

**CITY OF PHILADELPHIA**

**DEPARTMENT OF BEHAVIORAL HEALTH  
AND MENTAL RETARDATION SERVICES**

**COMMUNITY BEHAVIORAL HEALTH  
REQUEST FOR PROPOSALS (RFP)  
FAMILY BASED MENTAL HEALTH SERVICES (FBMH)**

**Issued April 24, 2008**

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 develop up to fourteen (14) new FBMH teams to the existing CBH provider network. The additional FBMH teams will include; general FBMH teams, specialized teams in Trauma and Sexual Abuse, Youth Empowerment, Children's Crisis and Medically Complex Co-Occurring teams. The final number of FBMH teams to be added will be determined by an ongoing assessment of need and available funding. This Request for Proposals (RFP) will enhance the availability of this specialized service. Family Based Mental Health services are provided to families who are enrolled in Pennsylvania Medical Assistance, capitated through the HealthChoices program to CBH and who meet medical necessity criteria.

This opportunity is open to all community based licensed behavioral health provider organizations. Providers must be willing to enter into cooperative agreements with other community-based providers in an effort to offer the array of supports identified in this request. Providers do not need to offer the full continuum of services and supports but must be willing to create partnerships to build capacity for this population. Providers responding to the RFP must have experience in working with multiple systems of care in providing case management/case coordination services and provide information related to their qualifications serving this population.

Timelines for this RFP process will be short. The RFP will be placed on the CBH website on April 24, 2008. All questions from prospective bidders must be submitted via e-mail by April 30, 2008 to [sean.gallagher@phila.gov](mailto:sean.gallagher@phila.gov) with final responses placed on the CBH website by May 7, 2008. Proposal(s) submissions must be received at CBH located at 801 Market Street, 7<sup>th</sup> Floor, Philadelphia, PA 19107 no later than 3PM on May 14, 2008. Any response(s) received after that date and time would be returned to the applicant, unopened. Final provider selections will be announced on the CBH website in June 2008.

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

Department of Behavioral Health and Mental Retardation Services  
Community Behavioral Health  
Request for Proposals – Family Based Mental Health Services

## **TABLE OF CONTENTS**

- I. General Information for Prospective Bidders**
- II. Program Philosophy**
- III. Proposal Content and Format Requirements**
- IV. Spending Plan/Budget**
- V. Evaluation Plan**
- VI. Data Reporting**
- VII. Criteria for Selection**
- VIII. Appendices**
  - A. Proposal Cover Sheet**
  - B. Developmental Assets for Adolescents**
  - C. Ecosystemic Family Therapy Model**
  - D. OMAP Necessary Criteria**
  - E. Implementing Recovery – Oriented Services**
  - F. Implementing Evidence Based Practices**
  - G. Differences between Evidence Based Practice and Clinical Practice Guidelines**
  - H. Implementing Culturally Competent Services**
  - I. Implementing Trauma Specific Services**
  - J. Promoting Resilience for Children and Families**
  - K. CBH Provider Agreement**
  - L. Minority Business Enterprise Council Language**
  - M. Socially/Economically Restricted Businesses**
  - N. Training and Education Requirements**
  - O. Family Based License Application**
  - P. Chapter 5260 - Family Based Regulations**
  - Q. OMHSAS Bulletins**
  - R. OMHSAS Policy Clarifications**
  - S. FBMH Draft Regulations**
  - T. City of Philadelphia Disclosure Forms**

## **SECTION 1: GENERAL INFORMATION FOR PROSPECTIVE BIDDERS**

### **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 expand its existing pool of state licensed behavioral health providers who deliver Family Based Mental Health (FBMH) Services. It is the intent of this Request For Proposals (RFP) to solicit proposals from interested providers possessing the professional expertise, appropriate state licensing and requisite Pennsylvania Medical Assistance enrollment to offer the scope of 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 agency officially combines the three elements of Philadelphia's behavioral health system – the Office of Mental Health (OMH), the Office of Addiction Services (OAS) formally known as the Coordinating Office of Drug and Alcohol Programs 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 planning and hard work to manage Philadelphia's behavioral health system in a holistic fashion. 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 in 1997 to manage the behavioral health care services for the city's approximately 420,000 Pennsylvania Medical Assistance recipients.

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 Philadelphia's Medical Assistance recipients are primarily funded for on a capitated basis through a contractual agreement 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.

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. The DBH/MRS has established and worked closely for

years with the Consumer and Family Task Force and with mental health, addictions, and mental retardation advocacy groups. The DBH/MRS 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, documents 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 consumer/client 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 that have demonstrated the need for improvements/enhancements.

Coordination of funding streams has allowed DBH/MRS to use non-Pennsylvania Medical Assistance 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 Pennsylvania Medical Assistance 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 DBH/MRS 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:

- Reduce health disparities through the revision of culturally competent services
- Promote cross-systems collaboration to improve treatment outcome
- 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 and resiliency.
- 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:

A. Promotion of a recovery-oriented service system

A recovery-oriented system is a system focused on outcomes for people with behavioral health conditions. It 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 the recovery process is designed by each individual. A recovery-oriented system focuses on supporting the person’s wellness as a whole, not just stabilizing 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 provider 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 necessary steps 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.

B. Evidenced Based Practices

Evidenced based practices are interventions that have shown significant scientific evidence of effective consumer/client outcomes. The use of evidenced 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. Prospective bidders 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.

#### C. 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, regardless 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 and commitment to culturally affirming practices would result in additional points awarded in the proposal review stage.

#### D. 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 encounter more barriers to their recovery. 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.

#### E. 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 service delivery model.

*\*\* Please refer to Appendices E, F, G, H, I and J that provide further elaboration of the above principles.*

### **I.4 SUSTAINABILITY OF PROGRAMS**

The successful bidder(s) selected in this RFP 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 the ability to provide behavioral health services as outlined by the PA Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS) regulations for FBMH teams. Prospective bidders should consider that individuals who meet or ultimately will meet the criteria for Pennsylvania Medical Assistance eligibility are the primary recipients of the services provided by this RFP. Bidders should also be aware that an evaluation process will be established to identify specific and concrete outcomes. The continuation of the provider agreement 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 PROVIDER AGREEMENT**

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 successful 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. (See Appendix K)

## **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 provider agreement opportunity, the bidder understands and agrees to the following reservation of rights.

### **A. CBH's Reservation of Rights in Connection with the Notice of Provider agreement Opportunity Process**

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

- 1) to reject any and all proposals and to reissue a notice of provider agreement opportunity at any time prior to execution of a final provider agreement;
- 2) to issue a new notice of provider agreement opportunity in terms and conditions substantially different from those set forth in a previous notice of provider agreement opportunity;
- 3) to issue a new notice of provider agreement opportunity with terms and conditions that are the same or similar as those set forth in a previous notice of provider agreement opportunity in order to obtain additional proposals;
- 4) to extend a notice of provider agreement opportunity in order to allow for time to obtain additional proposals prior to notice of provider agreement opportunity application deadline; or,
- 5) to cancel a notice of provider agreement opportunity with or without issuing another notice of provider agreement 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 provider agreement 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 provider agreement 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 provider agreement 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 provider agreement opportunity or contains erasures, ambiguities, alterations or items of work not called for by the notice of provider agreement opportunity;
- 5) to waive any informality, defect, non-responsiveness and/or deviation from the notice of provider agreement 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 provider agreement award and/or provider agreement execution.

