACT TIME PERIOD

The initial contract resulting from this RFP will start within 90 days of the awarding of the contract and will run for a period of one year. The contract will be eligible for renewal on an annual basis depending on the laboratory's ability to meet its contractual obligations successfully (i.e. customer and consumer satisfaction, financial viability, operational infrastructure and quality of services).

I.20 ADDENDA TO THE RFP

If it becomes necessary to revise any part of this RFP through additions, deletions, or providing qualifying information, this information will be provided to all parties who submitted a letter of intent by the prescribed deadline stated on page one of this RFP.

I.21 MINORITY BUSINESS ENTERPRISE COUNCIL (MBEC)

The City of Philadelphia Minority Business Enterprise Council (MBEC), under Executive Order 03-05 dated March 4, 2005, is responsible for assuring that businesses owned and controlled by minorities (MBE), women (WBE) and disabled (DSBE) persons are given the opportunity to participate fully in the economy of the City of Philadelphia. While non-profit organizations are not subject to participation ranges, services that are subcontracted by non-profit organizations to for-profit organizations, including supplies and renovation/construction services, may fall under

the purview of MBEC. Appendix C provides the language governing non-profit organizations as included in the Executive Order. It is the expectation of CBH that the successful bidder will meet the intent of the M/W/DSBE legislation.

All proposals that meet Minority Business Enterprise Council (MBEC) requirements will be given additional points in the proposal review and scoring process.

I.22 SOCIALLY/ECONOMICALLY RESTRICTED BUSINESSES (SERB)

The purpose of the SERB program is to promote the use of small and emerging businesses giving them opportunities to participate in state related contracting (see Appendix D). This state initiative would apply in the situation of a capitation contract as presented in this RFP.

Many of the companies that qualify for SERB may be too small as prime contractors on some contracts, however, those contracts may provide subcontracting and joint venture opportunities that would be within the capacity of a small business. The SERB Program encourages prime contractors to consider SERB businesses when seeking supplies and services their own companies cannot provide.

All proposals that meet Socially/Economically Restricted Business (SERB) will be given additional points in the proposal review and scoring process.

I.23 NON-DISCRIMINATION

The successful bidder, as a condition of accepting and executing a contract with CBH through this RFP, agree to comply with all relevant sections of the Civil Rights Act of 1984, the Pennsylvania Human Relations Act, Section 504 of the Federal Rehabilitation Act of 1973, and the Americans with Disabilities Act, hereby assuring that:

The laboratory does not and will not discriminate against any person because of race, color, religious creed, ancestry, national origin, age, sex, sexual orientation, handicap or disability in providing services, programs or employment or in its relationship with other contractors.

SECTION II PROPOSAL CONTENT AND FORMAT REQUIREMENTS

All proposals submitted in response to this RFP must be submitted in the format outlined below. To be considered, the bidder must respond to all requirements detailed in this section of the RFP. Any other information considered to be relevant but not directly applicable to this section may be provided as an appendix to the proposal.

II.1 PROPOSAL COVER SHEET

All bidders must completely fill out, sign and attach the cover sheet (see Appendix E) as the first page of the proposal.

II.2 CAPABILITY STATEMENT

Minimally, the successful bidder must be licensed by the Commonwealth of Pennsylvania and hold a valid license issued under the provisions of Section 35 of the Clinical Laboratory Improvement Act of 1967, as amended (42 U.S.C. 263) and applicable regulations and comply with regulations which exceed or differ from those of the Federal Statute, as stated in Paragraph 5.83 of the Clinical Laboratory provisions, amended August 16, 1975, and bidder shall so verify in his/her bid. All bidders must be presently enrolled as a Pennsylvania Medicaid provider and be in good standing with both Medicare and Medicaid programs. All bidders must also have obtained a National Provider Identifier number.

All of the above conditions also apply to any referral laboratory to which the successful bidder forwards specimens for testing. Evidence of above mentioned documentation should be included as part of the response to the RFP. The contracted services being solicited are considered commercial activities; thus all laboratory facilities must meet county and state permit, zoning, and health codes requirements.

Additional points will be awarded to bidders that have acquired College of American Pathologists (CAP) certification. The selected laboratory will be expected to complete CAP accreditation prior to the second year of the contract. Extension of subsequent contract years will depend upon successful acquisition of the CAP accreditation.

The Capability Statement must address the following areas:

- A. A brief narrative description of the applicant laboratory, including its purpose, corporate status (profit or non-profit), organizational structure, and current sources of funding support. Organizational charts and financial statements should be used to support appropriate aspects of this narrative. A list of the individuals who comprise your governing body, their gender, race and business addresses is to be included in Section III – Budget. All bidders must disclose the name of any person or entity having a direct or indirect ownership or controlling interest of 5% or more in the laboratory.
- B. A brief description of the laboratory's involvement in activities or projects similar to or related to those addressed by this RFP. It would be relevant to discuss current or previous experience providing behavioral health laboratory services. This experience should be briefly described and any achievements/problems noted. Unique aspects of such activities or projects should also be detailed here as appropriate.
- C. Any experience in developing programs that entailed working with community based services. A description of the linkages and ongoing relationship between the laboratory and the community where the proposed services will be provided should be documented here. In addition, the concept of community should go beyond geography to include advocacy groups, professional groups and grass

roots organizations.. This section should provide documentation from some or all of the following types of persons/organizations, acknowledging their support for the development of the services you are proposing:

religious organizations	civic groups	community organizations
elected officials	advocacy groups	professional organizations

- D. A brief description of the laboratory's background in delivering culturally competent services. Include any information about efforts made to insure that the needs of unique cultural groups are met, along with information regarding the multi-lingual capability of direct treatment, support or administrative staff.
- E. Resumes and/or job descriptions of the primary personnel who will be involved in the contract.
- F. A sample of the CBH Provider Agreement is provided for review (Attachment B) and the successful bidder must stipulate in writing that the laboratory will comply with all contractual expectations detailed in the Provider Agreement.

II.3 PROGRAMMATIC REQUIREMENTS

This section offers the opportunity to describe the way(s) in which your laboratory intends to provide the proposed services. You should include a description of how you plan to provide the services.

II.4 SCOPE OF SERVICES

All applicants are to describe a program model that encompasses the areas of importance referenced in the previous sections of the RFP. All proposals must include as a minimum the following components:

- A. Staffing
The program description should include a discussion of issues related to staffing, including levels of staffing, supervision, number of staff, minimum educational and experience qualifications and expertise of staff, different types of staff to be employed and staff coverage during a typical week. Bidders must submit a timetable that outlines a plan to achieve sufficient staff levels to manage the projected capacity. The use of persons in recovery in your program should be addressed here. Include in your submission a staff schedule that shows typical coverage in a calendar week. This would include a schedule for acquiring specimens; either through courier services or the use of phlebotomists.

B. Training

Training will be an important component of a laboratory's operations. Training will be required prior to the opening of the program, as well as during the early stages of operation. Training and education requirements are attached to this proposal as Appendix F. Ongoing training will follow requirements as outlined by CLIA and CAP certifications.

C. Specimen Pick-up

The successful bidder will be responsible for establishing a scheduled on-going system for picking up and transporting specimens from Community Behavioral Health's in-network provider sites (see Appendix H) to the laboratory, Monday through Friday, except for public holidays. All specimen pick-ups should be carried out during the dates and times agreed upon by the successful bidder and each in-network provider. This would include phlebotomy services, which are to be conducted at provider sites. The laboratory must honor a consumer's choice of treatment provider; therefore no centralized specimen collection centers will be accepted as part of the RFP.

Provider locations may be added to Community Behavioral Health's provider network during the contract period. The successful bidder should be able to provide full complement of services to the new provider.

D. Laboratory Testing/Reports

D.1 Appendix I lists the laboratory tests, which the successful bidder must be able to perform or procure expeditiously. This list should not be considered to be all-inclusive. Lab tests not previously included as a reimbursable service by CBH are highlighted in *italics*.

D.2 The successful bidder must submit an attachment listing the normal range of values for each test listed as part of the response to the RFP and when relevant indicate the values considered normal for children. In addition, all these normal values must be listed on laboratory test results.

D.3. Laboratory specimens must be evaluated and written reports prepared and returned to the provider within 24 hours of receipt of specimen, with the exception of cultures and other test, which may require more than 24 hours of analysis in accordance with standard laboratory procedures.

D.4 The successful bidder is required to have a system in place to provide laboratory test results electronically should the provider choose to received test results in that manner. At minimum, the successful bidder is required to provide written test results via fax with preference for online

access and simultaneous reporting to primary care providers if client consent is obtained.

- D.5 Any laboratory test marked STAT are to be picked up by a courier within four hours of receiving the request and processed within 12 hours, including referral to other testing facilities if necessary.
- D.6 As a minimum, 85% of the test volume sent to the successful bidder must be performed on-site. However, if a referral to another laboratory is necessary, the successful bidder shall be responsible to insure the same expeditious handling.
- D.7 The successful bidder must provide a list of critical test values to providers upon award of the bid. Each laboratory report with an abnormal test result should be marked prominently as such.

E. Supplies

The successful bidder will furnish to Community Behavioral Health and its providers current laboratory manuals detailing the services available, specimen protocols and other information as necessary to insure proper specimen collection and integrity. Changes and/or additions and deletions shall be forwarded in writing to Community Behavioral Health and its providers on a monthly basis. In addition to printed materials, the successful bidder must provide access to an electronic version of the manual for real time changes and updates.

Any auxiliary specimen collection apparatus required for specific laboratory tests (e.g. 24 hour urine collection containers, fixatives for urine specimens, oral collection devices, dipsticks, latex gloves, etc.) may be requested in advance by providers if needed.

F. Quality Control

The successful bidder shall provide Community Behavioral Health with a statement of methodology utilized in the internal monitoring of quality control.

The successful bidder will permit inspection of facilities as part of the RFP process, as well as document their laboratory's performance evaluation program. The laboratory will comply with all quality control requirements of the Clinical Laboratory Improvement Act and College of American Pathologists (when CAP certification is obtained), for the category of tests covered in this contract.

G. Billing

The successful bidder must have prior experience with third-party billing, including but not limited to Medicare, Medical Assistance (Medicaid), Blue Cross/ Blue

Shield, Commercial Carriers, Managed Care Plans and other third-party payers for selected laboratory services.

The successful bidder must submit claims electronically using the CMS 1500 (0805) Claim Form for each billable service.

The successful bidder shall accept Community Behavioral Health payment as payment in full and will not seek nor accept additional remuneration from the patient.

II.5 SITE REQUIREMENTS

It should be noted that there is a preference for laboratories whose sites are located within the City of Philadelphia and secondarily, the state of Pennsylvania.

This section must include the specific address where the laboratory services are to be located; the relationship of the responding agency to the property (owned, leased, under agreement to be purchased, etc.); extent of alterations or renovations required for the property and timetable to complete them; current use of the property; and an impact statement assessing the effect and possible response that the site will have on the surrounding community. In order to provide flexibility, bidders may consider various types of sites.

All bidders will be responsible for working with their respective Department of Licenses and Inspections to ensure compliance with all permit, zoning, housing and use code and licensing requirements. Bidders should be aware of and adhere to requirements of the Americans with Disabilities Act (ADA) wherever possible. It will also be the responsibility of the successful bidder to secure a certificate of occupancy prior to finalizing the contract. A statement must be included indicating a willingness to comply with all of the above requirements.

SECTION III SPENDING PLAN/BUDGET

III.1 BUDGETS

This RFP will utilize a shared-risk capitation based payment structure. Appendices G, H and I provide the necessary information to calculate a capitation rate. The Pennsylvania Department of Public Welfare maintains information regarding the MA rates for each laboratory test on their website. Budgets accompanying the proposals must support the Scope of Services previously described.

**Please note that there are laboratory tests that will not be included in the first year capitation rate and will be paid for on a fee-for-service basis at the current MA rate. These are lab tests*

that had not been reimbursable services in the past, therefore no payment history can be established for inclusion into the capitation rate. They are as follows:

Blood Urea Nitrogen (BUN)

Clomipramine (Anafranil)

Clozapine (Clozaril)

Hemoglobin; glycosylated (A₁C)

Lamotrigine (Lamactil)

Liver Panel

Methadone

Prostate Specific Antigen (PSA)

Each proposal must be accompanied by an operating budget and must include a budget narrative. The full operations budget should be provided for a one-year period.

To summarize this section, the following are to be provided:

- A. Operating budget and narrative
- B. Proof of incorporation
- C. A certified audit and management letter for the laboratory for the most recent corporate year.
- D. Proof of payment of all appropriate Federal, State and local taxes for the past twelve(12) months.
- E. Each responding agency must provide a list of the names, gender, race and business addresses of all members of its Board of Directors. Please indicate which, if any, board members are consumers, recovering persons or family members.
- F. Proof of a Line of Credit, which, at a minimum, makes available 10% of the total program budget.

SECTION IV EVALUATION PLAN

The laboratory awarded the contract through this RFP process will be subject to evaluation by CBH. By accepting the award of this RFP, the successful bidder agrees to comply with the evaluation requirements in the CBH Credentialing Manual. The successful awardee agrees to supply all the required data necessary for the evaluation and to participate in required consumer assessments. The successful awardee will also agree to an annual review where contract compliance will serve as a base of evaluation. The contracted laboratory will complete an annual self-audit of all contractual obligations using an assessment tool and narrative summary to demonstrate contract adherence. The results of the self-audit will be made available to the CBH review team prior to their re-credentialing visit.

Bidders should describe their organizational capacity to provide all required information listed above and state their commitment to participate fully in all evaluation efforts. In this section, bidders should identify a point person or people who will have primary responsibility for evaluation activity.

SECTION V DATA REPORTING

The successful bidder will be required to meet all data reporting requirements established by CBH . At a minimum, all presently available client encounter data gathered from the CBH claim form will be collected. To fulfill the data reporting requirements, the successful bidder must work with the CBH Claims and Information Services Departments to ensure the quality and completeness of data. All client encounter data from the preceding month must be submitted by the 15th of the following month. CBH will not release the monthly capitation payment until all required data is received.

All bidders must submit a plan for data reporting that will include both individual client data and aggregate data. The successful bidder will be required to submit reports to CBH on a regular basis in an agreed upon format. The successful bidder must designate a qualified person to serve as MIS Liaison to this office. All data that are rejected by the CBH information system must be corrected and resubmitted.

SECTION VI CRITERIA FOR SELECTION

A CBH Proposal Review Committee will conduct a blind review of all responses to this RFP. Based on the criteria detailed below, the Committee will make recommendations to the Chief Executive Officer concerning those proposals deemed most appropriate for selection. The make-up of the review committee will minimally be: three CBH staff persons representing appropriate departments, one CBH physician, one DBH/MRS staff person, one Consumer Satisfaction Team member and one representative from the City of Philadelphia Department of Public Health. In reviewing the proposals, the Committee will weigh all submissions according to the following criteria:

V.1 EXPERIENCE/CAPABILITY (up to 15 points)

1. Staff experience and demonstrated competence in providing similar or related services.
2. Management experience in directing a project of the nature, size and scope detailed in the proposal.
3. An understanding of addiction and mental illness and how the proposed project can best support effective integrated treatment.

V.2 COMMUNITY PARTICIPATION/LINKAGES (up to 15 points)

1. Community linkages, partnerships and collaborations should include individual provider agencies, provider associations, advocacy groups, grass roots and professional organizations, as well as those community groups and individuals who represent the population to be served.
2. The choice of site and its relationship the communities with the City of Philadelphia and the surrounding five counties. Plans to develop programming that supports the overall system goals of the DBH/MRS.

V.3 SYSTEM GOALS AND VALUES (up to 15 Points)

1. The extent to which system-wide goals, values and principles, as described throughout this document, are understood and incorporated into the application.
2. The degree to which the proposal indicates a strong commitment and a willingness to follow through to integrate the goals, values and principles into the overall laboratory structure .

V.4 PROGRAM DESIGN (up to 20 points)

1. Project design for the delivery of services in the Scope of Services will be evaluated on the basis of its appropriateness for the population to be served, the type and variety of services proposed and the extent to which reporting is timely and accessible.
2. Appropriateness of the proposed staffing pattern will be evaluated through a review of the staff complement, the service tasks and the training plan identified in the Scope of Services.
3. Ability to define and measure successful outcomes served in the proposed program will be assessed based upon information contained in the Scope of Services.
4. Program proposals that include College of American Pathologists accreditation will be given additional points in the proposal review.

V.5 BUDGET/CAPITATION PLAN (up to 20 Points)

1. The operating budget, budget narrative and any accompanying documentation will be evaluated for its support of the Scope of Services under a capitated plan.
2. Proposals will also be evaluated on the following items:

- a. Proof of payment of all required Federal, State and local taxes for the most recent twelve (12) month period.
- b. Proof of Line of Credit, which at a minimum makes available 10% of the total program budget.
- c. Submission of a certified corporate audit and management letter for the most recent corporate fiscal year.

V.6 BUSINESS OPERATIONS (up to 15 points)

1. Laboratories that have sites located within Philadelphia County will be given priority point assignment, the next level of priority point assignment would be the surrounding Philadelphia counties and then those proposals from laboratories incorporated within the state of Pennsylvania.
2. Proposals from laboratories that meet MBEC requirements will receive additional review points.
3. Proposals from laboratories that meet SERB requirements will receive additional review points.
4. Additional points will be awarded to those proposals that demonstrate company policies and practices that encourage and are successful in the hiring of individuals who participate in a welfare to work program, or who are identified as persons in recovery and/or who are citizens of Philadelphia County.