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

Proposals, which CBH determines in its sole discretion, are responsive to a notice of provider agreement opportunity, will be reviewed and evaluated by CBH. CBH reserves the right to request respondents to make one or more presentations to DBH/MRS staff at CBH's offices, at the respondents' sole cost and expense, addressing respondents' ability to achieve the objectives of the notice of provider agreement 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 provider agreement 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 provider agreement. 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 provider agreement 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 provider agreement opportunity in order to solicit new respondents. CBH reserves the right not to enter into any provider agreement with any respondent, with or without the re-issuance of a notice of provider agreement 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 CONTACT PERSON**

Any questions regarding this RFP should be directed to Dr. Sean Gallagher at CBH. He will be the sole point of contact and will respond to questions by email only. He can be reached at the following address: [sean.gallagher@phila.gov](mailto: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 PROPOSAL SUBMISSION DATE**

The RFP is to be posted on the CBH and Department of Behavioral Health websites on April 24, 2008. A formal Bidders Conference will not be held. As noted above, all questions from prospective bidders must be submitted by e-mail to [sean.gallagher@phila.gov](mailto:sean.gallagher@phila.gov). Questions will be accepted up to close of business on April 30, 2008 with written responses questions posted on the CBH website by close of business on May 7, 2008. All proposals must be delivered to CBH no later than May 14, 2008 at 3:00 PM. Proposals received after this deadline will be returned, unopened to the applicant.

The selection process requires a blind review of all proposals. Therefore, two written versions must be prepared by prospective bidders; a redacted version and an un-redacted version. In the redacted version, **any and all identifying information** about the prospective bidder **must** be confined to the cover page. A prospective bidder who does not provide a fully redacted copy will have their proposal returned without formal review.

Please proposals submit to:

Sean Gallagher, Ph.D.  
Director of Network Development  
Community Behavioral Health  
801 Market Street, 7<sup>th</sup> floor  
Philadelphia, PA 19107

- ❑ In addition, a prospective bidder must provide two electronic versions (redacted and un-redacted) of the proposal in a portable document format (PDF) on a Compact Disc. Any discrepancy between the hard copy and electronic version may be cause for disqualifying the proposal.
- ❑ An official of the submitting agency, authorized to bind the agency to all provisions noted in the proposal, must sign the proposal.

## **I.11 PROPOSAL REQUIREMENTS**

The prospective bidder will organize the proposal in the same order as presented in the RFP, clearly label each section with headings as they appear in the RFP and include a table of contents. Any attachments called for in the RFP should be placed at the end of the proposal, clearly labeled and referenced in the body of the proposal. Bidders are required to limit their narrative responses to 20 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 in print size of 12, using a Times New Roman font on 8 by 11.5 sheets of paper. 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 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 PROVIDER CONTRACTOR RESPONSIBILITY**

The selected providers 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 provider 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 response 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 provider agreement entered into between CBH and the successful bidder will include the CBH Provider Agreement (see Appendix K).

## **I.16 SELECTION / REJECTION PROCEDURES**

The successful bidder(s) 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 successful bidder(s) 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 provider agreement 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. The City of Philadelphia requires that appropriate campaign contribution disclosure forms be completed by each prospective bidder (see Appendix T).

## **I.18 LIFE OF PROPOSALS**

CBH expects to select successful bidder (s) 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 and including June 30, 2010. CBH reserves the right to rescind the RFP at any juncture in the RFP process including through the provider agreement negotiation period and/or up to the actual signing of a provider agreement with the successful bidder.

## **I.19 PROVIDER AGREEMENT TIME PERIOD**

The initial provider agreement resulting from this RFP will start within 90 days of receipt of the award letter and will cover the remaining period of the existing calendar year. The provider agreement will be eligible for renewal on an annual basis depending on the provider's ability to meet its obligations successfully (i.e. CBH credentialing, 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 proposal 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 sub-provider contracted by non-profit organizations to for-profit organizations, including supplies and renovation/construction services, may fall under the purview of MBEC. Appendix L 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 rating process. (See Appendix L)*

## **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 provider contracting (see Appendix M). This state initiative would apply in the situation of a capitation provider agreement as presented in this RFP. Many of the companies that qualify for SERB may be too small as prime provider contractors on some contracts, however, those contracts may provide sub-provider contracting and joint venture opportunities that would be within the capacity of a small business. The SERB program encourages prime provider 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 rating process. (See Appendix M)*

## **I.23 NON-DISCRIMINATION**

The successful bidder, as a condition of accepting and executing a provider agreement with CBH through this RFP, agree to comply with all relevant sections of the Civil Rights Act of 1964, the

Pennsylvania Human Relations Act, Section 504 of the Federal Rehabilitation Act of 1973, and the Americans with Disabilities Act, hereby assuring that the provider agency 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 provider contractors.

## **SECTION II: PROGRAM PHILOSOPHY**

### **II.1 INTRODUCTION**

The Family Based Mental Health Services program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21 years, and their families. The FBMHS program is accessed by referral and is offered to families where FBMHS is determined to be clinically necessary and appropriate. FBMHS is available to children and adolescents, who are at risk for out-of-home placement due to severe behavioral, emotional disorders or mental illness; as step-down for children and adolescents who are returning to their natural or substitute-care families; and as an alternative to placement for youth who are adjudicated delinquent with behavioral health issues but who can be treated in the community.

Family Based Mental Health Services Program guidelines for medical necessity (and its subsequent revisions) provide a basis for the referral of children and adolescents and their families for this service. Refer to 55 PA Code Chapter 5260 for the specific state regulations. (Appendix P).

### **II.2 PROGRAMMATIC REQUIREMENTS**

The guiding tenets of FBMHS are that family environments are the most nurturing for the development and functioning of children and adolescents. The family is essential in the successful development and treatment. Successful treatment takes into account individual and family strengths as well as the resources of the human service systems and the community.

The FBMHS is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker. FBMH services are comprehensive in scope incorporating: intensive family therapy in the home, casework services, family support services, and availability for crisis stabilization 24 hours per day, 7 days per week. Each team maintains a caseload of up to 8 families at a time to insure the intensity of services and team availability. Team members receive supervision together as an integral part of the treatment program for the families served. In addition, there is an ongoing training curriculum for the treatment team that extends over a three-year period. This program is designed specifically for Family Based Mental Health Service Team Members.

FBMH service is conceptualized as being used both in the home and in the community as dictated by the clinical situation. The team works with the family resources that are available to them in the community. The commitment of FBMHS to all of the children in the family and the integrity of the family serves preventive as well as treatment functions. Services offered by the FBMHS program include formal individual and family therapy sessions scheduled with the child and/or family, based on their current needs. In addition, program service requirements include the following:

- 24 Hr. Crisis intervention and stabilization
- Ongoing information gathering in support of active treatment
- Collaborative development and modification of the treatment plan including multiple systems involved with the family, (e.g. DHS, School District, Juvenile Justice and Faith Based Organizations).
- Clinical intervention by each member of the clinical team with the identified patient to help attain treatment goals and objective in the treatment plan, including: remediation of the child's symptoms, improvement in family relationships, community integration, and enhancing psychosocial functioning and skills in home school and community.
- Support for the parents in the areas of behavioral management, skill building, family education and parenting skills.
- School based consultation and intervention as needed
- Referral, coordination, and linkages to other agencies, social services, and community services as appropriate
- Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as: transportation, recreation, and developing a network in order to obtain these services.

Family Support Service (FSS) is a requirement of the Family Based Mental Health Services Program under Department of Public Welfare regulations (See Appendix P). Family Support Services are defined as formal and informal services or tangible goods, which are needed to enable a family to care for a child who has a serious emotional disturbance. FSS includes supportive services and tangible goods that will assist in facilitating the achievement of the child's treatment goals. If a child is in temporary placement then FSS should be used to facilitate the return of the child to the natural family and FSS should be available to the natural family as well as the substitute-care family.