APPENDIX A

RESOURCE LISTING

Department of Behavioral Health and Mental Retardation Services

Document 1

Implementing Recovery-Oriented Services: What are Recovery Oriented Services and Systems of Care?

A. Introduction

Creating a recovery-oriented system of care is one of the foremost priorities of the Philadelphia Department of Behavioral Health and Mental Retardation Services. Reorienting to a recovery-oriented system involves looking beyond the diagnoses and difficulties of the people we serve to appreciating and incorporating their strengths, interests, and aspirations as we assist them in the process of rebuilding their lives. A recovery-oriented system of care also promotes the use of evidence-based practices and the value of peer support and other peer-driven supports. Finally, recovery-oriented systems work toward the elimination of health disparities through the provision of culturally responsive and competent care so that all persons may share equally in access to effective services and experience positive outcomes. As the service system continues to evolve, all services must be consistent with recovery values and principles.

Although recovery has been a foundational concept and term in the addictions field since the advent of 12 step groups, the use of the term in the mental health field is relatively new, despite the fact that some of the underlying principles (e.g. psychiatric rehabilitation) have been around for many years. We now know that even people with serious mental illness experience a diverse range of outcomes, with at least as many of them, if not more, experiencing partial to full recovery as those experiencing prolonged disability. The assumption that serious mental illness inevitably involves deteriorating functioning with little hope for living a fulfilling life is no longer an expected outcome.

Recovery has been defined in many different ways. Traditionally, recovery in the addictions field was the process of learning to live a full life without alcohol and drugs. The concept of recovery was expanded by consumer groups to include an experience of restoring or developing a new sense of purpose in life and sense of identity apart from one's condition (e.g. addiction, trauma, and/or mental illness) that is often described as transformational. For some, recovery may mean no longer experiencing symptoms of mental illness. For others, recovery may involve learning how to cope with or grow beyond one's mental illness despite enduring symptoms or setbacks. The overarching focus of recovery in all behavioral health is the restoration of self-esteem, positive identity, meaningful role in society, and, to the extent possible, independent living. Recovery is a way of living a satisfying, hopeful, and contributing life even if there are

limitations caused by a disorder. Rather than an end state or outcome, it is an ongoing *process* of pursuing one's own potential given the cards that one has been dealt in life.

B. Guiding Values and Principles

Applied to behavioral healthcare, recovery is a collaborative, strengths-based, consumer- and family driven, person-centered approach that builds upon hope and dignity and promotes the highest levels of autonomy and personal responsibility. The recovery framework supports individual and family participation in addition to the development of a strong support system and sense of belonging. Recovery oriented services include education about health and wellness, behavioral health treatment and rehabilitation, and the provision of community supports, is culturally relevant and holistic, and is collaborative and driven by recovery outcomes.

As a recovery-oriented system of care, the Philadelphia Department of Behavioral Health and Mental Retardation Services aims to identify and build upon each individual's strengths and address his or her behavioral health needs and concerns across levels of disability and over time so that each person has access to the opportunities, effective, culturally-responsive treatment and rehabilitation, and community supports he or she needs in order to achieve a sense of mastery over his or her condition while regaining a meaningful, constructive sense of membership in the community. Over the up-coming months we will endeavor to embed the language, spirit, and culture of recovery into all aspects of our system.

C. Recommendations for Action

1. Mission/vision statements, language, and service delivery expectations reflect recovery principles (e.g., person-first language is always used).
2. Access and engagement
 - a. Agencies offer a range of pre-engagement strategies.
 - b. Peer engagement specialists are used.
 - c. Specialized outreach strategies are used for people who have yet to benefit optimally from previous treatment episodes.
 - d. *Persons who relapse are rapidly admitted.
 - e. *Admission criteria do not exclude people based on prior treatment failure.
3. Service recipient involvement
 - a. Persons in recovery know agency grievance procedures, participate on advisory board/management meetings, contribute to planning processes, and participate in the development and provision of program/services, staff training, agency needs assessments and evaluations, and satisfaction surveys.
 - b. Agencies offer peer-run services, hire peer staff, and actively seek people in recovery for employment at all levels of the organization.
 - c. Satisfaction surveys are routinely conducted with service recipients and family members, and ideas about how to improve care are solicited and acted upon.

- d. Staff orientation/education activities include training related to recovery vision and principles and stages of change philosophy. Persons in recovery take leadership in the design and delivery of such activities.
4. Individualized, person- and family-centered recovery planning builds on strengths rather than emphasizes deficits
 - a. Plans are holistic and include individual and family needs, wishes, assets, interests, cultures, and goals that go beyond symptom management and stabilization. Staff help with the development and pursuit of individually defined life goals such as employment and education.
 - b. Persons in recovery actively participate in the development of their recovery plans, attend planning meetings, and designate meeting participants, which may include natural supports, and sign and receive copies of their plans.
 - c. The achievement of goals by people in recovery and staff are formally acknowledged and celebrated.
 - d. Except in extreme cases in which state statutes require involuntary intervention, coercion is not used to influence a person's behavior or choices.
5. Build competencies and skills
 - a. Respect and hope is conveyed that recovery is "possible for me." Staff use the language of recovery in everyday conversations (e.g., hope, respect, high expectations, etc.).
 - b. Recovery education, skill development, and self-management strategies are key components.
 - c. Recovery support staff are utilized.
 - d. Persons in recovery use relapse-prevention plans and advance directives.
 - e. Staff assist persons in recovery to engage and maximize use of natural supports such as friends, family, neighbors, the faith community, special interest groups, and adult education.
 - f. Autonomy is promoted.
6. Peer support and outreach includes linkages to peer mentors and support within the service and outside the service. The use of self-help resources is promoted.
7. Community inclusion and focus on building community connections
 - a. Program activities are integrated into community life and provided in natural environments whenever possible. Work and meaningful activities are accessible, educational needs are identified, and socialization needs are addressed.
 - b. Every effort is made to involve significant others (spouses, family, friends) and natural supports (clergy, neighbors, landlords) in the planning of the person's services, if so desired by the person.
 - c. Staff have knowledge of resources and facilitate access to resources and community involvement as defined by the person in recovery. Assistance in becoming involved in non-mental health/addiction activities is readily available. Staff identify and regularly update traditional and non-traditional resource directories.

- d. Structured educational activities are provided to the community to de-stigmatize mental illness and addictions.
8. Continuity of care
 - a. Service recipients are not discharged for experiencing an increase or relapse in symptoms of their illness.
 - b. Persons in recovery are linked to appropriate services upon discharge.
 - c. Agencies have mechanisms for follow-up post-discharge.
 9. Recovery-oriented performance Indicators reflect where each person “is” in their recovery process and what service recipients identify as the most important indicators of their success. Examples include:
 1. If and how people stand by me when I need or want them to
 2. How I was treated when I was not doing well
 3. If I have good family/community/indigenous social supports
 4. If I have a job
 5. If I like where I live
 6. If I am treated with dignity and respect

D. Evaluation

The recovery-orientation of the program will be assessed within eighteen months post start-up and will focus primarily on the recommendations detailed in the previous section.

Evaluation data will be obtained through:

1. Focus groups with people in recovery and family members
2. Focus groups with agency staff
3. Consumer satisfaction and recovery surveys
4. A review of organizational enhancements that support a recovery orientation

E. Resources

Print Resources

Anthony, WA. Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*. 16, (4), April, 1993.

Curtis, LC. Practice Guidance for Recovery-Oriented Behavioral Healthcare for Adults with Serious Mental Illnesses. Chapter in *Personal Outcome Measures in Consumer Directed Behavioral Health*. The Council on Quality and Leadership in Supports for People with Disabilities, Towson, Maryland. 2000.

Mead, S, and Copeland, ME. What Recovery Means to Us. Accessed May, 2005 at http://www.mentalhealthrecovery.com/art_recoverymeans.html

Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers. National Center for Substance Abuse and Child Welfare under contract with the U.S. Department of Health and Human Services Administration and the Administration for Children and Families, 2005

Web-Based Resources

Behavioral Health Recovery Management

<http://www.bhrm.org/index.htm>

<http://www.bhrm.org/guidelines/mhguidelines.htm>

Iowa Consortium for Mental Health

<http://www.medicine.uiowa.edu/icmh/recovery/>

The Hamilton County Community Mental Health Board Recovery Website

<http://www.mentalhealthrecovery.com/>

Repository of Recovery Resources

<http://www.bu.edu/cpr/recovery/>

Substance Abuse and Mental Health Services Administration

National Mental Health Information Center.

<http://www.mentalhealth.org/publications/allpubs/NMH05-0193/default.asp>

University of Illinois at Chicago National Research and Training Center on Psychiatric Disability

<http://www.psych.uic.edu/uicnrtc>

*The definitions, values, principles and recovery practices contained in this document are preliminary, are based primarily on policies, papers, and presentations developed by the State of Connecticut Department of Mental Health and Addiction Services, and will be further modified in the future.

Department of Behavioral Health and Mental Retardation Services

Document 2

Implementing Evidence-Based Practices: The Rationale for Utilizing Evidence-Based Practices

A. Introduction

The Surgeon General's Report on Mental Health (1999) indicated that "critical gaps exist between those who need service and those who receive services...between optimally effective treatment and what many individuals receive in actual practice settings." This report, along with a document released by the Institute of Medicine (2001), highlighted the finding that despite extensive evidence that demonstrates the effectiveness of particular behavioral health practices, these practices are not routinely integrated into behavioral health settings. In fact, research indicates that it takes approximately 15 years for scientific practice to become incorporated into health care settings.

A core value of The Department of Behavioral Health and Mental Retardation Services is that a recovery-oriented system of care is one that provides the highest quality and most effective behavioral health services to consumers and persons in recovery. As such, we are committed to developing a system of care that is grounded in evidence-based practices. DBH/MRS recognizes that this shift will be a developmental process. Research shows that training and education alone do not have a significant influence on practice behaviors. Consequently, to continue our pursuit of this goal, DBH/MRS will align resources, policies, and technical assistance to support the ongoing transformation of our system to one that promotes and routinely utilizes evidence-based practices. This document will provide a brief description of DBH/MRS' approach to evidence based practices and provide recommendations for incorporating them into practice settings.

B. What are Evidence-Based Practices (EBP)?

The term evidence-based practice has been referred to as the process of "turning knowledge into practice." The idea is to convert what we know based on scientific evidence into what we do. One of the most popular definitions is: "Evidence based practices are interventions for which there is consistent scientific evidence showing that they improve client outcomes." The DBH/MRS however, recognizes that there are numerous challenges to implementing EBPs in the real world. Among these are; implementing new strategies with limited resources, attempting to utilize practices that are not normed on populations similar to the population being served in Philadelphia, and the fact that many community based organizations that do achieve excellent outcomes, do not have the resources to conduct empirically based studies that validate the evidence base of their services.

As a result of these real world challenges, the DBH/MRS endorses an expanded view of evidence which not only acknowledges that evidence occurs on a continuum, but which also emphasizes the importance of the role that consumers and family members play in identifying

which services are most effective for them. Consequently, **the definition of EBP subscribed to by the DBH/MRS is “practical and specific clinical interventions and supports that are designed for specific groups of people in a particular setting and that are determined in collaboration with consumers to enhance their recovery.”**

As the scientific evidence that supports clinical practices are often inadequate or incomplete, DBH/MRS is using the following four categories to assess the levels/types of evidence that support proposed practices.

C. Levels of Evidence

Evidenced Based

- Interventions, which have a body of, controlled studies and where at least one meta-analysis shows strong support for the practice.
- Results have a high level of confidence, due to randomized control factor

Example: A series of randomized controlled trials comparing supported employment (also referred to as “IPS, Individual Placement and Support”) with a variety of traditional, “step-wise” vocational programs has clearly established supported employment as a highly effective intervention. This intervention results in significant gains in competitive employment rates, earned income levels, and employment tenure among individuals with severe behavioral health disorders.

Evidence Supported

- Interventions that have demonstrated effectiveness through quasi-experimental studies (e.g., “Time Series” studies or detailed program evaluations that include data on the impact of the programs or interventions).
- Data from administrative databases or quality improvement programs that shed light on the impact of the program or intervention.

Example: As one component of a quality improvement program in a local mental health authority, an in-service training program for providers and consumers/people in recovery was offered regarding the use of strategies to improve the collaborative, person-centered nature of treatment planning. Pre-post data collected prior to and after the training intervention indicated significant improvements in consumer satisfaction and consumers’ level of participation in treatment planning.

Evidence Informed

- Evidence of the effectiveness of an intervention is inferred based on a limited amount of supporting data.
- Based on data derived from the replication of an EBP that has been modified or adapted to meet the needs of a specific population.
- This data is fed back into the system. New interventions are developed, traditional interventions are modified, and ineffective interventions are eliminated.
- Provides a template/framework for other systems to modify their programs and interventions.

Example: MET has been shown to be a highly effective approach for engaging people into treatment. While no studies have examined the use of MET specifically with African American men, based on the overall effectiveness of MET, it is reasonable to extrapolate and pilot this approach within this population. Data from the pilot will determine if extrapolation was an appropriate decision and identify potential MET modifications necessary for the specific population of African American men.

Evidence Suggested

- Consensus driven, or based on agreement among experts.
- Based on values or a philosophical framework derived from experience, but may not yet have a strong basis of support in research meeting standards for scientific rigor.
- Provides a context for understanding the process by which outcomes occur.
- Based on qualitative data, e.g., ethnographic observations.

Example: Experience has shown us the importance of Culturally Competent and Recovery-Oriented Care, yet scientific evidence lags behind the expert and values-based and anecdotal consensus regarding the effectiveness of these approaches.

This expanded view of evidence based practices encourages providers to not only become aware of the level of evidence that supports the utilization of a particular intervention, but to also identify what the next steps may be in increasing the evidence base of those services that anecdotally appear to be effective.

Department of Behavioral Health and Mental Retardation Services

Document 3

Differentiation Between Evidence-Based Practices and Clinical Practice Guidelines

Clinical practice guidelines are developed from research findings or by consensus panels of experts in the field. They are intended to assist clinicians in making more informed decisions about how to treat individuals and families. Clinical guidelines and evidence-based practices share the same purpose: “to translate research into practice, increase the effectiveness of treatment, provide a framework for collecting data about treatment, ensure accountability to funding sources, and to encourage some consistency in practice.” The primary difference between the two is that practice guidelines are developed by reviewing a broad spectrum of research literature to obtain a synthesized picture of what works. Evidence-based practices however, reflect one theoretical approach and provide detailed instructions for how to implement that single approach to treatment (The Iowa consortium for substance abuse research and evaluation, 2003).

A. Guiding Values and Principles

The DBH/MRS’ philosophy regarding evidence-based practices centers around four core values. These are:

1. Consumers and persons in recovery have the right to the highest quality and most effective treatment that is available at any given time.
2. Services should aid consumers in their recovery journey. As such, evidence based practices should not focus on the maintenance of illness, or simply symptom reduction, but rather the promotion of full, functional lives that foster independence and the attainment of personally meaningful goals such as employment, personal relationships and community integration.
3. Evidence based practices need to be culturally competent for the population being served. As such, programs may need to adjust practices to ensure that they are relevant, accessible, and effective for cultural groups that are different from the original study group in language and/or behavior.
4. Evidence based practices should not be chosen and implemented in a vacuum. Instead, providers should collaborate with consumers, family members and other stakeholders when selecting and implementing a practice.

B. Strategies for the Adoption and Implementation of Evidence-based Practices

Research indicates that there are numerous factors that influence an organizations’ level of success in adopting and implementing an Evidence Based-Practice. These include organizational readiness to adopt a new practice, the organizational infrastructure to support the implementation

of the practice, the level of stakeholder buy-in, the level of commitment to devoting resources to the implementation process, attitudes and knowledge about research, the presence of practice-research partnerships (The Iowa consortium for substance abuse research and evaluation, 2003).

C. Recommendations for Action

The Philadelphia Department of Behavioral Health and Mental Retardation Services is embarking on a systematic process to increasingly integrate EBP's into routine service delivery. It is not the expectation of the DBH/MRS at this time that providers select only practices that are supported by rigorous scientific evidence. Instead, the expectation is that providers articulate the type and level of evidence that supports the proposed practice. Additionally, the proposed evaluation of the program must be rigorous enough to assess not only the quality of services provided, but also the effectiveness of the services. The ability to monitor outcomes is one of the foundational components of implementing evidence-based practices. Program outcomes should be relevant and measurable. The more relevant the outcomes are to persons in recovery and to the organization, the more likely it is that the practice will be accepted by stakeholders (Rosswurm & Larrabee, 1999). For the purposes of this RFP, addressing the following issues will accomplish initial steps toward the goal of identifying and integrating EBPs into the Philadelphia behavioral health system of care.

- 1) Upon what level of evidence is the practice/program based?
- 2) What is the nature of that evidence and how was it obtained (e.g. scientific data, expert consensus in the literature, focus group data, program evaluation data, anecdotal positive treatment outcomes during previous implementations of the practice etc.?)
- 3) Upon which population has the practice demonstrated effectiveness and is this comparable to the treatment population of your agency?
- 4) How is the practice likely to increase access to services, engagement and retention rates?
- 5) Can the practice be logistically applied in different setting?
- 6) Is the practice sufficiently operationalized for staff use? Are its key components clearly laid out?
- 7) What evidence do you have to suggest that the practice will be well accepted and supported by providers and persons in recovery?
- 8) How does the practice address cultural diversity and different populations? If the cultural relevance is insufficient, what process will be used to adapt the practice for the cultural groups served by your organization?
- 9) Can staff from a wide diversity of backgrounds and training use the practice?
- 10) What is the plan for continuing to build the level of evidence that supports its implementation with your population?