### **II.3. CLINICAL MODEL**

PA Family Based Regulations require that all family based providers attend the state mandated training program in Eco-systemic Structural Family Therapy (ESFT) model and adhere to this

16

City of Philadelphia

Department of Behavioral Health and Mental Retardation Services

Community Behavioral Health

Request for Proposals – Family Based Mental Health Services

model of therapy. It is expected that providers may add additional training program(s) to this existing statewide training program to strengthen and address the unique issues of specialty populations. The evidence-based model to be used is the Eco-systemic Structural Family Therapy Model (ESFT). ESFT is a modification of the well-researched Structural Family Therapy Model developed by Salvador Minuchin (1974). This framework encompasses assessment methods, therapeutic goal setting and treatment interventions with families and youth with serious emotional disorders. This model is based on the assumption that individual functioning is linked to the child's environment, therefore, assessment focuses on the needs and strengths of both the individual and the environment. Individual assessment focuses on developmental domains (cognitive, emotional, social and physical). Recurring relational patterns of interaction are explored both within the family and between the family and community. Adaptive family interactions can promote mastery of specific individual challenges and non-adaptive family interactions that often exacerbate symptoms.<sup>1</sup> (See Appendix C)

Family partnership is one of the six core principles, which provide the framework for Pennsylvania's Children's Mental Health System. Family partnership is defined (1995): "Family-focused services recognize that the family is the primary support system for a child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation." Inherent in these services is the collaboration between family and professional staff, which is crucial in providing good services to children and adolescents with serious emotional disorders. The family structures and dynamics, and their impact on children with SED must be considered in utilizing family-based treatment methods and interventions.

It is the intention of CBH to provide a level of review and make final approval of all individuals considered for entrance into the proposed program. CBH will act as gate-keeper to the program. However, the treatment resources established through this RFP are not to be viewed solely as part of any specific agency that is operating the program but rather a DBH/MRS resource. All bidders must include a statement of understanding regarding this point. It should be noted that reimbursement will be denied for any individual who receives services without prior authorization by CBH.

Prospective providers will also be required to submit a psychiatric services plan, as part of their clinical model, detailing how children and family members will access psychiatric evaluations, re-evaluations for medication and medication monitoring. The plan should include a framework for integration of these services into the family treatment.

---

<sup>1</sup> Effective Family-Based Mental Health Services for Youth with Serious Emotional Disturbance in Pennsylvania, 2004. Marion Lindblad-Goldberg, Ph.D., C. Wayne Jones, Ph.D., and Martha Dore, Ph.D.

## **II.4 FBMH OBJECTIVES**

The primary goal of Family-Based Mental Health services, as delineated by DPW regulations, is to;

- a. enable parents to care for their children who have serious emotional and behavioral disorders,
- b. reduce the need for out-of-home placement,
- c. strengthen and maintain families by means of therapeutic interventions,
- d. improve family and individual coping skills,
- e. teach family members to care for their child or adolescent, and
- f. serve as an advocate for the child or adolescent.

To achieve the primary goals noted above, Family-based services are characterized by the following process;

- a. a brief period of crisis stabilization,
- b. followed by extensive treatment, education and skill building,
- c. using both in-home and community-based services,
- d. working under a time sensitive agreement,
- e. providing flexible services that are team-delivered,
- f. with an expectation of utilizing creative interventions,
- g. provision of “relief” services (i.e. respite, therapeutic recreation, etc), when needed, and
- h. the completion of a discharge plan.

As part of the treatment process, the FBMH team is required to develop a discharge plan that provides for the following;

- a. proactive community linkages at least 30-45 days prior to discharge,
- b. required referral to a step-down level of care from Family Based Services,
- c. planned transition to the lower level of care, and follow up with families on a monthly basis for six months after discharge.

## **II.5 ASSESSMENT**

A thorough and comprehensive family assessment is the first step in gathering useful data that will guide specific treatment goals and objectives. Towards that end, a Comprehensive Biopsychosocial Evaluation - Family (CBE-F) must be completed no later than 60 days after the start of treatment. This comprehensive evaluation includes relevant clinical information regarding key family relationships and dynamics, particular vulnerabilities and strengths, significant trauma and abuse, which have impacted family functioning and family genogram.

The family genogram are standard methods traditionally utilized in family therapy in order to illustrate patterns, relationships and interaction among family members.

The use of structured tools aids in providing a measurable/operational definition of the goals and should be directly related to the initial assessment. For example, a measurable indicator of increase in family functioning may be the degree to which family members improve on scales of satisfaction with communication, cohesion and flexibility. These tools provide useful objective data, which can bolster, substantiate or refute the subjective clinical conceptualization of the family. CBH will require the use of two (2) structured tools that providers will administer at three (3) distinct points of treatment (Intake, 120 day, Post/Discharge/Termination):

- FAMILY ASSESSMENT FORM (FAF)
- CHILD AND ADOLESCENT FUNCTIONING ASSESSMENT SCALE (CAFAS).

The Family Assessment Form (FAF) is a practice-based instrument developed by the Children's Bureau in Southern California in collaboration with Family Based workers. This tool has been proven to be a valid and reliable outcome measure of family functioning. It gives clinicians a structured way to document a psychosocial assessment in the following 6 areas of family functioning--living conditions, financial conditions, social support, caregiver/child interactions, developmental stimulation and caregiver interactions. The FAF must be completed during the first thirty (30) days of treatment during the first three (3) in-home visits and administered again at termination of treatment.

The Child and Adolescent Functioning Assessment Scale (CAFAS) is a rating scale, which assesses a child/youth (ages 6-17) degree of impairment in day-to-day functioning at school and home due to emotional, behavioral, psychological, psychiatric or substance abuse problems. The CAFAS must be completed during the first thirty (30) days of treatment, 120 days after treatment has begun and at termination.

Clinicians have the option of administering other structured tools in addition to the two cited above if it is deemed clinically appropriate or necessary (e.g. Child Depression Inventory for Children (CDI), Achenbach Child Behavior Checklist, etc).

## **II. 6. ADMISSION CRITERIA**

- a. A current recommendation by a licensed psychiatrist, physician or psychologist for Family Based Mental Health Services programming. The recommendation must be made as part of a complete Comprehensive Biopsychosocial Evaluation (CBE) resulting in a full multi-axial DSM-IV TR diagnosis with a clinical formulation that will inform an appropriate treatment plan.

- b. The child must at risk for an out-of-home placement, i.e. RTF or inpatient hospitalization. OR the child has been recently discharged from an inpatient hospital unit or a Residential Treatment Facility and it has been determined in the CBE that other less restrictive or less intrusive services are not sufficient for prevention/ improvement of the child's and family condition, and
- c. Evidenced behaviors that indicate manageable risk for safety to self/others and child does not require treatment in an inpatient hospital of RTF.

### **SECTION III: 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.

#### **III.1 PROPOSAL COVER SHEET**

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

#### **III. 2. CAPABILITY STATEMENT**

Minimally, the successful bidder must hold a valid license issued by the Commonwealth of Pennsylvania under the provisions 55 PA Code Chapter 5260 by July 10, 2008. Once a license has been obtained all bidders must have applied to be enrolled as a Pennsylvania Medical Assistance provider by the above date and have been in good standing with both Medicare and Pennsylvania Medical Assistance programs. All bidders must also obtain a National Provider Identifier number by the date noted above. The contracted services being solicited are considered commercial activities; thus all facilities must meet county and state permit, zoning, and health codes requirements.

The Capability Statement must address the following areas:

- A. A brief narrative description of the prospective bidder, 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. Those agencies not presently under contract to DBH/MRS must also include in Section III a copy of their agency’s most recent certified audit and management letter with their proposal submissions. 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 agency.

- B. A brief description of the prospective provider'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 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 agency and the community where the proposed services will be provided should be documented here and where possible letters of support from those agencies that have worked with the respective providers.
- D. 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
  - Advocacy groups
  - Elected officials
  - Professional organizations
- E. A brief description of the agency’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.
- F. Resumes and/or job descriptions of the primary personnel who will be involved in the provider agreement.
  - Agency Director
  - Project Director/Clinical Supervisor
  - Project Fiscal Officer

- Treatment Staff
- G. A staff hiring plan for the FBMH teams that will focus on; the qualities of clinical staff member, the average length of time of employment with your agency, building and maintaining team cohesiveness, and prevention of “staff burnout”.
- H. A sample of the CBH Provider Agreement is provided for review (Attachment K) and the successful bidder must stipulate in writing that the agency will comply with all contractual expectations detailed in the Provider Agreement.
- I. A brief description of agency expertise and experience in providing services for the proposed team and targeted population. This includes staff competencies in the areas of child and adolescent development along with any experience in specialized treatments Experience in conducting all levels of assessments and evaluations; conducting planning meetings for youth over 16 across the spectrum of behavioral health, education, vocational, and other support systems. A demonstrated record of providing services to the selected population and outcomes achieved as a result of those services. Experience in family engagement and engaging natural supports that have helped facilitate movement to self-sufficiency.
- J. Experience with the family-court process such as pre-hearing conferences, status hearings, presenting recommendations, etc. Understanding of DHS processes including board extensions, FSP development, family-reunification process, etc. Experience in mediating differences in the perspectives of youth, parents, formal networks and informal supports.
- K. A brief description of your understanding of what FBMH program is and their targeted population(s) to be served. Regarding the target populations identified in this RFP, the DBH/MRS has acknowledged that there are gaps in service. There are areas where current services may be insufficient and lack of appropriate referral opportunities to the next level of care. There may also be service needs where the “steps” between levels of care are too steep and the resulting “step-down” is too great for individuals to make the transition. Detail the agency’s experience in working with children and adolescents and their families to promote family cohesiveness may provide a unique perspective on these needs and gaps. Given that experience and knowledge, identify those gaps your agency will be addressing through your proposed program.
- L. A statement of philosophy regarding family focused services. Due to family context being crucial to the longitudinal success of each consumer, describe the way that the

program will work closely with the consumer's family to both address clinical issues and build upon specific strengths within the family, as a part of each consumer's treatment planning. Please describe how your agency will engage and utilize the family in developing and implementing a child's treatment plan given that a parent and family can never be considered non-compliant by FBS program. A brief description of how the family member will be treated by staff and how the agency think "outside the box" to connect with and engage each child/adolescent's family.

- M. Describe the role cultural competency plays in the delivery of the proposed services and throughout your agency as well as specific activities in your proposed program that will address and improve cultural relevance of the program for the children and adolescents and their families. Describe how cultural differences will be integrated into the FBS program and the many ways cultural competency can serve as the mechanism for addressing behavioral health disparities in your proposed program and in your agency. Due to the crucial nature of effective communication within families, also briefly describe plans to assess the ability to communicate with families whose primary language is other than English.

### **III.4 SCOPE OF SERVICES**

#### **A. Target Populations**

The targeted population for these additional FBMH teams will include youth who may or may not be involved in the dependent or delinquent systems of care and have a DSM-IV diagnosis of a serious emotional disturbance (SED). These are children and youth that have clinical complexities requiring specialized interventions. These children, youth and families experience a range of mental health disorders, substance abuse disorders, co-occurring mental health and substance abuse and a host of psychosocial factors that may increase the potential for truancy, abuse, neglect and use of higher levels of psychiatric services. Some children and youth have substantial clinical complexities such as co-occurring medical conditions, sexualized behaviors related to reactive attachment disorders, sexually reactive behaviors, limited cognitive abilities and behavioral health issues within the family. More specifically, many of these children and youth have also experienced:

1. Trauma related to the loss of attachments resulting from children being placed at infancy and experiencing multiple foster placements or are institutionalized in settings that, without understanding the experience of these children, implement interventions that re-traumatize these children.

2. The impact of being removed from the family home, suffering relationship losses, having a family history of a mental health or substance abuse disorder, and being victim to the effects of poverty (including homelessness).
3. Disruption in their relationships with family of origin and social supports.
4. Trauma related to physical, sexual and emotional abuse, witness to and victims of gun violence, and domestic violence and a lack of knowledge of trauma-informed and trauma-specific treatment.
5. Having parents/caregivers with behavioral health issues that affect their ability to support their children with SED.
6. Developmental disabilities including mental retardation with co-occurring behaviors that require one-to-one staff support initially as they transition from residential placement into community-based programs.
7. Limited intellectual functioning that has affected academic performance, eventually leading to be placed in individualized educational programming needed to help ascertain and support their academic needs.
8. Significant effects caused by the instability that accompanies long periods of out-of-home placement during childhood and adolescence.

B. 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.

C. Training

Training is an important component of an agency's operations. FBMH training is specified within the state's licensing guidelines. Training is required prior to the opening of the program, as well as during the early stages of operation. Both state and local training and education requirements are attached to this proposal as Appendix N.

D. Billing

1. The successful bidder must demonstrate a capability to manage third-party billing, including but not limited to Medicare, Medical Assistance (Pennsylvania Medical Assistance), Blue Cross/ Blue Shield, Commercial Carriers, and Managed Care Plans.
2. The successful bidder must submit claims electronically using the CMS 1500 (0805) Claim Form for each billable service.
3. The successful bidder shall accept Community Behavioral Health payment as payment in full and will not seek nor accept additional remuneration from the patient.

E. Specialized Family Based Mental Health Teams

1. *Youth Empowerment Teams (YET)*

Adolescents are faced with many challenging developmental tasks, some of which include physical/hormonal changes, pressure and/or desire to conform to particular social norms and expectations of a peer group, integration of self-concept, esteem and personal identity, becoming emotionally independent from one's family of origin, and incorporating a value system which aids in processing consequences and decisions. These developmental tasks become especially difficult for an adolescent to contend with in the face of personal/ social/environmental circumstances that may be fraught with the burden of trauma/abuse, neglect, racism/discrimination, poverty, family conflict, parental abandonment or inconsistency, addiction, mental health/substance abuse issues, etc. These factors are often the antecedents that place this unique, vulnerable population at high-risk for being unable to fulfill their greatest potential.

This specialized *Youth & Family Empowerment Team* will be uniquely qualified to help enhance a family's understanding of the distinct developmental challenges that adolescents face in all domains and improve their ability to cope with concomitant stress and adversity. These teams will serve the needs of youth 12-18 years old who are at risk of out of home placement, transitioning home from residential facilities or other placements; designated as "difficult to engage" in the therapeutic process, and who may also have extensive prior history of services (BHRS, PHP, AIP, RTF) that have led to minimal or no sustained improvement in functioning and healthy relationships with parents/caregivers. These adolescents are often among the older siblings in a family who may have taken on a parentified role in the family system, or been labeled or treated as

the scapegoat. The Youth Empowerment Team will be given the singular task of helping parents re-gain their competence and provide sufficient support so that the youth can view the family as a healthy resource in navigating their passage to successful adulthood.

In addition to adhering to ESFT model, the YET teams should clearly demonstrate they ways in which they will proactively incorporate the developmental assets framework (Appendix B) in therapy and as an effective strategy to empower and support youth and their families. “Search Institute's 40 Developmental Assets<sup>®</sup> are concrete, common sense, positive experiences and qualities essential to raising successful young people. These assets have the power during critical adolescent years to influence choices young people make and help them become caring, responsible adults.” These development assets fall in several categories: support, empowerment, boundaries and expectations, constructive use of time and commitment to learning, positive values, social competencies, and positive identity. This framework is consistent with the philosophy of family therapy as it focuses on ways to enhance resiliency, competency and mobilize natural resources in the family and community.

Providers should demonstrate that identified team members have strong ability to provide not only family therapy and case management, but can act as role models or mentors to youth and primary care giver. Mentoring is an important adjunct to family therapy for adolescents especially who may not readily participate in “traditional” therapeutic methods.

The mentoring relationship can be used to bolster the goals set for improvement in family functioning as well as the functioning of the individual adolescent. These goals may include:

- a. serving as a positive role model for clients to observe and learn socially effective values, attitudes, and behaviors;
- b. providing a therapeutic, non-threatening outlet for clients to explore issues, resolve conflict, and receive positive feedback;
- c. helping to link clients with positive experiences in the community such as employment, sports, community service, and recreational clubs;
- d. encouraging the development of independent living skills and;
- e. providing one-to-one tutoring support to provide the opportunity for academic and future vocational success.