References

[Mary Ann Rosswurm, June H Larrabee](#) Publication title: [Image -- The Journal of Nursing Scholarship](#). Indianapolis: [Fourth Quarter 1999](#). Vol. 31, Iss. 4; pg. 317, 6 pgs

Resources

Drake, R.E., Goldman, H., Leff, S.H., Lehman, A. F., Dixon, L., Mueser, K.T., Torrey, W.C., Implementing Evidence-Based Practices in Routine Mental Health Service Settings. *Psychiatric Services*. 52, (2), February, 2001.

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Web Sites

Agency for Healthcare Quality and Research

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp>

Iowa Consortium for Mental Health

<http://www.medicine.uiowa.edu/icmh/evidence/>

NRI Center for Mental Health Quality and Accountability

<http://nri.rdmc.org/CMHQA.cfm>

National Association of State Program Mental Health Directors, Research Institute, Inc.

<http://www.nri-inc.org>

Northeast Addiction Transfer Technology Center

<http://www.neattc.org/>

New York State Office of Mental Health

<http://www.omh.state.ny.us/omhweb/EBP/>

Promising Practices Network on Children, Families and Communities
<http://www.promisingpractices.net/>

Substance Abuse and Mental Health Services Administration, National Mental Health Information Center

Toolkits:

Shaping MH Services Towards Recovery Evidence Based Practice Implementation Resource Kits: 1) Illness Management and Recovery, 2) Medication Management Approaches in Psychiatry, 3) ACT, 4) Family Psychoeducation, 5) Supported Employment, 6) Co-Occurring Disorders

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp>

The National Implementation Research Project at the University of South Florida

<http://nirn.fmhi.usf.edu/>

<http://www.mhanys.org/ebpdb/>

Department of Behavioral Health and Mental Retardation Services

Document 4

Implementing Culturally Competent Services

A. What is Cultural Competence?

The Philadelphia Department of Behavioral Health and Mental Retardation Services views systems of care and programs as culturally competent to the extent that they provide *effective* services to members of diverse backgrounds. Cultural competence is the acceptance and respect for difference, continuing self-assessment regarding one's own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations (Cross, Brazron, Dennis & Isaacs, 1998). A culturally competent system of care/service incorporates skills, attitudes and policies to ensure that it is effectively addressing the treatment and psychological needs of service recipients irrespective of their race, gender, religion, language, age, physical or mental status, diverse values or beliefs, sexual orientation, and ethnic or cultural background.

Implementing cultural competence is a complex, multi-level process involving interactions at different levels within the behavioral health system as well as interactions with the community and other provider agencies. In a culturally competent system, there is:

1. Access to care
2. Client engagement and retention in services
3. Effective treatment services
4. Supports in the community that facilitate recovery and community integration

B. Why Cultural Competence?

Cultural competence is a critical component of recovery-oriented services, because persons with behavioral health conditions do not share equally in the hope for recovery. The Surgeon General's report on Mental Health (1999) indicates that more than other areas of health and medicine, the behavioral health field is beset with disparities in the availability of, and access to, its services. These disparities are related to racial and cultural variables, age and gender. Not only are minorities less likely to receive needed behavioral health services, but national research indicates the treatment received is not of equal quality. Minorities are also under-represented in mental health research and experience a greater burden of disability. While these disparities occur in healthcare in general, as a recovery-oriented system of care, we must identify those persons or groups in Philadelphia who are experiencing disparities and ensure that they are equitably served with full access to effective services.

C. Causes of Behavioral Health Disparities

The root causes of behavioral health disparities are complex. Research indicates that while socioeconomic factors significantly influence access to treatment, they do not account for all of the existing disparities. In addition to the barriers that all Americans face when attempting to access services (e.g. cost, fragmented services, limited availability of services, and societal stigma), minorities contend with an additional constellation of barriers. These include; language and communication differences, fear and mistrust of the system, and limited provider understanding of cultural expression of distress among others (Supplement to the surgeon General's Report, 2001). The cumulative interaction of all of the barriers to receiving effective care, lead to behavioral health disparities. Cultural competence is a mechanism for provider to address many of the barriers to care and ensures that services are compatible with the cultural beliefs, practices, and languages of those served.

D. Guiding Values and Principles

Adapted from the Culturally Competent Guiding Values and Principles, National Center for Cultural Competence (NCCCC), Georgetown University Center for Child and Human Development

Consumer and Family

1. Family, consumers, and persons in recovery are the ultimate decision makers for services and supports for their children and /or themselves (Goode, 2002).
2. Family is defined differently by different cultures and is usually the primary system of support and preferred intervention (Goode, 2002).

Organizational

1. Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery. (Cross et al., 1989).
2. Systems and organizations incorporate cultural knowledge into policy making, infrastructure and practice (Cross et al., 1989).

Practice and Service Design

1. Culturally competent organizations design and implement services that are tailored to the unique needs of the persons, families, organizations and communities served (Cross et al., 1989).
2. Practice is driven in service delivery systems by consumer and recovering persons' preferred choices, not by culturally blind or culturally free interventions (Cross et al., 1989).

Community Engagement/ Natural Support

1. Community engagement should result in the mutual transfer of knowledge and skills among all collaborators and partners (Taylor and Brown, 1997).
2. Communities determine their own needs and community members are full partners in decision-making (Taylor and Brown, 1997).

3. Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood civic and advocacy associations, local merchants and alliance groups, religious organizations, and spiritual leaders and healers) (Cross et al., 1989).

E. Recommendations for Action

Modification of recommendations developed by the National Technical Assistance Center for State Mental Health Planning

We encourage providers responding to this RFP to carefully review this set of recommendations when submitting your proposals. It is the expectation of the DBH/MRS that these recommendations will be integrated into the organizational structure of provider agencies over the course of the first twelve to eighteen months.

Organizational Level

1. Executive leaders personally lead the cultural competence initiative to make it clear that cultural competence is a high priority.
2. A person exists with overall responsibility for cultural competence at an executive level. That person has the responsibility for review of major policies and agency products to ensure that cultural competence is included and/or addressed.
3. Cultural competence is addressed in job descriptions and performance appraisals of senior management staff.
4. Each agency should form a Cultural Competence Advisory Committee comprised of broad community representation including consumers, family members, staff at all levels and a person who is deaf or hard of hearing. The Committee should also be representative of the major race/ethnicity groups in the County (groups that are greater than 5% of the City population). The Committee is responsible for reviewing policies and making recommendations related to cultural competence. The Committee receives reports related to the implementation status of its recommendations. The Executive Director meets periodically with the Committee. Skeptics should be included as well as stakeholders to ensure well-rounded feedback.
5. Each agency should perform an organizational self-assessment. The self-assessment should include a full review of all existing cultural competence initiatives, as well as population and service assessments. Identifying potential disparities through data analysis and monitoring reports can inform the process. The assessment should include multiple levels, workforce analysis, and a description of how the system promotes cultural competence formally (e.g. hiring practices) and informally (multi-cultural events). The assessment occurs periodically (at least every two years).

6. Each agency should develop an agency-wide Cultural Competence Plan.
 - a. The plan should cover all administrative organizational components in its purview. (That is, cultural competence should be a requirement and responsibility at all administrative and organizational levels).
 - b. The cultural competence plan specifically addresses disparities identified through analyses.
 - c. The cultural competence plan has measurable objectives; is reviewed annually, feedback is provided to responsible entities related to the accomplishment of objectives.
 - d. The cultural competence plan is disseminated widely through the organization.
 - e. The cultural competence plan includes the development of culture specific services.
7. To identify disparities, executive leaders should require analyses related to utilization, performance measures, and outcomes by developing a cultural profile of the populations to be served and the populations actually served. Race/ethnicity data elements include: race, ethnicity, age, gender, poverty level, language spoken, country of origin and religion.
 - a. Analyses should be completed for different sub-populations (children, adolescents, elderly, persons with serious mental illness, homeless, etc.). Analyses should be done specifically on linguistic access and on first interactions with the system (for example, examine persons with only one contact with the system by race/ethnicity).
 - b. Agency monthly, quarterly and annual reports related to utilization, performance measures, and outcomes routinely include race/ethnicity breakouts.
 - c. Analyses are regularly conducted to examine disparities in services (medications, rehabilitation, clinical, in-home, etc.)
8. Agency policies and procedures and standards of care specifically address cultural competence.
9. Cultural competency practices are included in new staff orientation and in on-going training and support for all staff.
10. Providers must ensure that the composition of staff at all levels reflects the diversity of the populations served, including at the executive level.
11. Cultural competency is specifically included in quality improvement activities.
12. A key aspect of cultural competence is linguistic competence and access. Persons with limited English proficiency (including those who are deaf or hard of hearing and prefer to use sign language) need to have access to bi-lingual staff or qualified interpreters or translators. A qualified mental health interpreter is sufficiently fluent in both target and source languages so that they are able to accurately interpret to and from either language using any specialized vocabulary needed.

- a. Data is available related to the language needs of the population to be served and persons receiving services.
 - b. Language skills of staff are monitored and updated.
 - c. Provider and service directories are available in key languages.
 - d. Provider and service directories include information on language assistance available at its organizational components.
 - e. Culturally relevant and linguistically appropriate information regarding behavioral health services, as well as non-traditional and self-help resources are disseminated in a wide variety of formats.
13. Quality of life is recognized as a holistic integration of symptom reduction, family relationship, community support and integration, and spirituality. These domains are related to the individual's sense of personal meaning, fulfillment and well being in recovery. Every provider must assess the quality of life for all individuals receiving services, collected on "pre" and "post" instruments.

F. Evaluation of Cultural Competence

Within eighteen months of service implementation, a cultural competency evaluation will be conducted and may include, but not be limited to the following areas:

1. Executive leadership and staff and stakeholder participation
2. Cultural Competence Advisory Committee
3. Organizational Self-Assessment
4. Cultural Competence Plan
5. Data analysis – e.g. service utilization rates, performance measures, and outcomes by specific sub-populations
6. Administrative policies and procedures, standards of care and quality management
7. Training
8. Staff composition
9. Linguistic competence
10. Community engagement

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Resources

Print Resources

[Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. \(2000\). U. S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration.](#)

[Cultural Issues in Substance Abuse treatment. \(1999\). Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.](#)

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Supplement to Mental Health: Report of the Surgeon General
http://www.mentalhealth.org/cre/default.asp](http://www.mentalhealth.org/cre/default.asp)

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www.hogg.utexas.edu/PDF/Saldana.pdf](http://www.hogg.utexas.edu/PDF/Saldana.pdf)

The California Endowment
www.calendow.org

- Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals, 2003
- A Manager's Guide to Cultural Competence Education for health Care Professionals, 2003
- Resources in Cultural Competence Education for Healthcare Professionals, 2003

Center for Effective Collaboration and Practice
http://cecp.air.org/cultural/Q_howstart.htm

The Cross Cultural Health Care Program
www.xcultre.org

Diversity Rx – Resources for Cross-Cultural Healthcare
<http://www.diversityrx.org>

Hogg Foundation for Mental Health
Cultural Competency: A Practical Guide for Mental Health Service Providers
<http://www.hogg.utexas.edu/PDF/Saldana.pdf>

Minnesota Department of Human Services
Guidelines for Culturally Competent Organizations
http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/DHS_id_016415.hcsp

National Center for Cultural Competence
<http://www.georgetwon.edu/research/gucdc/nccc/>

National Mental Health Association
www.nmha.org

Substance Abuse and Mental Health Services Administration
National Mental Health Information Center

- Mental Health Topics: Culture and Ethnicity
<http://www.mentalhealth.org/topics/explore/culture/>

U.S. Department of Health and Human Services

- The Health Resources and Services Administration
Indicators of Cultural Competence In Healthcare Delivery Organizations
<http://www.hrsa.gov/omh/cultural1.htm>
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<http://www.surgeongeneral.gov/library/mentalhealth/cre/>

**The definitions, values, principles and cultural competence practices contained in this section are preliminary. They will be further developed in the future based on recommendations from the Philadelphia Multicultural Advisory Committee.*

Department of Behavioral Health and Mental Retardation Services

Document 5

Implementing Trauma-Specific Services in Trauma-Aware Settings: Why a Need to Develop Trauma-Specific Services in Trauma Aware Settings?

A. Introduction

As indicated in the Surgeon General's Report on Mental Health (1999), "critical gaps exist between those who need service and those who receive services...*between optimally effective treatment and what many individuals receive in actual practice settings.*"

Most individuals receiving services from public behavioral health systems have histories of interpersonal violence, abuse and neglect that begin in childhood. The impact of childhood abuse and trauma is immense for individuals and serves as a major barrier to successful entry into recovery, and, unless acknowledged and addressed, is detrimental to outcomes of almost all components of recovery oriented treatment and services.

At present, most services do not assess for nor address these trauma issues (compiled by Bloom)

- 90% of persons receiving services have been exposed to and most have experienced multiple incidents of trauma
- 75% of women and men being treated for chemical dependence report abuse and trauma histories
- 97% of women with mental illness who are homeless have been severely sexually and/or physically abused; 87% had these experiences both as children and as adults
- 81% or more of individuals diagnosed with Borderline Personality Disorder report sexual and physical abuse as children, most perpetrated by their fathers
 - Childhood abuse can result in adult experience of shame, flashbacks, nightmares, severe anxiety, depression, alcohol & drug use, feelings of humiliation & unworthiness, ugliness & profound terror. (Harris, 1997; Carmen, 1995; Herman, 1992; Janoff-Bulman & Frieze, 1983; van der Kolk, 1987; Browne & Finkelhor, 1986; Rimsza, 1988)
- In one study 90% (n= 475) of individuals receiving behavioral health services reported at least one severe experience of trauma; 40% of them met the criteria for PTSD. Of these 2% had that diagnosis noted in their records
- Persons with Post Traumatic Stress Disorder often experience multiple co-occurring behavioral health problems and disorders (Bloom)

Ignoring and neglecting to address trauma have extensive implications for the Behavioral health System and Provider Organizations

- Increased use of high-end services and resulting costs incurred (Bloom,
- Staff exposed to material from persons with abuse and trauma histories do not receive essential support to keep them effective and well; they often experience secondary trauma (Saakvitne, 2000)

- Development of non-constructive organizational cultures, norms and interactions with persons being served

Examples (Bloom,):

- ✓ Continuous crisis
- ✓ Collective denial of problems – we’re ok
- ✓ Isolation, over-control, manipulation
- ✓ Unclear boundaries
- ✓ Atmosphere of blame
- ✓ Intolerance for differences, diversity, creative problem-solving
- ✓ Open expression of positive emotion discouraged
- ✓ Loss of sense of humor
- ✓ Negative emotions tolerated or even encouraged
- ✓ Culture of toughness, harshness
- ✓ Violence or threat of violence used to control others

B. Definition of “Trauma-Specific” and “Trauma-Informed” (Jennings, 2004)

Examples (Harris & Falot, 2001; Saakvitne, 2000):

- Grounding techniques that help survivors of trauma manage dissociative symptoms and/or anxiety
- Behavioral therapies which teach skills for the modulation of powerful emotions
- Programs designed specifically for survivors of childhood trauma are consistent on several points:
 - ✓ Need for safety, respect, information, connection, and hope for persons being served
 - ✓ Importance of recognizing the adaptive function of “symptoms;” and the need to work in a collaborative empowering way with survivors of abuse

Trauma-specific service models should be delivered within a relational framework that is based upon empowerment of the survivor and creation of new connections. (Herman, 1992)

- Relational damage and betrayal that occur when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust
 - ✓ These patterns have great impacts on individuals and their ability to relate to others and to achieve the kind of lives they want.
 - ✓ Recovery cannot occur in isolation.

Trauma-specific services promote recovery-oriented relationships with practitioners and peers characterized by belief in gentle *persuasion* rather than coercion, *ideas* rather than pressure, confrontation or force, and mutuality rather than authoritarian control. These are exactly the beliefs that were shattered by the original traumatic experiences (Herman, 1992).

C. Rationale, Guiding Values and Principles

A core value of The Department of Behavioral Health and Mental Retardation Services is that a recovery-oriented system of care is one that provides the highest quality and most effective behavioral health services to consumers and persons in recovery.

Trauma-specific and trauma-informed services are essential to the success of such recovery-oriented, integrated services. Failure to develop services that address the painfully damaging experiences of childhood abuse and trauma actually prevent services from supporting and promoting recovery.

Providing trauma-specific services in trauma-informed settings is essential to transitioning our current system of behavioral health care to one that is recovery-oriented. Failure to address these issues mitigate against achieving the components of recovery-oriented services, including collaborative, strengths-based, consumer-driven, person-centered approaches that build upon hope and dignity and promotes the highest levels of autonomy and personal responsibility.

Persons recovering from behavioral health problems and disorders have themselves begun to address trauma and childhood abuse as part of their own ongoing processes and some have written self-help guides and manuals to be used by individuals to help themselves as well as provide support to their peers (Copeland, 2002; Copeland and Harris, 2000; Copeland and Mead, 2004, among others).

C. Recommendations for Action

- **Move away from an illness/symptom-based model to an injury/trauma recovery-oriented model—**
 - Shift from asking the question, “What is wrong with you?” to “What happened to you?”
 - Without such a shift in both perspective and practice, the dictum to “Do no harm” is compromised, recipients of mental health services are hurt and re-traumatized, recovery and healing are prevented, and the transformation of behavioral health care will remain a vision with no substance in reality.

- **Consumer/Trauma Survivor/Recovering Person Involvement and Trauma-Informed rights.**
 - The voice and participation of individuals being served by behavioral health systems, including those who identify themselves as trauma survivors, should be at the core of all systems activities—from policy and financing to training and services.
 - Trauma-informed individualized plans of care should be developed *with* every adult and child receiving behavioral health system services.
 - Consumers with trauma histories should be significantly involved and play a lead role in orienting the mental health system toward trauma and recovery.

- Procedures and practices need to be in place that inform individuals of their rights within service settings with specific rights related to people with trauma histories (e.g., right to trauma treatment, freedom from re-traumatization)
 - Individuals need to be informed of these rights as well as what constitutes violations
 - Grievance procedures need to be developed and effectively communicated to persons being served and staff. (*See Recommendations 2.1,2.2, 2.3, 2.4, and 2.5 of the President’s New Freedom Commission on MentalHealth final report [2003]*)

- **Clinical practice guidelines for working with people with trauma histories.**
 - Findings from studies, including SAMHSA’s Women, Co-Occurring Disorders and Violence study, provide evidence that trauma treatment is effective.
 - Several clinical approaches have been manualized and guidelines have been developed.
 - Include trauma-sensitive training and supervision
 - Practitioners should be perceived as respectful, caring, in partnership with consumer/survivors.
 - Address Vicarious Traumatization in staff
 - Supervision, peer-supervision, self-care for the caregiver

- **Trauma screening and assessment.**

(*See Recommendations 4.1, 4.2, 4.3, and 4.4 of the President’s New Freedom Commission on Mental Health final report [2003]*)

- **Trauma-specific services in trauma-informed settings**
 - A “trauma-informed” service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services.
 - A “trauma-informed” organizational setting is capable of supporting and sustaining “trauma-specific” services as they develop.
 - All clinical, rehabilitation, peer support and administrative and support staff should have basic understanding of trauma and trauma dynamics—including trauma caused by childhood or adult sexual and/or physical abuse
 - Review existing trauma-specific and trauma-informed models- see references and the following:

Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services

2004--Prepared by: Ann Jennings, Ph.D. for
National Technical Assistance Center
for State Mental Health Planning (NTAC),
National Association of State Mental Health Program Directors (NASMHPD)
Under contract with the Center for Mental Health Services (DMHS), Substance abuse
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Department of Behavioral Health and Mental Retardation Services

Document 6

Promoting Resilience for Children and Families

A. Introduction

The *Surgeon General's Report on Mental Health* clearly articulates that “mental health is fundamental to overall health and well-being.” In transforming the system, the Office of Behavioral Health is shifting to a new paradigm that engenders hope and optimism not only for our consumers but for practitioners as well. As part of the shift to a resilience orientation, we depart from a focus on services for at risk children and families to concentrate on services that promote self-esteem, social, emotional, and behavioral well-being as a fundamental part of a child’s and his/her family’s optimal development. A resilience orientation is in line with two central rudiments of our vision for reorienting Philadelphia’s Behavioral Health System: the empowerment of families and youth at all levels of the service system and a focus on their hopes and strengths. This necessitates a different lens for how we view children and families in our system of care. To quote Dr. Margaret Beale Spencer, we “explore youths’ and families’ emerging capacity for healthy outcomes and constructive coping methods while developing under difficult and stressful conditions”. The essence of the message we want to convey is best articulated in the words of Paulo Freire -“Respect for the autonomy and dignity of every person is an ethical imperative and not a favor we may or may not concede to each other”.

B. What is Resiliency?

Resilience has been described as an individual’s capacity for growth, recovery or improvement in behavioral health following life challenges (Ryff, Singer, Dienberg, Love & Essex), successful adaptation following exposure to stressful life events (Werner, 1989) and an individual’s capacity for transformation and change (Lifton, 1993).

C. Resiliency Paradigm: Critical Rationales

More powerful than risk factors are the protective bulwarks of caring relationships, high expectations, and opportunities for meaningful participation that serve to shield children across ethnic, social class, geographical, and historical boundaries. The shift to a resiliency paradigm engenders hope and optimism not only for our consumers but for us as well. This is a point where the concept of resiliency mirrors the recovery model that will be the basis for adult treatment in mental health. This new paradigm will in turn not only effect positive treatment outcomes but also can prevent the burn out that Behavioral Health Professionals sometimes experience when consumer’s response to their interventions is not what was expected; not effective.

The extant body of research points to the lethal effects of programs that label and track youngsters, further stigmatizing those with behavioral health problems. In transforming our system we want to foster a sense of self-efficacy. Everyone has the innate capacity for behavioral health and well-being. Services need to be conceptualized with a focus on protective factors thus offering a more buoyant outlook than the perspective that can be gleaned from the literature on the negative consequences of perinatal trauma, care giving deficits, and chronic trauma. (Werner 1994). We must choose the most effective strategies and approaches for preventing the development not only of alcohol and other drug abuse as well as the concomitant problems of teen pregnancy, delinquency, gang violence, and school failure. Such services must enhance the most favorable human development by interlacing the concept of resiliency in all aspects of prevention, intervention and treatment as well as in our behavioral health policies and standards.

Regrettably, developmental psychology has been historically framed within a deficit perspective regarding youth. Research also illustrates that there are a number of risk factors that augment the chances of adolescents developing health and behavior problems. However, certain protective factors can help shelter youngsters from problems. In her synthesis of the resiliency literature, Bonnie Bernard, a prevention researcher, unearthed the key protective factors in young people's families, schools and communities, describing them as follows:

- Having a caring and supportive relationship with at least one person.
- Communicating consistently clear, high expectations to the child.
- Providing ample opportunities for the child to participate in and contribute meaningfully to his or her social environment.

Fortunately, in times of crisis, behavioral health professionals can also be as instrumental, as parents and peers, in helping children learn resiliency skills so that they can rebound from adversity by offering guidance and support.

D. Recommendations for Action

- Integrating resiliency as well as cultural factors in planning, implementing, and evaluating services.
- Basing services on an individualized, comprehensive holistic assessment that identifies the child's resiliency traits.
- Encouraging full family participation in planning, implementing and evaluating services.
- Acting as brokers or guides to help consumers navigate the complicated system of services in the communities.
- Promoting self-acceptance, hope and optimism for the future in all interventions.
- Supporting active participation in a community of faith.
- Fostering ethnic pride, role adaptability, resourcefulness, community involvement and family unity in family interventions.
- Enhancing bonding, parental monitoring and other parenting practices in all prevention interventions.
- Promoting consumer and family voices in policy and decision-making arenas.
- Incorporating gender –specific interventions that promote optimal psychological development in programs planned for children and adolescents.

- Reducing the affect of environmental stressors, such as poverty, neighborhood violence through the use of interventions that promote protective factors.
- Working with other systems to find more effective methods to intervene with families in order to reverse the trend of placing children in the dependant, delinquent and behavioral health systems.

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APPENDIX B

CBH - PROVIDER AGREEMENT

This Agreement is made as of January 1, 2007, by and between COMMUNITY BEHAVIORAL HEALTH ("CBH"), a Pennsylvania not-for-profit corporation and «**Contract_Name**», a _____ ("Provider") together with those Subcontractors of Provider which are identified on and made a party hereto by the Joinder Agreement attached hereto as Exhibit A.

BACKGROUND

CBH is in the business of arranging for, monitoring and managing the provision of behavioral health services by health care providers to people who reside in the City of Philadelphia; and

CBH has entered into a contract with the City of Philadelphia to perform professional services under a contract between the City and the Commonwealth of Pennsylvania Department of Public Welfare to administer the HealthChoices Behavioral Health Program; and

Provider is a licensed health care professional, facility or other provider of behavioral health services; and

CBH and Provider mutually desire to preserve and enhance patient dignity for the recipient population described further herein; and

This Agreement shall apply to the provision of behavioral health services to Enrollees eligible under the Program.

In consideration of the mutual promises herein contained, the parties hereto, each intending to be legally bound, agree as follows:

I. General Terms.

A. *Incorporation of Background.* The Background is incorporated by reference herein.

B. *Definitions.* The following terms, as used in this Agreement, shall have the meanings set forth below:

- (1) "Agreement" shall mean all of the Agreement Documents.

(2) "*Agreement Documents*" shall mean this Provider Agreement, the Contracts, the Program Standards and Requirements, the Provider Manual and any and all other documents, schedules and exhibits incorporated or referenced in this Provider Agreement, and any and all amendments to any of these documents. For purposes of interpreting this Agreement, in case of a conflict among the Agreement Documents and this Agreement the following hierarchy shall pertain: In case of conflict between this Agreement and a statutory or regulatory requirement (a "Law"), the Law shall control. Thereafter in case of a conflict between this Agreement and the Commonwealth Contract, the Commonwealth Contract shall control. In case of a conflict between this Agreement and the City Contract, the City Contract shall control. In case of a conflict between this Agreement and the Program Standards and Requirements, this Agreement shall control. In case of a conflict between this Agreement and the Provider Manual, this Agreement shall control. CBH shall provide a copy of any of the Agreement Documents upon Provider's request, except Exhibit A of Amendment I of the Commonwealth Agreement.

(3) "*Alternative and/or Supplemental Behavioral Health Care Services*" shall mean such behavioral health care services which are not In-Plan Services but which CBH, in its sole discretion, determines shall be considered Covered Services for a specific Provider. Approved Alternative and/or Supplemental Behavioral Health Care Services, if any, shall be identified in the rate schedule attached hereto as Schedule A.

(4) "*Authorization(s)*" shall mean the documented formal written approval of CBH in accordance with the Provider Manual for care provided to HealthChoices Enrollees.

(5) "*Clean Claim*" shall mean a claim that can be processed without additional information from the Provider of the service or from a third party. A Clean Claim does not include: claims pended or rejected because they required additional information from a provider or from internal sources (i.e. claims pended for a determination of third party liability etc.); a claim under review for medical necessity; or a claim submitted by a Provider reported as being under investigation by a governmental agency, the City or CBH for fraud or abuse. However, if under investigation by the City or CBH, DPW must have prior notice of the investigation.

(6) "*Clean Rejected Claim*" shall mean a claim that is returned to the Provider or a third party due to ineligible recipient or service.

(7) "*Contracts*" shall mean the contract between CBH and the City of Philadelphia ("City") to perform professional services (the "City Contract") and the contract between the City and the Commonwealth of Pennsylvania Department of Public Welfare (the "Commonwealth Contract") to administer the HealthChoices Behavioral Health Program (the "Program") together with their exhibits and attachments, each of which are incorporated herein by reference and made a part of this Agreement.

(8) "*Coordination of Benefits*" shall mean those provisions by which City, CBH and Provider, either together or separately, seek to recover costs of Covered Services provided for an incident of sickness or accident on the part of the Enrollees, which may be covered by another insurer, service plan, government, third party payor, or other organization, from said insurer, service plan, government, third party payor, or other organization.

(9) "*Covered Services*" shall mean those Medically Necessary behavioral health services set forth in Schedule A attached hereto for which CBH has credentialed or otherwise authorized Provider in writing to provide to Enrollees in accordance with the terms and conditions set forth in this Agreement. Covered Services shall include In-Plan Services, Emergency Behavioral Health Services, and Alternative and/or Supplemental Behavioral Health Care Services. Services which are not Medically Necessary shall not be compensable for purposes of this Agreement, except as otherwise provided herein.

(10) "*Cultural Competency Program*" shall mean policies, procedures and practices designed to ensure consideration of the differences in cultural values, languages, help-seeking strategies and communication styles of Enrollees.

(11) "*Department of Public Welfare*" or "*DPW*" shall mean the Commonwealth of Pennsylvania, Department of Public Welfare.

(12) "*DSS CARES Software*" shall mean the software provided by the City of Philadelphia to Provider for use in the performance of its duties under this Agreement, as applicable.

(13) "*Eligibility Verification System ("EVS")*" shall mean the automated system made available to Providers for on-line verification of eligibility for Medical Assistance, prepaid capitation, HMO or MCO enrollment, third party resources, and scope of benefits.

(14) "*Emergency Behavioral Health Services*" shall mean services provided after sudden onset or exacerbation of a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate behavioral health attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any organ or part.

(15) "*Enrollee*" shall mean a person who DPW has determined to be eligible to receive behavioral health services under the Program and has so indicated in its Eligibility Verification System ("EVS").

(16) "*Event of Insolvency*" shall mean (a) the filing of a voluntary petition by Provider under the Federal Bankruptcy Code or any similar state or federal law; or (b) the filing of an involuntary petition against Provider under the Federal Bankruptcy Code or any

similar state or federal law which remains undismissed for a period of forty-five (45) days; or (c) Provider's making of an assignment for the benefit of creditors; or (d) the appointment of a receiver for Provider or for the property or assets of Provider, if such appointment is not vacated within forty-five (45) days thereafter; or (e) any other proceeding under any bankruptcy or insolvency law or liquidation law, voluntary or otherwise.

(17) "*In-Plan Services*" shall mean those behavioral health services defined in the Program Standards and Requirements as "In-Plan Services".

(18) "*Medical Necessity*" or "*Medically Necessary*" shall mean the clinical determination by CBH in accordance with processes set forth in the Provider Manual, to establish a service or benefit which will, or is reasonably expected to (a) prevent the onset of an illness, condition, or disability; or (b) reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury or disability; or (c) assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

(19) "*Notice*" shall, except as expressly stated otherwise herein, mean written notice delivered by hand delivery, sent by certified or registered mail, postage prepaid, or by commercial overnight carrier to the address set forth in Article XII herein.

(20) "*Participating Provider(s)*" shall mean licensed physicians and other health care professionals, hospitals, residential treatment facilities, outpatient facilities or other providers of mental health and/or substance abuse services which meet CBH's credentialing standards and have entered into an agreement with CBH to provide services under the Program; collectively, all Participating Providers are referred to herein as "the Network."

(21) "*Primary Care Practitioner*" shall mean a specific physician, physician group, or health center with a Participating Provider contract with HealthChoices program to provide medical care, operating under the scope of individual licensure responsible for providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services on behalf of an Enrollee.

(22) "*Provider Manual*" shall mean that manual by the same name published at www.phila-bhs.org and issued by CBH to Provider, including all amendments, updates and bulletins relating thereto.

(23) "*Program Standards and Requirements*" shall mean the Behavioral Health Program Standards and Requirements issued by DPW as amended, and containing the participation requirements and the terms and conditions of the HealthChoices Behavioral Health Program, including all amendments, appendices, and exhibits attached thereto, which is incorporated herein by reference and made a part of this agreement. A copy of the Program Standards and Requirements shall be provided to Provider upon written request to CBH.

(24) “*Settlement*” shall mean an agreement between Provider and a government agency to terminate action, which could lead to additional penalties, or repayment of monies previously paid, other than on a claim-by-claim adjudicated basis.

(25) “*Subcontract*” shall mean a contract subordinate to this Agreement, made between Provider and a Subcontractor.

(26) “*Subcontractor*” shall mean an individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other entity that is not an employee of Provider but that meets the credentialing requirements of CBH and has executed a Joinder Agreement in the form set forth in Exhibit A hereto, and who/that has contracted with or otherwise been engaged by Provider, for the performance of all or a part of the work or services which Provider has contracted to perform under this Agreement.

(27) “*Unclean Rejected Claim*” shall mean a claim that is returned to the Provider or third party for additional information.

II. Responsibilities of Provider.

A. *Covered Services.* Throughout the term of this Agreement, Provider shall:

(1) Render Medically Necessary Covered Services to Enrollees in accordance with the credentials granted by CBH and the terms and conditions of this Agreement as more fully set forth herein;

(2) Satisfy any applicable credentialing standards as set forth in the Provider Manual and cooperate with CBH or its delegate in conducting credentialing and recredentialing activities; comply with all applicable federal and state certification and licensing laws and regulations; perform services hereunder in accordance with the standard of care to which Provider is held at law and adhere to all applicable mental health and drug and alcohol program regulations and policy directives, unless a waiver is granted by the Commonwealth of Pennsylvania.

(3) Maintain hours of operation for Enrollees that are no less than the hours of operation maintained by Provider for enrollees of all other third party payors or, if Provider serves only Medicaid Members, hours of operation no less than hours maintained by Provider for Medicaid fee-for-service enrollees.