Interventions used to accomplish the above objectives must be recovery oriented, creative, dynamic, and flexible and draw on existing natural resources in the family (immediate and extended), community, and school settings. Specifically, YET must

demonstrate an ability to form strong positive linkages to community-based resources to support the youth and family. This linkage must go beyond simply making a referral but should be established based on family need and built around the youth's educational, vocational, recreational, self-esteem, needs while also including their talents and strengths.

## *2. Medically Complex Co-Occurring Team (MCCT)*

For the vast majority of individuals, families are the first line of healthcare. Whether the member is a child with cystic fibrosis or an adolescent with diabetes, or a parent with multiple sclerosis or a grandparent with Alzheimer's disease, it is the family, first and foremost, that cares for an ill loved one. One family member's chronic illness influences the lives of every member of the family. Roles and routines change. The only certain thing is that chronic illness is a family experience, one that is shared by all. Frequently, however, the families of the chronically ill do not seek treatment for problem triggered by or exacerbated by the physical disorder. The task of the family therapists is to address of chronic illness in the family.

Pennsylvania Medical Assistance eligible families are dealing with diverse medical issues such as cancer, diabetes, hemophilia, sickle cell disease, heart disease, stroke and spina bifida during the past year. The experience of illness by the family and its diagnosed member can have transformative aspects. While it is true these families can be much more vulnerable than other families, it is also true that, once they get their coping mechanisms together, this can draw them more powerfully together than other families. They can become very close and very strong. Some families organize themselves around chronic illness in ways that can lead to difficulty in the healthy functioning of the family. Some families may become wedded to the structural arrangement that the chronic illness has created in the family.

This can make it difficult for the young adult who wants to break away from the family, or the wife who wants to return to the workforce after years of childcare. Sometimes, the arguments between the parent and the child may be ways in which the children are trying to propel them from the home. Children may also unconsciously attempt to "rescue" chronically ill relatives by becoming family problems themselves and thus diverting attention from the sick person. There are other problems for the siblings when one of them is chronically ill. The well sibling may feel the need to take over the entire burden of success for his generation, as though single handedly he could rescue the parents from the sorrow they experience from having a chronically ill child.

Family Based Services teams, with knowledge and experience in dealing with families who are dealing with the complexities of physical illnesses, are needed throughout the city of Philadelphia. Teams with working knowledge of the physical health systems and relationships with the child-serving hospitals, such as CHOP, St. Christopher's, etc. are essential.

The MCCT would have an advisor/team member with medical knowledge and experience. The MCCT would collaborate with the medical team working with the client's family, ensuring open lines of communication and establishing the parent(s) as an active member of the treatment team for both physical and behavioral health issues.

### *3. Crisis Response Center Family Focused Team (CRCFFT).*

The Crisis Response Center (CRC) at Germantown Hospital Center is the only portal of entry for children and adolescents in psychiatric and behavioral crisis. The CRC has some 4,000 children and adolescent visits per year. About 40% are not crises in the true psychiatric sense, not a danger to self and others. A significant number of both urgent and non-urgent visits involve family crises, which require immediate intervention. The staff at the CRC do not have the time or skills to perform emergency family interventions in most of these family crises and resort to psychiatric hospitalization. Family crises that might well respond to immediate family intervention and not require psychiatric hospitalization include:

- Young children (ages 4-10) whose families are having problems managing their symptoms,
- Developmentally delayed children and adolescents whose families have not been taught to manage symptoms with behavioral techniques,
- Children and adolescents who are having trouble adjusting to foster care or other out of home placements,
- Adolescents having problems adjusting to blended families, and
- Children and adolescents whose behaviors and symptoms interfere with family functioning

The CRCFFT will be attached to the Germantown CRC to provide emergency FBMHS services to children and adolescents in the CRC. If the attending psychiatrist feels that the psychiatric emergency is a family crisis then he/she will call the CRCFFT to do an evaluation (family evaluation). If the CRCFFT team determines that an immediate intervention has the chance of keeping this child or adolescent out of the hospital then they will formulate a treatment plan that should include immediate or emergency interventions. Emergency interventions would include: a "stat" family session, respite care, temporary placement with other family members, therapeutic staff support or crisis

worker in the home, or collaborative emergency placement with DHS. The CRCFFT would add this case to its roster until the situation is stabilized and the family could be transferred to a non-crisis Family Based Mental Health team. The CRCFFT would have to manage its caseload in order to be able to respond to and take on new crisis cases as they occur.

#### 4. *Sexual Abuse and Trauma Team (SATT)*

##### **SYSTEM NEED**

Childhood sexual abuse is one of the most traumatic, utterly disturbing events that a child could suffer through. The long-term impact of this trauma can be severe and pervasive; permeating every aspect of a child's life well into adulthood. Sexual abuse and trauma leads to loss of trust and self-esteem, shame and guilt, depression, adolescent substance abuse, risky deviant behavior and psychological, emotional and behavioral issues. Unfortunately, child sexual abuse occurs at an extremely alarming rate.

In 2004, the American Academy of Child and Adolescent Psychiatry published a *Facts for Families* regarding sexual abuse which stated that "Child sexual abuse has been reported up to 80,000 times a year, but the number of unreported instances is far greater, because the children are afraid to tell anyone what has happened". Information regarding the prevalence of childhood sexual abuse in Philadelphia is also quite sobering. Based on a statistical random digit dial survey of Philadelphia adults in 2006:

- 1 in 4 adult Philadelphians report being sexually abused as a child.
- 1 in 7 report being concerned that a child they knew was being sexually abused.
- 2 in 3 recognize sexual abuse as physical contact only.
- Almost one-half said they did not think they knew specific characteristics or behaviors that would identify an adult who was sexually abusing, or 'at risk' to sexually abuse a child.

Childhood sexual abuse and trauma not only affects the child, but also can be profoundly devastating to families, especially considering the fact that intrafamilial abuse is common. Experts have cited that the way a victim's family responds to abuse plays an important role in how the incident affects the victim. Family therapy is crucial in helping a child and family cope with the difficult feelings of guilt, anger, abandonment, violation of trust and personal safety and a host of other overwhelming emotions.

In addition to being experienced in the area of Structural Family Therapy, it is recommended that clinicians have experience and training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) developed by Drs. Judith Cohen, Esther Deblinger and Anthony Mannarino. The Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized TF-CBT as an effective evidence based model program and because of the well-designed scientific studies supporting TF-CBT, SAMSHA is encouraging its broader use by practitioners.

Trauma-Focused Cognitive Behavioral Therapy is a structured treatment that takes place over as short a period as twelve weeks. A child and (whenever possible) the child's parent or supportive caregivers participate. The treatment begins with *education*. The therapist shares information with the child and caregiver about common reactions and symptoms that may result from sexual abuse. This helps children understand that their reactions and feelings are normal and that treatment can help them. It helps non-abusing parents to accept that the abuse wasn't their fault or the child's fault.

Another part of the therapy is overcoming *learned fears*. This means unlearning the connection a child has made between the abuse, her negative feelings about it, and *trauma reminders*, other things and events she's associated with the experience. Desensitization may be necessary when a child continues to have intense reactions to particular things, places, people, or situations that remind him or her of the trauma. One of the most significant parts of the treatment is the *trauma narrative*. The clinician helps the child to tell a coherent account of what happened, how it felt, and what it meant. By putting her memories in order, the child no longer feels haunted by them. The therapist helps identify and correct the child's distorted ideas and beliefs about the abuse.

### **III.5 SITE REQUIREMENTS**

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

This section must include the specific address where the administrative offices are to be located; the relationship of the responding agency to the property (owned, leased, under agreement to be purchased, etc.).

All bidders will be responsible for working with their respective county offices of Licenses and Inspections to ensure compliance with all permit, zoning, and use code. 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 provider agreement. A statement must be included indicating a commitment to comply with all of the above requirements.