(4) Notify CBH within five (5) days of Provider’s becoming aware, at any time during the term hereof including any renewal term, of (i) any change in Provider’s accreditation or other certification status, (ii) an Event of Insolvency, (iii) any event which results in or is likely to result in an involuntary change in the location, range or scope of services offered by Provider, or (iv) Provider’s failure, for any reason to satisfy or comply with any of the credentialing standards, laws, rules or regulations described herein or in the Provider Manual;

(5) Provide CBH no less than forty-five (45) days Notice of any anticipated voluntary change in the location, range or scope of services offered by Provider;

(6) Comply and require any Subcontractors to comply with all rules, regulations, policies and protocols implemented by CBH including, but not limited to, rules pertaining to eligibility verification, preauthorization, billing procedures, utilization management and quality assessment/quality improvement, credentialing, peer review, encounter and outcomes reporting, risk management, provider training and orientation, and grievance systems and appeal procedures as set forth in the Provider Manual and this Agreement. CBH shall not take any adverse action against Provider for assisting an Enrollee in the understanding of or filing of a complaint or grievance under the Enrollee complaint and grievance system. If at any time a Subcontractor or individual providing services on behalf of a Subcontractor ceases to comply with the terms of this Article II.A.6 or any applicable section of this Agreement, CBH may demand that the Provider either terminate its agreement with the Subcontractor, or that the Subcontractor cease allowing the individual in question to perform services for Provider hereunder;

(7) Accept as patients any and all Enrollees who are referred to Provider and provide Covered Services on a non-discriminatory basis which shall not discriminate or differentiate in the treatment of Enrollees based on color, creed, age, sex, sexual preference, marital status, religion or otherwise, including by reason of the fact that certain patients are Enrollees, and in a manner which enhances the continuity of Covered Services, and which are of a quality consistent with the standards of nationally recognized organizations in Provider's discipline and accepted practices in the community;

(8) Cooperate with and participate in Coordination of Benefits as set forth in the Provider Manual and indemnify and hold harmless CBH for any costs, claims, damages or losses (including reasonable attorneys' fees) arising out of any failure of Provider to cooperate with and participate in Coordination of Benefits hereunder. Provider understands that, with the exception of Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services to children pursuant to Chapter 1241 of Title 55 of the Pennsylvania Code, all other private or governmental health insurance benefits shall be utilized before submitting claims to CBH. Provider shall make reasonable efforts to secure from the Enrollee sufficient information regarding the primary coverage necessary to bill such insurers or programs;

(9) Prior to rendering services, verify the eligibility of Enrollees to whom Provider seeks to provide Covered Services, in accordance with procedures set forth in the Provider Manual. Provider agrees to repay to CBH, immediately upon request, any amounts received for services rendered to Enrollees who CBH determined, within twelve (12) months of the date of payment by CBH for the service, were ineligible for coverage at the time of service, or who CBH determines, within eighteen (18) months of the date of payment by CBH for the service, were deceased on the date of service. Notwithstanding a subsequent determination by CBH that the Enrollee was not eligible for benefits at the time of service, Provider shall be entitled to payment for Covered Services rendered to Enrollees for whom Provider obtained

proof of eligibility of such Enrollee at the time of service from DPW and can demonstrate to CBH that Provider obtained such proof of eligibility;

(10) Interact and coordinate services with the Enrollee's primary care physician ("PCP") as specified in the Provider Manual. Pursuant to such coordination, Provider shall make referrals for social, vocational, education or human services when needed, provide Enrollee health records to Enrollees' PCPs as requested, comply with the Agreement Documents to assure coordination of services and to resolve clinical disputes and be available to the PCP for consultation regarding Enrollees. In furtherance of such coordination efforts, Provider shall make good faith efforts to obtain written consent from Enrollees to exchange clinical information with the Enrollee's PCP and the Enrollee's insurer for physical health services. Provider shall maintain signed consent forms in the Enrollee's medical record. Provider shall document all attempts to obtain such consent for release of information as described herein, and in the event an Enrollee refuses to sign a consent form; Provider shall document such refusal in the Enrollee's medical record. Failure by Provider to obtain such a release after good faith efforts shall not be grounds for termination of this Agreement;

(11) In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth, render all services provided for in this Agreement to the extent practical within the limits of Provider's facilities and staff which are then available;

(12) Cooperate and comply with any external quality assurance program used by DPW in connection with the services provided hereunder including consumer and family satisfaction programs implemented by CBH pursuant to the Contracts and the Program Standards and Requirements, and DPW's independent consumer and family satisfaction assessments. Such cooperation shall include assisting in the identification and collection of any data or clinical records to be reviewed as part of any such external program;

(13) Comply with (a) applicable provisions of the City Contract as "CBH" hereunder or, where the term "Provider" is used, as the "Provider" hereunder; (b) the terms of Exhibit PA-6 of the City Contract (relating to use and disclosure of Protected Health Information) as "CBH", as applicable; (c) provisions of the waiver approved by the Department of Health and Human Services in connection with DPW's implementation of the Program; and (d) all applicable present and future court orders, injunctions and decrees, laws, rules, regulations, interpretations and requirements of any federal, state or local court, administrative agency or governmental body, including the City of Philadelphia, the Commonwealth of Pennsylvania and the United States. A copy of the City Contract shall be provided to Provider upon written request to CBH;

(14) Not employ or engage to provide services hereunder any individual who is ineligible to participate in the Medicaid program;

(15) Disclose to CBH in writing, the name of any person or entity

having a direct or indirect ownership or control interest of 5% or more in the Provider. The Provider shall inform CBH in writing within five (5) days of any change in or addition in the ownership or control of Provider;

(16) Provider may request that an Enrollee be transferred to another Participating Provider if (a) the Enrollee requires services other than those for which CBH has credentialed Provider; (b) or it is determined by a healthcare professional qualified to make such determination, that such transfer is medically appropriate; or (c) Provider is unable to establish a working relationship with the Enrollee. Any other requests for transfer of an Enrollee will be granted in CBH's sole discretion.

B. *Books and Records.* Throughout the term of this Agreement, Provider shall:

(1) Maintain all books, records and other evidence pertaining to revenues, expenditures pursuant to this Agreement in accordance with standards and procedures set forth in the Provider Manual and Appendix W (Audit Clause) to the Commonwealth Contract as the "Contractor" hereunder and provide access to such books, records and other evidence upon reasonable notice and during normal business hours to CBH, its employees, contractors and subcontractors, state and federal government agencies as may be necessary for compliance by CBH with state and federal law, as well as for program management purposes. Provider shall use good faith efforts to develop and maintain a corporate compliance program in accordance with standards set forth in the Provider Manual with the objective of preventing fraudulent billing and/or embezzlement of funds. In addition, Provider shall use good faith efforts to develop and maintain a Cultural Competency Program in accordance with standards set forth in the Provider Manual.

(2) Comply with all state and federal laws regarding the confidentiality of medical records. Provider shall maintain written policies and procedures regarding the confidentiality of Enrollee records which policies must address access by Enrollees to their clinical records consistent with applicable state and federal confidentiality requirements. To the extent that Provider is required to release Enrollee records pursuant to this Agreement, Provider shall make a good faith effort to obtain a written release of such records from Enrollee prior to releasing such records. Provider shall document all attempts to obtain such consent for release, and in the event an Enrollee refuses to sign a consent form, Provider shall document such refusal in the Enrollee's medical record. Failure by Provider to obtain such a release after good faith efforts shall not be grounds for termination of this Agreement.

(3) Use good faith efforts to obtain authorization from each Enrollee for release of medical record information to CBH before delivering services to the Enrollee. CBH shall have the right to inspect, in accordance with this paragraph, any medical records, books, billing and financial information maintained by Provider pertaining to City, to CBH, to Enrollees, to Covered Services and the cost of such services, and to Provider's participation hereunder. CBH shall also have the right to review any Subcontracts entered into by Provider relating to Provider's obligations under this Agreement. Failure by Provider to obtain a release

as described herein after good faith efforts shall not be grounds for termination of this Agreement.

(4) Upon request by CBH at any time, grant CBH, acting through any authorized representative thereof, or any authorized state or federal official, access to Provider's premises for inspection, and make available for review by CBH, acting through any authorized representative thereof, or by any authorized state or federal official, any Provider records required under this Agreement at Provider's offices during normal business hours. Provider shall, upon request by CBH; forward certain designated records relevant to this Agreement to DPW or other authorized state or federal officials for audit, review or evaluation. Provider shall bear the cost of copying any records requested by CBH, or any Commonwealth or federal agency hereunder.

(5) Unless a greater minimum retention period is required by CBH, retain all records required under this Agreement and make such records available for audit, review or evaluation to CBH or any authorized representative of CBH, for a minimum seven(7) years after the final payment under this Agreement, including any renewals thereof, or until the Enrollee is twenty-two (22) years old, whichever is later, or if an audit involving such records is in progress or audit findings are yet unresolved, until all work related to such audit is completed or for such longer period as may be required by applicable law. Provider shall maintain Enrollee clinical records in paper form for two (2) years from the last date of service before converting the same to any other form or medium. Provider shall bear the cost of copying any records requested by CBH, or any Commonwealth or federal agency hereunder.

(6) In accordance with 42 CFR §420.205, submit to CBH, the DPW, or to the Secretary of Health and Human Services or its designees, within twenty (20) days of request, information related to transactions associated with the performance of services hereunder, which shall include full and complete information regarding: (a) Provider's ownership of any Subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request; and (b) Any significant business transactions between the Provider and any wholly owned supplier or Subcontractor or between the Provider and any other provider, vendor or subcontractor during the five year period ending on the date of the request.

(7) Maintain medical records of Enrollees in a current, detailed, organized and comprehensive manner and in accordance with applicable DPW regulations, as set forth at 55 Pa. Code §1101.51(e), any other applicable laws and regulations, customary professional medical practice, and in a manner that shall permit effective quality assurance review.

(8) Upon request and from time to time, provide CBH with reasonable access to otherwise confidential information and reports from physicians, facilities, medical, adjunct, or other staff files, insurance companies, and other third parties as reasonably required to determine Provider's qualifications to provide services hereunder. In addition, Provider shall allow CBH access to professional liability insurance carrier data and information regarding

Provider's medical or behavioral malpractice history, including the number, type, nature and disposition of claims filed against Provider. If applicable, prior to the effective date of this Agreement and annually thereafter, Provider shall request and provide to CBH a copy of any report about Provider made to the National Practitioner Data Bank. Any information made available to CBH pursuant to this paragraph shall be held in strict confidence by CBH and shall not be released to another entity without written consent from Provider, except as required by law or court order or to such extent as is necessary to comply with the regulations and requirements of the Pennsylvania Department of Public Welfare or the City of Philadelphia.

C. *Confidentiality and Non-Disclosure.*

(1) CBH and Provider hereby acknowledge and agree that in the course of their relationship under this Agreement, CBH shall disclose to Provider certain Confidential Information, as hereinafter defined, which the parties acknowledge and agree is proprietary and valuable to CBH. Provider hereby agrees to treat such Confidential Information in accordance with the provisions of this Agreement and to take or refrain from taking the actions set forth herein with respect to the Confidential Information.

(2) For purposes of this Agreement, the term “Confidential Information” means any and all information, in whole or in part, and in whatever form or medium, furnished to Provider by or on behalf of CBH or created by Provider pursuant to this Agreement, including but not limited to data and/or information relating to CBH’s business, and any and all professional and business practices, strategic plans, trade secrets, financial statements, financial information, contractual provisions, business plans, marketing plans or materials, business or clinical protocols or templates, contact lists, sources of business, software programs, copyrighted materials, or other proprietary information. Confidential Information does not include information which Provider can demonstrate (i) is generally available to or known by the public other than as a result of disclosure by Provider or (ii) was obtained by Provider from a source other than CBH, provided that such source is not bound by a duty of confidentiality to CBH or another person or entity with respect to such information.

(3) Provider agrees that it:

(i) shall use Confidential Information solely in the course of its relationship with CBH;

(ii) shall not use Confidential Information to compete with or to the detriment of CBH or its affiliates;

(iii) shall keep the Confidential Information strictly confidential and, except as authorized by the terms of this Agreement, will not disclose or distribute the Confidential Information to any person or entity without the prior written consent of CBH. Provider may disclose Confidential Information to such of its directors, officers, employees and agents (the “Representatives”) who need to have the Confidential Information to evaluate whether to enter into a business relationship with CBH, so long as those Representatives agree to

be bound by the terms of this Section of the Agreement, and then only to the extent necessary to such evaluations. Provider shall be responsible for any breach of this Section of the Agreement by its Representatives.

(4) Except as and to the extent mutually agreed or required by law, Provider shall not, and shall direct its Representatives not to, directly or indirectly, make any public comment, statement or communication with respect to, or otherwise disclose or permit the disclosure of the existence of Provider's relationship with CBH, without prior written consent from CBH.

(5) Upon request by CBH at any time, Provider shall promptly return to CBH the original and all copies of all non-oral Confidential Information.

(6) In the event that Provider is or its Representatives are requested or required (by oral questions, interrogatories, requests for information or documents in legal proceedings, subpoena, court order, civil investigative demand or other similar process) to disclose any of the Confidential Information, it shall provide CBH with prompt written notice of any such request or requirement so that CBH may seek a protective order or other appropriate remedy and/or waive compliance with the provisions of this Agreement. If, in the absence of a protective order or other remedy or the receipt of a waiver in accordance with this Agreement, Provider is nonetheless legally compelled to disclose Confidential Information to any tribunal, regulatory authority, agency or similar entity, Provider may without liability hereunder or under other applicable law, disclose to such tribunal, regulatory authority, agency or similar entity, only that portion of the Confidential Information which is legally required to be disclosed, provided that it exercises reasonable efforts to preserve the confidentiality of the Confidential Information.

(7) Provider shall not use any materials disclosed to it by CBH or any materials prepared for or on behalf of CBH, or any works Provider has created or derived from Confidential Information, including, but not limited to studies, survey research or other analyses, or reporting relating to or arising out of its role as a CBH Provider, whether in Provider's advertising or marketing materials, in press releases, in articles or journal publications, or in any other form of publication, distribution, or disclosure without the express prior written authorization of CBH.

(8) Provider shall not make reference to its relationship with or use the name of CBH in any public statement of any sort without limitation, without the express prior written permission of CBH.

(9) Each party acknowledges that money damages would not be a sufficient remedy for any breach of confidentiality and nondisclosure under this Agreement by Provider, and that CBH shall be entitled as a matter of right to specific performance and injunctive relief as remedies for any such breach, as well as all other remedies available at law or in equity. In the event that any action, suit or other proceeding at law or in equity is brought by CBH to enforce this Agreement or to obtain money damages for the breach hereof, CBH, shall

be entitled upon demand to reimbursement from Provider for all reasonable expenses (including, without limitation, reasonable attorney's fees and court costs) incurred in connection therewith.

D. *Compliance with Law.*

(1) Provider shall participate in the Medical Assistance program and shall provide Covered Services Medically Necessary to the care for those individuals being served. Provider shall perform Covered Services in accordance with the requirements of the waiver by the Centers for Medicare and Medicaid Services (formerly HCFA) under Section 1915(b) of the Social Security Act, 42 U.S.C. §1396n, and shall comply with all applicable federal and state laws generally and specifically governing participation in the Medical Assistance program, and with all applicable rules and regulations. Without limiting the generality of the foregoing, Provider shall comply with Title VI and VII of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Americans with Disabilities Act of 1990; the Pennsylvania Human Relations Act of 1955, as amended; the Commonwealth of Pennsylvania's Contract Compliance Regulations set forth at 16 Pa. Code 49.101 and Title 28 Pa. Code Chapter 27, Communicable and Noncommunicable Diseases and the Pennsylvania Managed Care Consumer Protection Act (Act 68) of 1998.

(2) Provider shall comply with all applicable laws, regulations, and policies of the Pennsylvania Department of Health and the Pennsylvania Insurance Department except to the extent a waiver has been granted by the Pennsylvania Department of Health and/or Insurance, or absent other direction from DPW to the effect that any such regulations, directives or other policies, procedures or similar provisions are inapplicable in whole or in part to Provider's obligations or rights under this Agreement.

E. *EVS Duties.* Provider shall check EVS for any day on which Provider is providing services to verify patient eligibility. Provider shall notify CBH when EVS indicates patient is enrolled with CBH, no matter when in the course of the patient's treatment this status occurs. Provider shall notify CBH within 24 hours when an individual becomes a CBH Enrollee during an inpatient stay. Upon notification, CBH shall conduct a concurrent hospital review.

F. *Delegation by CBH.* Provider acknowledges and agrees that any delegation by CBH for performance of quality assurance, utilization management, credentialing, provider relations or other medical management systems, shall be subject to CBH's oversight and monitoring of such delegate's performance. Notwithstanding any such delegation, nothing in the Agreement shall be construed to limit: (a) the authority of CBH to ensure provider participation in and compliance with CBH's quality assurance, utilization management, credentialing, member grievance and other systems and procedures; (b) CBH's authority to sanction or terminate a clinician found to be providing inadequate or poor quality care or failing to comply with CBH systems, standards or procedures pursuant to this Agreement. Provider acknowledges and agrees that, if in the judgment of CBH, Provider has failed to cooperate with CBH in the provision of cost-effective, quality services to Enrollees, or has failed to cooperate with and abide by the provisions of CBH's quality assurance, utilization management,

credentialing, or member grievance systems, or is found to be harming Enrollees, CBH may revoke the delegated authority from the Provider or may terminate this Agreement.

G. *DSS CARES License*. If Provider is using the DSS CARES Software, Provider shall comply with the requirements of the DSS CARES license agreement attached hereto as Exhibit B and incorporated by reference herein.

III. Responsibilities of CBH. Throughout the term of this Agreement, CBH shall in accordance with procedures set forth in the Provider Manual:

A. Administer the Covered Services provided under this Agreement and coordinate and approve Authorizations for Covered Services to Providers.

B. Administer a Quality Management Program and provide Provider with program information and modifications thereto, as determined relevant by CBH.

C. Conduct a Credentialing Program to select, evaluate, approve and monitor all Providers.

D. Process and pay all Clean Claims for Covered Services within forty-five (45) days of CBH's receipt thereof in the form designated in the Provider Manual. If CBH does not pay within such timeframe it shall pay such interest as shall be imposed by law on managed care organizations under Act 1998-68 or any successor legislation. CBH's obligation under this Section III.D is also subject to applicable Coordination of Benefits and other non-duplication of payment rules under the Program.