## **SECTION IV SPENDING PLAN/BUDGET**

### **IV.1 BUDGETS**

Budgets accompanying the proposals must support the Scope of Services previously described.

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. Existing FBMHS programs have a rate of \$41.06 per 15minute unit. Each new program proposed in this RFP, will have the same rate. These rates assume the following staffing expectations per team: one (1) master's prepared clinician and one (1) mental health worker.
- B. Proof of incorporation
- C. A certified audit and/or management letter of the agency 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.
- G. The budget should include spending plan for use of FFS funds that would include annual review of overall expenditures with a line item review to determine the appropriateness of expenditures.

## **SECTION V EVALUATION PLAN**

All programs approved through this RFP process will be subject to evaluation by DBH/MRS and during the initial year program monitoring will occur. By accepting the award of this RFP, bidders agree to comply with the evaluation requirements of DBH/MRS. Awardees agree to supply all the required data necessary for the evaluation and to participate in required consumer assessments. The evaluation plan should include focus on the following areas:

### **V.1. INDIVIDUAL OUTCOMES**

This outcomes component will assess the immediate effects that the program has on the individuals receiving the service. The purpose is to learn about short-term changes in participants' knowledge, attitudes, beliefs, or actual behavior, and to determine whether the goals of the program are met. After the award is made, DBH/MRS will select specific individual outcome measures, based on the distinct goals of the program, to include in the evaluation. The individual outcome measures will be based on resiliency-oriented principles such as:

- A. Improving quality of life;
- B. Consumer and family satisfaction;
- C. Improving community and educational integration;
- D. Participation in meaningful activities and social relationships;
- E. Discharge Choice;
- F. Peer support; and
- G. Achieving positive clinical outcomes.

The outcomes selected will be measurable and based on information that the program can collect and report to DBH/MRS. Baseline information will be collected on these measures, and periodic assessments will be carried out to measure change as a result of the program. The Consumer Satisfaction Team will participate in this part of the evaluation.

### **V.2. PROGRAM LEVEL PROCESS**

This outcomes component will determine to what extent the program is being implemented as planned. It is intended to answer the questions "who is being served," "what is actually happening in the program," and "is the program delivering the contracted services?" This evaluation will be carried out through the collection and analysis of participant (demographic) and program (service) data outlined at the end of this section; and by the DBH/MRS monitoring team, which will monitor compliance and budget issues. Information that will be analyzed in this evaluation component will address the following kinds of questions:

- A. What are the demographics of the people who are being served (age, gender, race/ethnicity)?
- B. How many people are being served?
- C. What type of service (intervention/activity) is being provided and what is the frequency of the service?
- D. How many staff /consumers are involved with the service provision?
- E. Are the services being carried out as planned?
- F. How many people successfully complete the program?
- G. What organizational structure is in place to manage the program?

### **V.3. ORGANIZATIONAL LEVEL PROCESS**

This RFP requires bidders to specify the measurable changes within its organization that are anticipated within 12 months of the award that will demonstrate:

- A. Positive movement toward creating an atmosphere of resiliency for children and families;
- B. Improvement in the cultural competency of the organization;
- C. Increasing the use of evidence-based practices; and
- D. How the organization is doing in the treatment of children with severe behavioral health care needs.

The evaluation will include measurement of changes in this program and in the entire organization toward promoting a resiliency, cultural competence, and an increasing evidence basis to service delivery. As noted above in the individual evaluation section, DBH/MRS will specify objectives based on the preceding principles that the agency should work toward achieving.

The DBH/MRS monitoring team will track the on-going progress toward meeting these objectives. As part of the overall program evaluation, awardees will be required to prepare periodic reports for DBH/MRS's review on the progress that has been made toward meeting these objectives.

### **V.4. SYSTEM LEVEL PROCESS**

The system evaluation will examine the impact of the programs on the DBH/MRS service system for the children and adolescents receiving these services. The system level outcome evaluation will include the measures selected by DBH/MRS similar to the ones specified below:

- A. Number of crises (including Crisis Response Center visits, 302 commitments and inpatient episodes);
- B. Engagement: how the program recipients utilize other DBH/MRS services before and during, their participation in the program;
- C. Continuity of care: linkages to the next appropriate level of care; and
- D. Stabilization: after completion of the program, is there stability in participant functioning in the community?

This evaluation will be carried out using reported service data and information collected by the DBH/MRS monitoring team.

## **SECTION VI 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 data that is rejected by the CBH information system must be corrected and resubmitted.

## **SECTION VII 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 Director of DBH/MRS concerning those proposals deemed most appropriate for selection. The make-up of the review committee will be composed of internal departmental staff as well as consumers and family members. In reviewing the proposals, the review committee will weigh all submissions according to the following criteria:

### **VII.1 EXPERIENCE/CAPABILITY (up to 20 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.

4. Experience and understanding the target population knowledge of how to work effectively with and take into account the subgroup

## **VII.2 COMMUNITY PARTICIPATION/LINKAGES (up to 20 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.

3. Plans to develop programming that supports the overall system goals of the DBH/MRS and willingness to provide services in high need areas of the city.

## **VII.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 agency structure.

## **VII.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.

## **VII.5 BUDGET PLAN (up to 10 Points)**

1. A budget narrative and any accompanying documentation will be evaluated for its support of the Scope of Services under a fee for service plan utilizing the aforementioned rate of \$41.06 per 15 minute unit.
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.

## **VII.6 BUSINESS OPERATIONS (up to 15 points)**

1. Providers that have home offices 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 to those proposals incorporated within the state of Pennsylvania.
2. Proposals from that meet MBEC requirements will receive additional review points.
3. Proposals from 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**

**PHILADELPHIA  
DEPARTMENT OF BEHAVIORAL HEALTH  
AND MENTAL RETARDATION SERVICES**

**RFP 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 \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF OFFICIAL AUTHORIZED TO BIND BIDDER TO A PROVIDER AGREEMENT TITLE

\_\_\_\_\_  
TYPED NAME OF AUTHORIZED OFFICIAL IDENTIFIED ABOVE

DATE SUBMITTED \_\_\_\_\_

# Appendix B

## 40 Developmental Assets® for Adolescents (ages 12-18)

Search Institute® has identified the following building blocks of healthy development—known as Developmental Assets®—that help young people grow up healthy, caring, and responsible.

### **Internal Assets External Assets**

#### **Support**

1. Family support—Family life provides high levels of love and support.
2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other adult relationships—Young person receives support from three or more nonparent adults.
4. Caring neighborhood—Young person experiences caring neighbors.
5. Caring school climate—School provides a caring, encouraging environment.
6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.

#### **Empowerment**

7. Community values youth—Young person perceives that adults in the community value youth.
8. Youth as resources—Young people are given useful roles in the community.
9. Service to others—Young person serves in the community one hour or more per week.
10. Safety—Young person feels safe at home, school, and in the neighborhood.
11. Family boundaries—Family has clear rules and consequences and monitors the young person's whereabouts.

#### **Expectations**

12. School Boundaries—School provides clear rules and consequences.
13. Neighborhood boundaries—Neighbors take responsibility for monitoring young people's behavior.
14. Adult role models—Parent(s) and other adults model positive, responsible behavior.
15. Positive peer influence—Young person's best friends model responsible behavior.
16. High expectations—Both parent(s) and teachers encourage the young person to do well.

#### **Constructive Use of Time**

17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. Religious community—Young person spends one or more hours per week in activities in a religious institution.

20. Time at home—Young person is out with friends “with nothing special to do” two or fewer nights per week.

**Commitment to Learning**

21. Achievement Motivation—Young person is motivated to do well in school.

22. School Engagement—Young person is actively engaged in learning.

23. Homework—Young person reports doing at least one hour of homework every school day.

24. Bonding to school—Young person cares about her or his school.

25. Reading for Pleasure—Young person reads for pleasure three or more hours per week.

**Positive Values**

26. Caring—Young person places high value on helping other people.

27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.

28. Integrity—Young person acts on convictions and stands up for her or his beliefs.

29. Honesty—Young person “tells the truth even when it is not easy.”

30. Responsibility—Young person accepts and takes personal responsibility.

31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

**Social Competencies**

32. Planning and decision-making—Young person knows how to plan ahead and make choices.

33. Interpersonal Competence—Young person has empathy, sensitivity, and friendship skills.

34. Cultural Competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.

35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.

36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.

**Positive Identity**

37. Personal power—Young person feels he or she has control over “things that happen to me.”

38. Self-esteem—Young person reports having a high self-esteem.

39. Sense of purpose—Young person reports that “my life has a purpose.”

40. Positive view of personal future—Young person is optimistic about her or his personal future.

This page may be reproduced for educational, noncommercial uses only. Copyright © 1997, 2006 by Search Institute, 615 First Avenue N.E., Suite 125, Minneapolis, MN 55413;800-888-7828;

[www.search-institute.org](http://www.search-institute.org).

All Rights Reserved.

The following are registered trademarks of Search Institute: Search Institute®, Developmental Assets® and Healthy Communities • Healthy Youth®

## Appendix C

### Theoretical Assumptions of the Ecosystemic Family Therapy Model

- All behavior is a form of communication within a defined cultural context.
- Symptoms occur within the context of social interactions.
- Causality is a circular, not linear, phenomenon.
- Families are evolving multibodies systems that continually regulate their internal structure, rules and roles in response to developmental and environmental changes.
- Adaptive functioning is determined by the fit of a family's structure to the functional demands made upon it from within and beyond the system.
- Family members relate to each other in patterned ways that are observable and predictable.
- Repetitive patterns created by family roles and rules evolve in an interlocking and complimentary fashion.
- Family members develop a preferred degree of emotional and functional levels of proximity and distance in relating to one another.
- Families are hierarchically organized, with unwritten rules for interactions between and within the subsystems.
- Inadequate hierarchical structure and boundaries maintain symptomatic behavior.
- Family patterns are replicated in the surrounding ecosystems.
- Individuals are inherently competent, although rigid interactional patterns can inhibit the expression of that competence.
- Change in the family structure contributes to change in the behavior of individual members.
- Promoting alternative transactional patterns broadens the flexibility and competence of individuals and subunits in the family and its ecosystems.
- Families are their own best resource for change.<sup>2</sup>

---

<sup>2</sup> Lindblad-Goldberg, M., Dore, M.M. and Stern, L. (1998) *Creating Competence from Chaos: A Comprehensive Guide to Home-Based Services*. New York: W.W. Norton and Co.

## **Appendix D**

### **OMAP Guidelines for Mental Health Necessity Criteria - FBMHS**

The Family Based Mental Health Services Program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21, and their families. Utilization of the FBMHS program occurs following referral for this service and the subsequent determination by the FBMHS treatment team that the service is clinically appropriate. FBMHS is available to children who are at risk for out-of-home placement due to a severe emotional or behavioral disorder, or due to a severe mental illness. FBMHS is also used as a step-down for children returning to their family, which may include natural or substitute care families, following out-of-home placement.

Consistent with the CASSP principles and philosophy, the guiding tenets of FBMHS are that children grow-up best in their own home, that the family is a resource and partner in the treatment process, that treatment utilizes strengths in addressing areas of need and concern, and that coordination among other human service systems and with the community is essential. In addition, while the child receives treatment, services also work to enhance the family role as a resource and partner in the treatment process.

The Family Based Mental Health Services Program is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker, which is comprehensive in scope, incorporating intensive home therapy, casework services, family support services and 24 hour, 7 day availability for crisis stabilization. Each team maintains a caseload of up to eight (8) families to ensure the intensity of service and team availability to the families they serve. Team members receive supervision together as an integral part of an ongoing program for the families served. In addition, there is an ongoing training curriculum that extends over a three-year period designed specifically for Family Based Mental Health Service Team members.

The service is broadly conceived for flexible use in the home and community. The specific frequency and schedule of face-to-face contacts are developed collaboratively with the family, based on needs at that time. This allows the team to provide for individual family needs when they are closely associated with the child's treatment, such as time for family education/training regarding therapeutic components and skill building for the child and family. The team also works with the family to identify resources available to them. Teams are available to provide 24 hour service, and they also work with other systems when they are involved with the child and family, such as Drug and Alcohol Services, Children and Youth, Juvenile Justice, special education, etc. Clinical treatment within FBMHS is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, conjoint family meetings, which can include different combinations of family members and community members as indicated. Due to its commitment to support both the development of children and the integrity of the family, FBMHS, while primarily treatment, also serves a

preventive function. The needs of all the children within a family, not just the child in response to whom services were initiated, are actively considered and included as part of the treatment process.

Services offered by the FBMHS program include formal individual and family therapy sessions with the child and/or family. In addition, program service requirements include the following:

- Crisis intervention and stabilization;
- Emergency availability;
- Ongoing information-gathering in support of active treatment;
- Collaborative development and modification of the treatment plan;
- Clinical intervention by each team member with the child in attaining identified treatment goals and objectives within the treatment plan, including: remediation of child's symptoms (i.e. behavioral, affective, cognitive, thought impairments, etc.), improvement of family relationships, community integration, and other aspects of psychosocial competence and skill development in the home, school, or community;
- Support for the parents in implementing effective behavior management and parenting approaches specific to the presenting problems of their child;
- School-based consultation and intervention as needed;
- Referral, coordination, and linkage to other agencies, social services, and community services, as appropriate;
- Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as transportation and recreation, and developing a network in order to receive these services.

The Family Support Service (FSS) is a requirement in the Family Based Mental Health Services Program under Health Choices. Family-Based Family Support Services (FBMHS) are formal and informal services or tangible goods which are needed to enable a family to care for and live with a child who has a serious emotional disturbance. FBMHS/FSS include supportive services and tangible goods, which facilitate achievement of the child's treatment goals. If a child is in temporary out-of-home placement, FBMHS/FSS should be used to facilitate the return of the child to the natural family and in this instance should be available to both the natural family as well as the foster family.

A cost component for FBMH/FSS is built into the HealthChoices capitation rate. As such, it is recommended that the provider and the BH-MCO agree to a method for setting aside an appropriate percentage of the FBMHS provider fee for the purchase of services or goods needed to further the child's treatment goals. The FBMHS budget identifies administrative and program costs which include family support services.

- The FBMHS unit of service is billed for activities or direct services, which are provided by the Family-Based team members using existing procedure codes. Only such FBMHS units are reported as encounter data.
- There is no separate reporting requirement for FBMH Family Support Services.
- The provider must have an accounting system that identifies revenue sources and expenditures.

Admission (**must meet criteria I and II**)

I. Diagnostic Evaluation and Documentation

- A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I));
- B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition; Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;
- C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.