IV. Compensation and Submission of Claims.

A. CBH shall compensate Provider for Covered Services rendered in accordance with the terms and conditions of this Agreement at the rates set forth in Schedule A and incorporated herein. The rates set forth in Schedule A and the methodologies used to establish rates may be modified by CBH upon issuance by CBH of written notice to Provider ("Rate Notice"). By execution of this Agreement, Provider agrees that CBH may modify, upon issuance of a Rate Notice to Provider, the rates payable to Provider for Covered Services hereunder as of the date specified in the Rate Notice. A Provider who does not accept the terms of a Rate Notice may terminate this Agreement upon thirty (30) days prior written Notice to CBH.

B. Except as set forth herein, Provider shall bill CBH for Covered Services rendered to Enrollees, in the manner specified by CBH in the Provider Manual. To be considered for payment, Provider shall submit a Clean Claim no more than one hundred eighty (180) days following the date of service for Covered Services requiring an authorization and no more than ninety (90) days following the date of service for Covered Services not requiring an authorization. In the event Provider is pursuing Coordination of Benefits, Provider must obtain a final determination from the primary payor dated no more than one hundred eighty (180) days

following the date of service and submit a Clean Claim to CBH within ninety (90) days after receipt of a final determination from the primary payor. Unclean Rejected Claims must be resubmitted as Clean Claims within the 180-day and 90-day requirements stated herein. CBH reserves the right to make no payments for claims received beyond the time requirements set forth herein.

C. Subject to the Provider's right to collect applicable co-payments, coinsurance and deductibles from Enrollees, Provider agrees that in no event, including, but not limited to, nonpayment by CBH, the insolvency of CBH, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Enrollee or persons other than CBH acting on their behalf for Covered Services under this Agreement. Provider further agrees that (a) this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Enrollees; and that (b) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Enrollee or persons acting on their behalf.

D. Services provided to Enrollees may, under rules of subrogation or coordination of benefits, be eligible for payment from third parties for services rendered. Provider shall cooperate with CBH in identifying and collecting payments from third party payors due to Coordination of Benefits rules or subrogation by informing CBH at the time of the submission of any claim of any opportunity to obtain payment from a third party source and inform CBH of any recovery or avoidance of expense obtained by a Provider from a third party resource with respect to Covered Services provided to Enrollees.

E. It is recognized that Enrollees might request services of Provider that are not authorized or covered by the HealthChoices Program and are, therefore, payable by Enrollees. In such cases, Provider agrees to advise Enrollees of their payment responsibility prior to rendering any such services. Thereafter, Provider may bill an Enrollee its standard charge for services that are not Covered Services if the Enrollee was informed, prior to receiving the service, that the particular service is not covered under the Program and consented in writing to such treatment nonetheless.

F. In the event an Enrollee is terminated from the Program, CBH will provide benefits for Covered Services provided to the Enrollee in accordance with Appendix V to the Contracts (Recipient Coverage Policy).

G. Provider further agrees that: (i) the payment provisions in this Section IV shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Program Enrollees; and (ii) the provisions in this Section IV supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Enrollees or persons (other than DPW) acting on the Enrollee's behalf.

V. **Term.** The initial term of this Agreement shall begin on the date first written above and shall continue in force until December 31, 2007, unless sooner terminated in accordance with this Agreement. The parties may, by mutual written agreement, renew this Agreement for one (1) annual renewal term. There shall be no liability or penalty to either party for failing to renew the term of this Agreement.

VI. **Insurance and Indemnification.**

A. *Indemnification.* Provider shall indemnify, defend and hold harmless CBH, its officers, employees and agents, from and against any and all losses, costs (including, but not limited to, litigation and settlement costs and counsel fees), claims, suits, actions, damages, liability and expenses, occasioned wholly or in part by Provider's act or omission or the act or omission of Provider's agents, subcontractors, employees or servants in connection with the Provider Agreement, including, but not limited to, those in connection with loss of life, bodily injury, personal injury, damage to property, contamination or adverse effects on the environment, failure to pay such subcontractors and suppliers, any breach of the Provider Agreement, and any infringement or violation of any proprietary right (including, but not limited to, patent, copyright, trademark, service mark and trade secret). This obligation to indemnify, defend and hold harmless CBH, its officers, employees and agents, shall survive the termination of the Provider Agreement. In addition to the foregoing, Provider shall indemnify, defend and hold harmless CBH, the City, its officers, employees and agents and the Commonwealth of Pennsylvania Department of Public Welfare from and against any and all liabilities, losses, settlement, claims, demands and expenses of any kind (including, but not limited to, attorneys' fees) ("Claims"), which may result or arise out of any dispute with Enrollees, agents, clients with respect to any defamation, malpractice, fraud, negligence or intentional misconduct caused by Provider or its agents, employees, subcontractors or representatives in the performance or omission of any act or responsibility assumed by Provider pursuant to the Agreement Documents, or other claim which Provider, City and/or CBH may become obligated to pay under the Commonwealth Contract. Without limiting the generality of the foregoing, Provider shall indemnify, defend and hold harmless CBH, the City, its officers, employees and agents and the Commonwealth of Pennsylvania Department of Public Welfare from and against any and all claims arising from the rendering or failure to render professional services, including professional malpractice and general professional medical services. This obligation to indemnify, defend and hold harmless CBH, the City, DPW, their officers, employees and agents shall survive the termination or expiration of this Contract.

B. *Responsibility.* Notwithstanding the acceptance and approval by CBH of any Covered Services performed, Provider shall continue to be responsible and liable under the Agreement for performance of the Covered Services in accordance with the terms of the Agreement. Review, approval or inspection by CBH shall not constitute any representation by CBH as to the substance or quality of the matter reviewed, approved or inspected and shall not waive any of CBH's rights or privileges or stop CBH from recovering compensation on account of Covered Services not performed in accordance with the Agreement.

C. *Insurance.* Unless otherwise specified by CBH in writing, Provider shall, at its sole cost and expense, procure and maintain in full force and effect, covering the performance of the Covered Services, the types and minimum limits of insurance specified below. All insurance shall be procured from reputable insurers admitted to do business on a direct basis in the Commonwealth of Pennsylvania or otherwise acceptable to CBH. All insurance herein, except the Professional Liability insurance, shall be written on an "occurrence" basis and not a "claims-made" basis. In no event shall work be performed until the required evidence of insurance has been furnished. The insurance shall provide for at least thirty (30) days prior written Notice to be given to CBH in the event coverage is materially changed, canceled, or non-renewed. CBH, the City of Philadelphia and the Commonwealth of Pennsylvania Department of Public Welfare, their officers, employees and agents, are to be named as additional insureds on the General Liability Insurance policy. An endorsement is required stating that the coverage afforded CBH, the City of Philadelphia and the Commonwealth of Pennsylvania Department of Public Welfare, their officers, employees and agents, as additional insureds, will be primary to any other coverage available to them; and, that no act or omission of CBH, the City of Philadelphia or the Commonwealth of Pennsylvania Department of Public Welfare shall invalidate the coverage.

(1) *Workers Compensation and Employers Liability.*

(a) Workers Compensation: Statutory Limits.

(b) Employers Liability: \$100,000 Each Accident - Bodily Injury by Accident; \$100,000 Each Employee - Bodily Injury by Disease; and \$500,000 Policy Limit - Bodily Injury by Disease.

(c) Other States Endorsement.

(2) *General Liability Insurance.*

(a) Limit of Liability: \$2,000,000 per occurrence combined single limit for bodily injury (including death) and property damage liability; \$1,000,000 advertising injury; \$2,000,000 general aggregate and \$2,000,000 aggregate for products and completed operations. Provided, however, that CBH may require higher limits of liability if, in CBH's sole discretion, the potential risk so warrants.

(b) Coverage: Premises operations; blanket contractual liability personal injury liability (employee exclusion deleted); products and completed operations; independent contractors, employees and volunteers as additional insureds; cross liability; and broad form property damage (including completed operations).

(3) *Automobile Liability.*

(a) Limit of Liability: \$1,000,000 per occurrence combined limit for bodily injury (including death) and property damage liability.

(b) Coverage: Owned, non-owned, and hired vehicles.

(4) *Professional Liability Insurance.*

(a) Health Care Providers subject to the Medical Care Availability and Reduction of Error Act ("MCARE") (for policies renewing or issued in Calendar Year 2006):

(i) Hospital and Nursing Homes including officers and employees: \$500,000 each occurrence; \$2,500,000 annual aggregate.

(ii) Individuals and Professional Corporations: \$500,000 each occurrence; \$1,500,000 annual aggregate.

(b) All Health Care Providers not subject to MCARE: \$1,000,000 each occurrence; \$3,000,000 annual aggregate.

(c) Professional Liability Insurance may be written on a claims-made basis provided that coverage for occurrences happening during the performance of the Covered Services required under the Agreement shall be maintained in full force and effect under the policy or "tail" coverage for a period of at least three (3) years after completion of the Covered Services.

D. *Evidence of Insurance Coverage.* Certificates of insurance evidencing the required coverage shall be submitted to CBH at least ten (10) days prior to rendering services to Enrollees and at least ten (10) days before any renewal term. The ten (10) day requirement for advance documentation of coverage may be waived in such situations where such waiver will benefit CBH, but under no circumstances shall Provider actually begin work (or continue work, in the case of renewal) without providing the required

evidence of insurance. CBH reserves the right to require Provider to furnish certified copies of the original policies of all insurance required under the Agreement at any time upon ten (10) days written Notice to Provider.

E. *Self-Insurance.* Provider may not self-insure any of the coverage required under the Agreement without the prior written approval of CBH. In the event that Provider desires to self-insure any of the coverage listed above, it shall submit to CBH, prior to the commencement of Covered Services hereunder, a certified copy of Provider's most recent audited financial statement, and such other evidence of its qualifications to act as a self-insurer (e.g., state approval) as may be requested by CBH. In the event such approval is granted, it is understood and agreed that CBH, its officers, employees, and agents, shall be entitled to receive the same coverages and benefits under Provider's self-insurance program that they would have received had the insurance requirements been satisfied by a reputable insurance carrier authorized to do business in the Commonwealth of Pennsylvania or otherwise acceptable to CBH. If at the time of commencement of the initial term of the Agreement, Provider self-insures its professional liability and/or workers compensation and employees liability coverage, Provider may, in lieu of the foregoing, furnish to CBH a current copy of the state certification form for self-insurance or a current copy of the letter of approval from the State Insurance Commissioner, whichever is appropriate for the coverage self-insured. The insurance (including self-insurance) requirements set forth herein are not intended and shall not be construed to modify, limit, or reduce the indemnification obligations in the Agreement by Provider to CBH, or to limit Provider's liability under the Agreement to the limits of the policies of insurance (or self-insurance) required to be maintained by Provider hereunder.

F. *Fidelity Bond.* Upon request by CBH, Provider shall, at its sole cost and expense, obtain and maintain during the initial term and any renewal term of the Agreement, a Fidelity Bond in an amount of the greater of (a) Ten Thousand Dollars (\$10,000), or (b) such other amount as CBH may require, covering Provider's employees who have financial responsibilities related to the receipt and disbursement of funds under the Agreement. The Fidelity Bond shall name CBH as a beneficiary thereof. Evidence of the existence of the Fidelity Bond shall be submitted to CBH prior to the commencement of Covered Services.

VII. Events of Default.

A. *Events of Default.* Each of the following shall constitute an Event of Default under this Agreement:

- (1) Failure by Provider to comply with any requirement of this Agreement;
- (2) Occurrence of an Event of Insolvency with respect to Provider;
- (3) Falseness or inaccuracy of any warranty or representation of Provider contained in this Agreement or in any other document submitted to CBH by Provider;
- (4) Misappropriation by Provider of any funds provided under this Agreement or failure by Provider to notify CBH upon discovery of any misappropriation;
- (5) A violation of law which results in a guilty plea, a plea of nolo contendere, or conviction of a criminal offense by Provider, its directors, employees, or agents or any of its clinicians (a) directly or indirectly relating to this Agreement or the services provided hereunder, whether or not such offense is ultimately adjudged to have occurred or (b) which adversely affects the performance of this Agreement;

(6) Indictment of or issuance of charges against Provider, its directors, employees or agents for any criminal offense or any other violation of Applicable Law directly relating to this Agreement or the services hereunder or which adversely affects the performance of this Agreement in accordance with its terms whether or not such offense or violation is ultimately adjudged to have occurred;

(7) In the event that Provider enters into any Corporate Integrity Agreement or other Settlement with any government agency or entity. Provider must notify CBH within thirty (30) days of entering into any such Corporate Integrity Agreement or Settlement, and CBH shall in its sole discretion determine whether to exercise any of its rights in Article VIII hereunder;

(8) Debarment or suspension, or receipt by CBH, the City, or DPW of notice of debarment or suspension of Provider under applicable federal, state or local law or regulation;

(9) In the event the Program is terminated or modified to such an extent that continuance of this Agreement is no longer possible or feasible, in CBH's sole discretion, or the Contracts are terminated for any reason;

(10) If funding from any source for this Agreement is not continued at a level sufficient (in CBH's reasonable judgment) to permit payment for Covered Services. Termination or reduction under this paragraph shall not affect any obligations or liabilities of either party arising before the date of such termination or reduction. The payment obligations of CBH under this Agreement are limited and subject to the receipt of funds from the City pursuant to the terms and conditions of the Contracts; or

(11) Provider or a Subcontractor engages in acts which in the good faith belief of CBH have the potential to harm an Enrollee or other patient of Provider.

B. *Notice and Grace.* CBH agrees that CBH will not exercise any right or remedy provided for in Section VIII (Remedies) hereof because of any Event of Default unless CBH shall have first given written Notice of the Event of Default to Provider, and Provider, within a period of thirty (30) days thereafter, or such additional cure period as CBH may authorize, shall have failed to correct the Event of Default; provided, however, that no such Notice from CBH shall be required nor shall CBH permit any period for cure if:

(1) Provider has temporarily or permanently ceased providing services;

(2) The Event of Default creates an emergency, which requires, in the discretion of CBH or an applicable state or federal regulatory agency, immediate exercise of CBH's rights or remedies to protect the health or safety of an Enrollee, which is endangered by actions of the Provider, its staff, agents or subcontractors;

(3) CBH has previously notified the Provider in the preceding twelve-month period of any Event of Default under a contract between CBH and the Provider;

(4) An Event of Default occurs as described in Section VII.A.(5) or VII.A.(6) hereof;

(5) Provider has failed to obtain or maintain the insurance or any bond required under this Agreement;

(6) Provider is no longer licensed or certified under applicable State law, is no longer eligible as a Provider under Titles XVIII and XIX of the Social Security Act, if Provider loses its malpractice insurance coverage and such loss remains uncured as determined by CBH in its discretion, or if Provider's privileges to practice its profession in any required facility are terminated for any reason;

(7) Provider becomes a "sanctioned person" within the meaning of §1128(a)(8) of the Social Security Act. If Provider would become a "sanctioned person" by virtue of a relationship with an individual who would himself become a "sanctioned person", Provider may apply to CBH for continuation of this Agreement by demonstrating to CBH's satisfaction that the relationship giving rise to such sanctioned status has been terminated;

(8) Provider is no longer credentialed by CBH; or (9) Provider fails to develop or maintain an acceptable corporate compliance program, as determined solely by CBH, in accordance with Article II.B. (1) above. Nothing contained in this Section shall limit CBH's rights under Article VIII (Remedies) hereof.

VIII: Remedies.

A. *CBH's Remedies.* In the event Provider has committed or permitted an Event of Default and has been notified thereof in accordance with Section VII.B (Notice and Grace) hereof, then CBH may, but shall not be obligated to, without further notice to or demand on Provider and without waiving or releasing Provider from any of its obligations under this Agreement:

(1) perform (or cause a third party to perform) this Agreement, in whole or in part, including, without limitation, obtaining or paying for any required insurance or performing other acts capable of performance by CBH. Provider shall be liable to CBH for all sums paid by CBH and all expenses incurred by CBH (or a third party) pursuant to this Section VIII.A. (1), together with interest at the highest legal rate permitted in the Commonwealth of Pennsylvania thereon from the date of CBH incurring such costs. CBH shall not in any event be liable for inconvenience, expense or other damage incurred by Provider by reason of such performance or paying such costs or expenses and the obligations of Provider under this Agreement shall not be altered or affected in any manner by CBH's exercise of its rights under this Section VIII.A;

(2) withhold, or offset against, any funds payable to or for the benefit of Provider;

(3) collect, foreclose or realize upon any bond, collateral, security or insurance provided by or on behalf of Provider;

(4) exercise any other right it has or may have at law, in equity, or under this Agreement;

(5) terminate this Agreement in whole or in part, as set forth more fully in Article IX (Termination) hereof. In the event of partial termination, Provider shall continue to perform this Agreement to the extent not terminated. If this Agreement is terminated, CBH shall issue a written Termination Notice which shall set forth the effective date of the termination; or (6) enforce the terms of this Agreement without limitation, by a decree of specific performance or by injunction restraining a violation, or attempted or threatened violation, of any provision of this Agreement, in addition to all other remedies to which CBH is entitled and to the fullest extent permitted under Applicable Law. Provider acknowledges that the services purchased from Provider are unique and not readily available.

B. *Sanctions.* In addition to remedies set forth above, CBH may impose sanctions for noncompliance with any requirements under this Agreement. The sanctions, which are imposed, will depend on the nature and severity of the noncompliance, which CBH, in its discretion, shall determine. Sanctions imposed may include but shall not be limited to:

(1) Requiring the timely submission and implementation of a corrective action plan acceptable to CBH;

(2) Imposing monetary fines of \$1,000.00 per day plus any additional fines or penalties imposed on the City by the Commonwealth resulting from or attributable to Provider's noncompliance with the terms of this Agreement;

(3) Suspension of all or a portion of payments; or

(4) Termination of this Agreement in accordance with Article IX hereof. Where appropriate and for good cause shown, CBH may in its sole discretion provide Provider a reasonable extension of time in which to meet reporting requirements hereunder.

C. *Concurrent Pursuit of Remedies; No Waiver.*

(1) CBH may exercise any or all of the remedies set forth in this Article VIII, each of which may be pursued separately or in connection with such other remedies as CBH in its sole discretion shall determine. No extension or indulgence granted to Provider shall operate as a waiver of any of CBH's rights in connection with this Agreement.

(2) The rights and remedies of CBH as described in this Article VIII and as described elsewhere in this Agreement shall not be exclusive and are in addition to any other rights or remedies available to CBH under this Agreement at law or in equity.

IX. Termination.

A. *Termination by Either Party.* Either party shall have the right to terminate this Agreement at any time during the term of the Agreement without cause upon sixty (60) days written Notice to the other party.

B. *Termination Due to Force Majeure Event.* Either party may terminate this Agreement if, as a result of the occurrence and continuation of a Force Majeure event the ability of such party to perform hereunder is substantially interrupted. In such event, the terminating party will give the non-terminating party

thirty (30) days written Notice of any termination pursuant to this Subsection, and such Notice shall set forth the proposed termination date. For purposes of this provision, a Force Majeure event shall mean an event of a major disaster or epidemic as declared by the Governor of the Commonwealth of Pennsylvania, or act of any military or civil authority, outage of communications, power or other utility.

C. *Continuation of Benefits.* Notwithstanding termination, Provider shall continue to provide services to Enrollees until the sooner of the date by which CBH makes alternate arrangements to assure continuity of care or the expiration of one hundred twenty (120) days post-termination, provided, however, in the event of termination as a result of CBH's insolvency or other cessation of CBH operations or under Section VII.A.(9) of this Agreement, Provider shall continue to provide services to all Enrollees, including Enrollees in an inpatient facility, through the period for which the premium has been paid the City receives Program funding from the Commonwealth.

D. *Cooperation.* Upon termination of this Agreement, Provider shall cooperate as reasonably requested by CBH in arranging for transfer of care of patients to other providers, and shall promptly provide information requested by DPW in connection with termination of the Agreement and transfer of care.

E. *Payment of Provider Upon Termination.*

(1) If after termination of this Agreement by CBH for an Event of Default, Provider renders services to Enrollees which were authorized prior to the date of termination by CBH pursuant to its authorization procedures then in effect, Provider shall be entitled to payment for such services at the rates set forth on Schedule A (or Schedule A-1 as applicable) on the date of termination of this Agreement; provided, however, that:

(a) no allowance shall be included for termination expenses or for anticipated profits, unabsorbed or underabsorbed overhead, or unperformed services; and

(b) CBH shall deduct from any amount due and payable to Provider prior to the termination date, but withheld or not paid, the total amount of additional expenses incurred by CBH in order to satisfactorily complete the work required to be performed by Provider under this Agreement, including the expense of engaging another provider for this purpose, and such other damages, costs, losses and expenses of CBH as may be incurred or result from such termination for default.

(2) If after termination of this Agreement pursuant to Section IX.A. above, Provider renders services to Enrollees which were authorized prior to the date of termination by CBH pursuant to its authorization procedures then in effect, Provider shall be entitled to payment at the rates set forth on Schedule A (or Schedule A-1 as applicable) on the date of termination of this Agreement. No amount will be allowed for termination expenses or for anticipated profits, unabsorbed or underabsorbed overhead or unperformed services. The deductions set forth at Section IX.E(1)(b) shall not apply to payments made pursuant to this subsection (2).

X. Representations and Warranties of Provider. Provider hereby makes the following representations and warranties to CBH, each of the following are preconditions to any of CBH's obligations hereunder and shall be continuing obligations throughout the term of this Agreement, the breach of which shall

be grounds for termination of this Agreement. Provider shall immediately notify CBH if at any time during the term hereof any of the representations and warranties set forth herein becomes inaccurate or untrue:

A. *Good Standing.* If Provider is an entity, Provider is either: (1) a not-for-profit corporation or other entity determined to be tax exempt pursuant to section 501(c) of the Internal Revenue Code by the Internal Revenue Service; or (2) a business corporation, partnership or other business entity duly organized, validly existing and in good standing under the laws of the state of its incorporation or organization. Provider is duly licensed, qualified and in good standing in the Commonwealth of Pennsylvania and in all jurisdictions in which it conducts business activities.

B. *Authority to Act.* Provider has full legal power and authority to enter into and perform this Agreement and provide the services without resulting in a default under or a breach or violation of (1) Provider's certificate or articles of incorporation or bylaws or other organizational documents, if applicable; (2) any applicable law or any license, permit or other instrument or obligation to which Provider is now a party or by which Provider may be bound or affected; and (3) Provider's tax exempt status, if applicable.

C. *Legal Obligation.* This Agreement has been duly authorized, executed and delivered by Provider, by and through persons authorized to execute the Agreement on behalf of Provider, and constitutes the legal, valid and binding obligation of Provider, enforceable against Provider in accordance with its terms.

D. *No Litigation Preventing Performance.* There is no litigation, claim, consent order, settlement agreement, investigation, challenge or other proceeding pending or threatened against Provider, its properties or business or any individuals acting on Provider's behalf, including, without limitation Subcontractors, which seek to enjoin or prohibit Provider from entering into or performing its obligations under this Agreement.

E. *Requisite Licensure and Qualifications.* Provider and all of the entities and individuals acting on Provider's behalf, including, without limitation Subcontractors, in connection with the services under this Agreement, possess and, at all times during the term of this Agreement, shall possess current unrestricted licenses, certifications, qualifications or other credentials as required by applicable law and the terms of this Agreement to perform the services hereunder. Provider shall provide CBH with copies of all licenses, credentials and/or certifications specified in this Section within five (5) days of request by CBH.

F. *True and Correct Information.* All the information contained in the application to provide services to Enrollees through CBH is true and remains true and the questions and answers contained in Provider's application are hereby incorporated into the representations and warranties contained in this Agreement by reference.

G. *Drug Enforcement Agency Narcotics Number.* Provider has and shall maintain throughout the term of this Agreement a current Drug Enforcement Agency narcotics number, if Provider is eligible to have such a number.

H. *Sanctioned Person.* Provider is not the subject of any pending or threatened formal or informal investigation, action, or proceeding by federal or state authorities which, if determined adversely with respect to Provider, would cause Provider to be a "sanctioned person." Provider shall further use his\her\its best efforts to ensure that such investigation or determination does not have a material and adverse impact on CBH, including but not limited to terminating Provider's relationship with CBH

should Provider become the subject of investigation if such termination will cure the potential adverse impact on CBH.

H. *Corporate Integrity Agreements.* Provider has not previously entered into and is not currently a party to any Corporate Integrity Agreement or other Settlement with any government agency or entity.

XI. Contractor Responsibility Provisions.

A. Provider certifies that it is not currently suspended, terminated or debarred by the federal government or from participation in the Medical Assistance program of any other state or from the Medicare Program and that it shall promptly notify CBH, in writing, of such suspension, termination or debarment.

B. If Provider enters into a Subcontract with or employs, in connection with the services to be provided under this Agreement, any Subcontractor or individual who is suspended or debarred by the Commonwealth or federal government or who becomes suspended or debarred by the Commonwealth or federal government during the term of this Agreement or any extension or renewal thereof, CBH shall have the right to require Provider to terminate such subcontract or assignment to this Agreement.

C. Provider agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of Inspector General for investigation of Provider's compliance with terms of this or any other agreement between Provider and the Commonwealth which results in the suspension or debarment of Provider. Such costs shall include, but are not limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. Provider shall not be responsible for investigative costs for investigations, which do not result in Provider's suspension or debarment.

D. Provider may obtain the current list of suspended and debarred contractors by contacting the Department of General Services, Office of Chief Counsel, 603 North Office Building, Harrisburg, PA 17125, telephone (717) 783-6472, fax (717) 787-9138.

XII. Notices. Any Notice required to be given pursuant to this Agreement by any party to any other party shall be sent to the following addresses or to such other addresses as the parties may, from time to time, request:

To Provider: _____

To CBH: Community Behavioral Health
801 Market Street, 7th Floor
Philadelphia, PA 19107
Attn: Nancy Lucas, CEO

**City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Community Behavioral Health – RFP for Behavioral Health Laboratory Services**

XIII. Change of Law.

A. Notwithstanding any other provision of this Agreement, if during the term hereof any Change of Law, as defined below, results in an Adverse Consequence, as defined below, the parties hereto agree to cooperate in making reasonable revisions to this Agreement in order to avoid such Adverse Consequence(s). If the parties fail to agree to such revisions after forty-five (45) days following written Notice by either party to the other requesting re-negotiation (the "Renegotiation Period"), then either party may submit the matter to arbitration pursuant to Article XIV hereof.

B. As used herein, the term "Change of Law" shall mean: (i) any new legislation enacted by the federal or any state government; (ii) any new third party payor or governmental agency law, rule, regulation, guideline or interpretation of a previously issued law, rule, regulation or guideline, or (iii) any judicial or administrative, order or decree.

C. As used herein, the term "Adverse Consequence" shall mean a Change of Law that prohibits, restricts, limits or otherwise affects either party's rights or obligations hereunder in a material manner or otherwise makes it desirable for either party to restructure the relationship established hereunder because of material legal or financial consequences expected to result from such Change of Law.

XIV. Arbitration.

A. Any controversy, dispute or disagreement arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration, which shall be conducted in Philadelphia County, Pennsylvania in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

B. Any party seeking resolution of such a dispute shall request arbitration not later than forty-five (45) days after the Renegotiation Period from the occurrence of the event giving rise to the arbitration request. A failure to act hereunder shall constitute a waiver of any and all rights or claims relating to the dispute.

C. The parties may agree in writing to an alternative dispute resolution process.

XV. Miscellaneous.

A. *Independent Contractors.* The parties agree that none of the provisions hereof is intended to create nor shall be deemed or construed to create any relationship between the parties other than that of independent contractors contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Except as herein specifically provided, neither party hereto shall exercise any control or direction over the methods by which the other party shall perform its responsibilities, obligations, duties and work. Nothing contained herein shall be construed to create between CBH and Provider any relationship of an employer-employee partners or joint venturers. Each party shall perform its responsibilities, obligations, duties and work hereunder in a competent, efficient and satisfactory manner and in accordance with appropriate standards established in the community.

B. *Entire Agreement.* This Agreement together with its attachments and those documents incorporated by reference herein constitutes the entire understanding of the parties. This Agreement may be amended by CBH upon thirty (30) days advance written Notice to Provider prior to the effective date of any such amendment, and such amendment shall be binding upon Provider unless Provider objects to it in writing within fifteen (15) days of receipt of such Notice by CBH; provided, however, that if Provider objects to such amendment, CBH shall have the right to terminate this Agreement on thirty (30) days written Notice to Provider. This Agreement may also be amended at any time by the written mutual consent of the parties hereto.

C. *Assignment.* Provider shall not assign this Agreement without obtaining the prior written consent of CBH. Any purported assignment in violation of this provision shall be of no effect. CBH may assign this Agreement without Provider's consent to any entity which controls CBH, is controlled by CBH, or is under common control with CBH, or to a new corporation formed by or with the approval of City that shall be specifically created to take over the business of CBH, or to any other entity that will assume some or all of the obligations of CBH to perform services under the HealthChoices Behavioral Health Program.

D. *Severability and Partial Invalidity.* The provisions of this Agreement shall be severable. If any provision of the Agreement or the application thereof for any reason or circumstances shall to any extent be held to be invalid or unenforceable, the remaining provisions of the Agreement or the application of such provision to persons or entities other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each provision of the Agreement shall be valid and enforceable to the fullest extent permitted by law.

E. *Gender/Number.* Whenever appropriate from the context of this Agreement, the use of any gender shall include any and all other genders and the single gender shall include the plural and the plural number shall include the singular.

F. *Conformance with Law.* Nothing contained in this Agreement shall be construed so as to require the commission of an act contrary to law. Whenever there is any conflict between any provision of this Agreement and any present statute, law, ordinance or regulation contrary to which the parties have no legal right to contract, the latter shall prevail, but in such event the provisions of this Agreement affected shall be curtailed and limited only to the extent necessary to bring it within the requirements of the law and to carry out the purposes of this Agreement.

G. *Headings.* The captions and headings throughout this Agreement are for convenience of reference only and shall in no way be held or deemed to be a part of or affect the interpretation of this Agreement.

H. *Non-Exclusive Agreement.* This Agreement is not intended to be exclusive, and either party may contract with any other person or entity for purposes similar to those described herein. Nothing contained in this Agreement shall prevent Provider from rendering health care services pursuant to other fee-for-service or contractual arrangements, whether in Provider's individual capacity or as a member of other provider arrangements.

I. *Independent Professional Judgment.* Nothing in this Agreement shall be deemed to change or alter any relationship, which exists, or which may come to exist between Provider and any Enrollee,

and CBH shall have no right to interfere with the care or treatment given or prescribed to any Enrollee. Provider agrees for purposes of this subparagraph that the determination of Authorizations, Medical Necessity and the quality assessment/quality improvement and utilization management programs of CBH shall not constitute "interference with the care or treatment given or prescribed to any Enrollee." Provider shall exercise independent professional judgment consistent with accepted standards of care and shall have and be subject to the same duties toward Enrollees as exists generally between patients and providers.

J. *No Third Party Beneficiaries.* Except as provided in Section IV.H hereof, no person shall have any rights under this Agreement unless such person is a party hereto. This Agreement is not a third party beneficiary contract and shall not in any respect whatsoever increase the rights of Enrollees or any other third party with respect to CBH or the duties of CBH to Enrollees or create any rights or remedies on behalf of Enrollees against CBH.

K. *Confidentiality.* Provider agrees that this Agreement is confidential and is not to be disseminated or the provisions contained herein revealed to parties other than to regulatory agencies or other governmental authorities that have a right to review this Agreement. Prior to the disclosure to any such regulatory agency, Provider shall advise CBH of the potential disclosure. Provider agrees not to use CBH and/or its authorized agents' trade secrets, including all manuals, processing instructions or forms, while this Agreement remains in force and following the termination of this Agreement. Provider agrees not to use CBH list of Enrollees or other information for competitive purposes, nor to provide Enrollee lists or information to others for Provider's pecuniary gain or any other purpose. This obligation shall survive termination of this Agreement regardless of the cause of such termination.

L. *Integration.* This Agreement contains all the terms and conditions agreed upon by CBH and Provider and no other contract, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any party hereto or to vary any of the terms contained in this Agreement. This Agreement replaces and supersedes any prior agreements between the parties respecting the subject matter hereof.

M. *Waiver.* Failure or waiver by either party hereunder at any time or from time to time to require performance by the other party of any of such party's obligations hereunder shall in no manner affect a party's to enforce such provision or any other provision hereunder at any subsequent time, and shall not be construed as a waiver of any subsequent breach by a party.

XVI. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania. CBH and Provider agree that each shall comply with all applicable requirements of Municipal, County, State and Federal Authorities, all applicable Municipal and County Ordinances and regulations, and all applicable State and Federal statutes and regulations now or hereafter in force and effect to the extent that they directly or indirectly bear upon the subject matters of this Agreement. These include, without limitation of the foregoing, 55 Pa. Code §1101 et seq., applicable requirements under any State fair employment practices or similar laws declaring discrimination in employment based upon race, color, creed, religion, sex, sexual preference or national origin as illegal and, if applicable, Title VII of the Civil Rights Act of 1964 or any applicable rule or regulation promulgated pursuant to any such laws herein above described.

City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Community Behavioral Health – RFP for Behavioral Health Laboratory Services

IN WITNESS WHEREOF, CBH and the Provider, intending to be legally bound, have executed this Agreement as of the day and year first above written.

«Contract_Name»

By: _____

(Title)

(Signature)

(Printed Name)

(Address)

(Address)

(Address)

COMMUNITY BEHAVIORAL HEALTH

By: _____

Its CHIEF EXECUTIVE OFFICER

**City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Community Behavioral Health – RFP for Behavioral Health Laboratory Services**

«Contract_Name»

**EXHIBIT A
Joinder Agreement**

By executing this document, _____ (ASubcontractor@) represents and warrants that he/she has reviewed the terms of the CBH-Provider Agreement and the Provider Manual which establishes the procedures implementing the Agreement, and agrees to be bound by those terms, including all aspects of the credentialing system established by CBH. To the extent that Subcontractor shall be engaged in any manner by Provider, including but not limited to by written contract, verbal agreement, or by a course of dealings, to perform any obligation imposed on Provider pursuant to the CBH-Provider Agreement, Subcontractor agrees to be bound thereby as if an original signatory, and represents and warrants that any and all agents, employees, or other individuals working on Subcontractor's behalf shall be bound thereby.

Subcontractor shall further furnish CBH with the names of all individuals who will provide services on Subcontractor's behalf. Any changes to this list shall be provided to CBH not less than five (5) days prior to the change. In no event shall any individual provide services on behalf of Subcontractor without having first provided CBH with a signed copy of this Joinder Agreement.

In WITNESS WHEREOF and intending to be legally bound, the Subcontractor has executed this agreement.

Subcontractor or individual

Date

APPENDIX C

MINORITY BUSINESS ENTERPRISE COUNCIL LANGUAGE

EXECUTIVE ORDER 03-05 RELATING TO THE PARTICIPATION OF MINORITY, WOMEN AND DISABLED BUSINESSES IN CITY CONTRACTS

SECTION 3. The Minority Business Enterprise Council and Advisory Board

G. Nonprofit Organizations

The City annually spends a substantial percentage of its contract dollars with nonprofit organizations and expects these organizations to share the City's commitment to diversity. Although City Contracts with nonprofit organizations are not subject to the City's M/W/DSBE participation ranges, all City Contracts with nonprofit organizations shall include provisions requiring that the nonprofit: (i) provide to the City annually, a written diversity program identifying the race, gender and ethnic composition of its board of directors, its employment profile, a list of all vendors that the nonprofit does business with in its M/W/DSBE procurement program and a statement of the geographic area(s) where its services are most concentrated and (ii) demonstrate, to the City's satisfaction, that the nonprofit's organization makes appropriate efforts to maintain a diverse workforce and board of directors and operates a fair and effective M/W/DSBE procurement program. The MBEC working with those Departments who contract with nonprofit organizations and with the approval of the Director of Finance, may adopt and publish a set of policies and procedures for the evaluation of nonprofit organizations that contracts with the City.

APPENDIX D - Social/Economically Restricted Businesses Socially and Economically Restricted Business Program (SERB)

The purpose of the SERB Program is to promote the use of small and emerging businesses by giving them opportunities to participate in state contracting.

Many of the companies that qualify for SERB are too small to bid as prime contractors on most state contracts, however even those contracts may provide subcontracting and joint venture opportunities that would be within the capacity of a small business. The SERB Program encourages prime contractors to consider SERB businesses when seeking supplies and services their own companies cannot provide.

In the RFP process, contracts are awarded according to a point system. Each proposal is evaluated, and points are assigned for the technical aspect of the proposal, cost, SERB participation, and other possible factors. The total of these points determines which bidder will win the contract.

How does a business qualify as a SERB?

A business can qualify as a SERB in one of three ways:

First, by being certified by the PA Department of General Services as a Minority Business Enterprise (MBE) or Women Business Enterprise (WBE) or

Second, by being located in a Pennsylvania Designated Enterprise Zone or

Third, by being certified by the U.S. Small Business Administration as a Small Disadvantaged Business (SDB) and/or in the 8(a) Business Development Program.

IN ADDITION: to qualify as a SERB, a company must gross less than \$8 million per year (\$18 million for Information Technology (IT) companies) and have 50 or fewer employees.

Never assume a business qualifies as SERB because it is certified or is located in an Enterprise Zone; you must also verify its gross annual revenues. Proof of gross revenues can include a recent tax or audited financial statement. If the company has subsidiaries or is the subsidiary of another company, the total revenue of the company and its subsidiaries must be under \$8 million (\$18 million for IT companies).

Priority Rankings for SERB points

Of the maximum number of points available for SERB, a prime bidder can earn:

Up to 100% if the prime bidder qualifies as a SERB.

Up to 90% if the prime bidder enters into a joint venture agreement with a SERB.

Up to 50% if the prime bidder is subcontracting to a SERB (includes purchase agreements.)

The prime contractor is responsible for verifying SERB status *with each contract*

1. If a business claims SERB status because it is DGS-certified, provide a copy of the certificate and proof that the company does less than \$8 million in gross annual revenues (\$18 million for Information Technology companies).

2. If a business claims SERB status because its headquarters is located in a Pennsylvania Designated Enterprise Zone, provide proof of the headquarters address (such as a lease or deed), a statement from the local Enterprise Zone office confirming that the address is in a zone, and proof that the company does less than \$8 million in gross annual revenues (\$18 million for Information Technology companies).
3. If a business claims SERB status because it is a SDB-certified and/or 8(a) business, provide a copy of their registration in PRO-Net (pro-net.sba.gov) and proof that the company does less than \$8 million in gross annual revenues (\$18 million for Information Technology companies).

Include the appropriate verifications in the SERB portion of the proposal.

Read the RFP and follow it carefully!

Important information to note:

1. You must name the specific SERB business(es) to which you are making commitments. Include the company name, address, and telephone number for each specific SERB business included in the proposal. You will not receive credit by stating that you will find a SERB after the contract is awarded or by listing several companies and stating you will select one later.
2. Specify the type of goods or services the SERB business(es) will provide. Specify the timeframe for the SERB(s) to provide the goods or services and the location where the SERB(s) will perform these services.
3. Specify the estimated dollar value of the contract to each SERB. If subcontracting, a signed subcontract or letter of intent must be included in the SERB portion of the proposal. Also estimate what percent of the total value of services or products purchased under the proposal will be provided by SERBs.

Bind the SERB portion separately from the rest of the proposal. (Most RFPs ask that the SERB section be sealed in an envelope). **Only one copy of the SERB section is needed.** Be sure to identify your company on the outside of the envelope.

How do I find qualified SERBs?

The Bureau of Contract Administration and Business Development (BCABD) maintains a database of all Minority Business Enterprises (MBEs) and Women Business Enterprises (WBEs) certified by the PA Department of General Services. Information on these firms is available on BCABD's website at www.dgs.state.pa.us/cabd.htm.

If you have difficulty using the website to search for MBEs and WBEs, contact BCABD for assistance. Please note that the businesses in BCABD's database are coded according to the goods or services they are certified to provide. If you have problems finding the correct codes for the supplies or services you are seeking, you can request a codebook from BCABD. Contact BCABD by e-mail at gs-cabdinternet@state.pa.us. If you do not have e-mail, call 717-787-6708.

For more information on Designated Enterprise Zones, contact the PA Department of Community and Economic Development at 717-720-7342 (phone), 717-787-4088 (fax), or dcged@state.pa.us (e-mail). Request a list of Enterprise Zone offices.

For more information on Federal certification (SDB and/or the 8(a) program), contact the U.S. Small Business Administration at 1-800-U-ASK-SBA (phone), 202-205-7064 (fax), or visit their website at www.sba.gov and click on *PRO-Net*.

SERB Commitments are Binding

Commitments to SERBs made at the time of proposal submittal or contract negotiation become part of the resulting contract and must be maintained throughout the term of the contract. Any proposed change must be submitted to and approved by BCABD.

Joint Ventures

A Joint Venture is an association of two or more companies to carry out a project for profit. A Joint Venture generally requires a shared interest in the performance of a common purpose. After the project is completed, the Joint Venture terminates.

The Joint Venture relationship is created by a contract between two or more companies. Each invests its money, labor or skills in the venture. The profits are divided between them.

All parties must agree on the terms of the contract before a Joint Venture relationship exists.

Co-ownership of the project is one indication of a true Joint Venture, which occurs when two or more companies pool their resources in a common enterprise comprised of equal obligations and benefits. If the contract indicates that one company is merely employed to provide certain goods or perform certain services and has no financial interest in the enterprise other than compensation, there is no Joint Venture. When a company has invested nothing in or contributed nothing to the project, there is no Joint Venture.

Generally, shared interest in the profits and losses resulting from a project is indicative of a Joint Venture. The participation in profits is an indispensable requisite of a Joint Venture relationship. The absence of participation in profits is conclusive that it is not a Joint Venture.

The burden of proving a Joint Venture is on the party who asserts it.

Examples of evidence indicating a Joint Venture relationship include: 1) showing a checking account with the Joint Venture name, 2) providing a copy of the contract establishing the Joint Venture, 3) providing an individual income tax return showing Joint Venture income, 4) documenting a pooling of assets into a common enterprise with a division of profits, 5) providing evidence of a parity in direction and management, and 6) showing proof of the securing of insurance in the name of the Joint Venture.

If asserting a joint venture with a SERB, the Joint Venture Agreement must be included in the SERB portion of the proposal.

For more information on Joint Ventures, contact BCABD's Evaluations Unit at 717-787-7629.

For more information on the SERB Program contact:
PA Bureau of Contract Administration and Business Development
613 North Office Building, Harrisburg, PA 17125
E-mail: gs-cabdinternet@state.pa.us
717-787-6708 or FAX: 717-772-0021

To reach our Western Regional Office, e-mail cjumba@state.pa.us or call 412-442-5872.

APPENDIX E

PROPOSAL COVER SHEET

BEHAVIORAL HEALTH LABORATORY SERVICES

REQUEST FOR PROPOSALS

COVER SHEET

CORPORATE NAME OF
APPLICANT ORGANIZATION _____

CORPORATE ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAIN CONTACT PERSON _____

TITLE _____ TELEPHONE # _____

E-MAIL ADDRESS _____ FAX # _____

PA Promise Number _____ NPI number _____

ADDRESS OF PROPOSED SITE _____

SIGNATURE OF OFFICIAL AUTHORIZED
TO BIND BIDDER TO A CONTRACT

TITLE

TYPED NAME OF AUTHORIZED OFFICIAL
IDENTIFIED ABOVE

APPENDIX F

Training and Education Requirements

I. Overview

In order to properly and effectively work with individuals with behavioral health disorders, staff must be able to develop a proper knowledge base as well as a competency based set of skills.

Training and education may take the form of a specific class, agency or system sponsored technical assistance activities, formal conferences, etc. Training and education activities may not include routine in-services, staff meetings, etc.

II. Specific Training and Education Requirements

This section provides a description of needed training and education for staff, which must occur in order for staff to be most effective in their ability to help people in recovery. These requirements are considered minimal and staff are encouraged to continue their education beyond these requirements.

Area #1: Understanding of the impact of behavioral health disorders and co-occurring medical disorders (sexually transmitted diseases, cardiovascular conditions, diabetes, etc.)

Area #2: Understanding and promoting recovery for those individuals with behavioral health disorders.

Area #3: Understanding of the importance of being a culturally competent staff member.

Area #4: Understanding of the impact of trauma on behavioral health issues.

III. Time Frames for Completion of Training and Education Requirements

Staff training and subsequent documentation of training and educational activities must be completed within 3 months from the first day of contracted services are to have begun. Ongoing training will continue according to CBH credentialing.

APPENDIX G

CAPITATION PLAN DATA

Loc2	Description of test	2002 units	2003 units	2004 units	2005 unit	2006 units
3	THYROID PANEL;W/THYROID-	486	-	-	-	-
4	CARBAMAZEPINE	490	478	1,410	1,205	972
5	LITHIUM	799	812	1,298	1,452	1,418
6	NORTRIPTYLINE	11	100	367	158	9
9	URINAL.DIP STICK/REAG BILIRUB.	512	559	61	10	18
11	DIPROPYLACETIC ACID	2,830	2,238	2,727	2,866	3,313
15	LEAD	76	135	290	222	218
16	THYROID STIMULATING HORMONE	2,749	2,785	2,860	4,169	5,490
19	BL.COUNT;HEMOGRAM,MANUAL,COMPL	2,631	2,130	386	303	383
24	SYPHILLIS,TEST;QUALITATIVE(EG,	4,230	4,152	3,946	5,151	6,400
25	PREGNANCY TEST	5,262	5,017	5,679	6,033	6,683
26	ALCOHOL(ETHANOL),BLOOD,	5,789	10,177	10,151	11,841	22,203
27	DRG.SCRN6-10(AMPH.BARB,COCAINE	84,725	85,970	93,379	103,934	130,771
40	THYROID PANEL;THYROXINE,TOTAL	3	-	-	-	-
42	DESIPRAMINE	3	51	106	247	143
43	IMIPRAMINE	10	79	176	228	1
45	URINAL.BY DIPSTICK/TAB REAGENT	5,294	4,805	5,288	8,024	10,101
46	URINAL.DIPSTICK/TAB AUTOM ANY	260	159	336	358	1,354
56	PROLACTIN	45	193	241	707	1,279
67	BLOOD COUNT;WHITE BLOOD CELL	322	257	310	284	42
71	DRUG SCREEN(1-5)AMPH,BARB,BENZ	953	2,785	2,928	2,313	2,874
76	HALDOL(HALOPERIDOL)	21	72	52	265	6
83	BLOOD COUNT;HEMOGRAM,AUTOMAT	1,268	3,063	10,736	12,767	13,920
86	BLOOD COUNT;HCT & HGB	1	-	-	-	-
88	PHENYTOIN, TOTAL	148	328	363	1,129	342
93	ANTIBODY (HIV)	822	1,035	539	1,768	2,347
101	BLOOD COUNT;HEMOGRAM &PLATELET	8,683	7,912	4,802	4,707	5,367
102	BASIC METABOLIC PANEL	1,921	925	1,297	973	844
103	ELECTROLYTE PANEL	1,320	1,129	1,773	3,115	3,728
104	COMPREHENSIVE METABOLIC PANEL	3,014	3,949	5,294	5,102	5,978
105	HEPATIC FUNCTION PANEL	4,028	5,129	6,367	8,823	9,429
107	INFECT AGENT ANTIG IMMUNO TECH	2,819	2,674	3,246	3,314	2,978
108	HEPATITIS B CORE ANTIBODY	480	771	1,237	1,073	1,259
109	HEPATITIS B SURFACE ANTIBODY	468	665	1,274	1,179	1,383
110	HEPATITIS C ANTIBODY	1,596	1,730	2,531	2,039	2,567
111	AMALASE	213	471	732	888	1,010
112	FTA	50	51	36	115	46
113	GLUTAMYL TRANSFERASE, GAMMA	2,995	3,157	2,341	4,743	5,830
114	LIPASE	171	457	719	867	619
115	MAGNESIUM	987	1,054	1,251	1,913	2,723
116	PRIMADONE	-	4	9	91	142
117	CREATINE KINASE	106	289	594	712	681
118	HEPATITIS A ANTIBODY	445	742	436	828	1,135
119	HEPATITIS A ANTIBODY	222	439	196	495	579
121	THYROXINE - TOTAL	1,426	1,891	1,967	3,626	4,667
122	THYROID HORMONE UPTAKE	1,416	1,860	1,933	3,573	4,637
123	ORAL DRUG TESTING	-	-	3,301	9,617	9,462
124	Lipid Panel	-	-	-	-	4,051
	Totals	152,100	162,679	184,965	223,227	279,402
	Eligible Members	362,403	366,283	382,761	407,622	412,162

Pa. Medicaid rates for Laboratory Services can be found on the Department of Public Welfare website.

City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Community Behavioral Health – RFP for Behavioral Health Laboratory Services

APPENDIX H

PROVIDER LIST

All Bidders will be given a list of contracted providers on the day of the Bidder's Conference. All unrepresented Bidders who submitted a Letter of Intent will be mailed a copy of the list of contracted providers.

APPENDIX I

LAB TESTS

Alcohol (Ethanol), Blood, Quantitative (All Methods)
Amylase
Ammonia
Antibody (HIV)
Basic Metabolic Panel
Blood Count, Hemogram, Manual, Compl (RBC,WBC,HGB,HCT,DIFF. & Indices)
Blood Count, HCT & HGB Asymptomatic Pt.
Blood Count, Hemogram & Platelet Count, Auto & Auto Comp diff WBC
Blood Count, Hemogram, Automated & Diff WBC(CBC)Asymptomatic Pt
Blood Count, White Blood Cell (WBC)
<i>Blood Urea Nitrogen (BUN)</i>
Carbamazepine (Tegretol)
<i>Clomipramine (Anafranil)</i>
<i>Clozapine (Clozaril)</i>
Comprehensive Metabolic Panel
Creatine Kinase (CK), (CPK)
Desipramine (Norpramin)
Drug Screen 1-5 (AMPH, BARB, Cocaine, METHD, METH, PHENCY, PCP,)
Drug Screen 6-10 (AMPH, BARB, Cocaine, METHD, METHQ, OPI, PCP, PRPXY,THC)
Electrolyte Panel
FTA
Glutamyl Transferase, Gamma (GGT)
Haldol (Haloperidol)
Hepatic Function Panel
Hepatitis A Antibody (HAAB), IGG
Hepatitis A Antibody (HAAB), IGM
Hepatitis B Core Antibody (HBCAB), IGG & IGM
Hepatitis B Surface Antibody
Hepatitis C Antibody
Imipramine (Tofranil)
Infect Agent Antig Immuno Tech Adenovoir Ent Type 40/41
<i>Lamotrigine (Lamictal)</i>
Lead
Lipase
Lipid Panel
Lithium
<i>Alkaline Phosphatase</i>
<i>Gammaglobulin; IgA, IgD, IgG, IgM,</i>
<i>Transferase; alanine amino (ALT) (SGPT)</i>
<i>Transferase; aspartate amino (AST) (SGOT)</i>
Magnesium
Nortriptyline (Aventyl, Pamelor)
Oral Drug Testing
Phenobarbital
Phenytoin (Dilantin)
Pregnancy Test
Primidone (Mysoline)
Prolactin
<i>Prostate Specific Antigen (PSA); complexed, total, free</i>
Syphilis Test, Qualitative (EG, VDRL, RPR,ART)
Thyroid Hormone Uptake
Thyroxine- Total
Tyroid Stimulating Hormone
Topiramate (Topamax)
Urinal by Dipstick/Tab reagent for etc. constituent w/microscopy
Urinal Dip Stick/Reag Bilirub.Gluc.Hemo,Leuk,etc wo/Mic,Auto
Urinal Dipstick/Tab Autom any # of constituent w/microscopy
Valproic Acid (Dipropylacetic Acid)

City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Community Behavioral Health – RFP for Behavioral Health Laboratory Services