II. Severity of Symptoms

- A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,
  - 1. the family recognizes the child's risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;
  - 2. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;
- B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:
  - 1. Suicidal/homicidal ideation
  - 2. Impulsivity and/or aggression
  - 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
  - 4. Psychomotor retardation or excitation.
  - 5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
  - 6. Psychosocial functional impairment
  - 7. Thought Impairment
  - 8. Cognitive Impairment
- C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;
- D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing

- symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;
- E. There is an exacerbation of severely impaired judgment or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;
- F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;
- G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

**Requirements for Continued Stay (must meet criteria I and II)**

- I. Diagnostic Evaluation and Documentation
  - A. Recommendation to continue FBMHS must occur:
    - 1. by the treatment team every 30 days through an updated and revised treatment plan, and
    - 2. by a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;
  - B. An updated treatment plan by the treatment team indicates child's progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.
- II. Severity of Symptoms
  - A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;
  - B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;
  - C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.
- III. Support Criteria

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

- IV. Continued Care Documentation
  - A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.
    - 1. The review of the child being served must:
      - a. clarify the child's progress within the family context and progress toward developing community linkages; and
        - 1. clarify the goals in continuing FBMHS; and

2. the need for continuing FBMHS if continuation beyond 32 weeks is recommended; and
  - b. whenever FBMHS service is considered for a term greater than 32 weeks:
    1. a psychiatrist, licensed psychologist, or physician must update the diagnosis; and
    2. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources;
  - B. Child demonstrates:
    1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); or
    2. increased or continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan);
  - C. Treatment plan is addressing the behavior within the context of the child's problem and/or contributing psychosocial stressor(s)/event(s);
  - D. Treatment plan is updated to reflect recommendation to continue care.
- V. Discharge and Service Transition Guidelines
- A. The treatment team, determines that FBMHS:
    1. up to 32 weeks of FBMHS services has been completed; and/or
    2. the service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
      - a. expected behavioral response, and/or
      - b. the FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
    3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
    4. creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
  - B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.

Family Based Mental Health Services (Must meet I/II and III) I. & II. [Combined]

**Diagnostic Indicators** [Axis I or Axis II; D&A on Axis I, and MR on Axis II do not stand alone] (Must meet A, B, C & D)

- A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the treatment team as an alternative to out-of-home placement or as a step down

- from inpatient hospitalization or Residential Treatment, or as a result of little or no progress in a less restrictive/intrusive service,
- B. Severe functional impairment is assessed in the child's presenting behavior. The intensity of service is determined on an individualized basis according to the following parameters: severity of functional impairments, risk of out-of-home placement, and risk of endangerment to self, others or property.
1. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission;
  2. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child, and
    - a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family; and/or
    - b. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;
  3. Presence of at least one (1) of the following:
    - a. Suicidal/homicidal threatening behavior or intensive ideation
    - b. Impulsivity and/or aggression
    - c. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
    - d. Psychomotor retardation or excitation.
    - e. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
    - f. Psychosocial functional impairment
    - g. Thought Impairment
    - h. Cognitive Impairment
  4. There is an exacerbation of severely impaired judgment or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised;
  5. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;
  6. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;
  7. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.
- C. Behavior is assessed to be manageable in the home setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of the treatment plan, as a result of:
1. the delivery of the therapy and casework services in the home, required to serve the child's specific treatment needs;

2. there is documented commitment by the family to the treatment plan
  3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent (age 14+) and family member develop a **safety plan** which, the family member signs.
- D. The severity and expression of the child's symptoms are such that:
1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above;
  2. on-site intervention in the home or community offers a more effective preventive to longer-term consequences.

### III. Support Criteria

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

### IV. Continued Care

Child must be reevaluated every 30 days for the purpose of updating the child's progress, progress toward developing community linkages, and the necessity for continuing Family Based Mental Health Services in the treatment plan.

The review of the child being served must:

1. clarify the child's progress in treatment, within the family context, and toward developing community linkages; and
    - a. clarify the goals in continuing FBMHS; and
    - b. the need for continuing FBMHS, if continuation beyond 32 weeks is recommended; and
  2. whenever FBMHS service is considered for a term greater than 32 weeks:
    - a. a psychiatrist, licensed psychologist, or physician must revise and/or update the diagnosis; and
    - b. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources;
- B. Treatment plan is updated to reflect the recommendation to continue care.
- C. Treatment plan is addresses the presenting problem within the context of the family and/or contributing psychosocial stressor(s)/event(s); and
- D. Child demonstrates:
1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation);
  2. increased or continued behavioral or emotional disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

## V. Discharge Criteria

A. Prescriber, with the participation of the interagency team, determines that:

1. Up to 32 weeks of FBMHS services has been completed;
2. The service results in an expected level of stability and treatment goal attainment for the intervention such that the child meets: expected positive behavioral response; and/or
3. FBMHS are no longer necessary in favor of a reduced level of support provided by other services;
4. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further Family Based Mental Health Services; the services provided create a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
5. The parent/guardian or adolescent, 14 years old or older, requests reduction in service or termination of the service.

## APPENDIX E

### Department of Behavioral Health and Mental Retardation Services

#### 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](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 provider agreement 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.

## **Appendix F**

### **Department of Behavioral Health and Mental Retardation Services**

#### **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.

## B. 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.

# **Appendix G**

## **Department of Behavioral Health and Mental Retardation Services**

### **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.

Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies. The Iowa Practice Improvement Collaborative Project, Iowa Consortium for Substance Abuse Research and Evaluation at the University of Iowa, Spring, 2003.

Evidence-Based Mental Health Notebook. Teaching Evidence-Based Practice in Mental Health. 2, (3), August, 1999.

Freese, Frederick J. III, Stanley, J., Kress, K., and Vogel-Scibilia, S. Integrating Evidence-Based Practices and the Recovery Model, *Psychiatric Services*, 52, (11), November, 2001.

Geddes, J., Reynolds, S., Streiner, D., Szatmari, P., Evidence-Based Practice in Mental Health: New Journal Acknowledges an Approach Whose Time has Come (editorial). *British Medical Journal*, 315, (7121) p1483(2). Dec 6, 1997

Torrey, William C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., Rush, J.A., Clark, R.E., Klatzker, D., Implementing Evidence-Based Practices for Persons With Severe Mental Illnesses. *Psychiatric Services*. 52, (1), January, 2001.

## 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/>

## **Appendix H**

### **Department of Behavioral Health and Mental Retardation Services**

#### **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

## **References**

Cross, T.L., Nason, B.J., Dennis, K.W., Isaacs, M.R. (1989). *Toward a Culturally Competent System of Care*. Washington, DC: Georgetown University Child Development Center.

Goode, T. (2002). *Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs*. Georgetown University Child Development Center, National Center for Cultural Competence. Retrieved May, 2005 from <http://gucchd.georgetown.edu/nccc/framework.html>

National Technical Assistance Center for State and Mental Health Planning and the National Association of State Mental Health Program Directors. (2004). *Cultural Competency: Measurement as a Strategy for Moving Knowledge into Practice in State Mental Health Systems*. Retrieved May, 2005 from [http://www.nasmhpd.org/general\\_files/publications/cult%20comp.pdf](http://www.nasmhpd.org/general_files/publications/cult%20comp.pdf)

Taylor, T., & Brown, M. (1997). Georgetown University Child Development Center, University Affiliated Program.

U.S. Surgeon General. (1999). *Mental Health: A Report of the Surgeon General*. Retrieved May, 2005 from <http://surgeongeneral.gov/library/mentalhealth/home.html>

## **Resources**

### **A. Print**

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.

Evans, A.C., Delphin, M., Simmons, R., Omar, g., and Tebes, J. (2004). Developing a framework of culturally competent systems of care. In R.T. Carter (Ed.), Handbook of Racial Cultural Psychology, Volume 2, John Wiley & Sons, New York, NY.

Betancourt, Joseph R., Green, Alexander R. and Carrillo, J. Emilio. Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches. The Commonwealth Fund. October, 2002

Cultural Competency Standards: Recommended Standards for Culturally and Linguistically Appropriate Health Care Services (CLAS). Adapted from the US Department of Health and Human Services Office of Minority Health & Resources for Cross Cultural Health Care.

Cultural Competency: Measurement as a Strategy for Moving Knowledge into Practice in State Mental Health Systems, National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors, September, 2004

How Does Cultural Competency Differ from Cultural Sensitivity/Awareness? American Institutes for Research, Center for Effective Collaboration and Practice. Accessed at [www.air.org/cecp/cultural/Q\\_howdifferent.htm](http://www.air.org/cecp/cultural/Q_howdifferent.htm), May, 2005.

#### B. Websites

<http://gucchd.georgetown.edu/nccc/products.html>

Bronheim, Suzanne. Cultural Competence: It All Starts at the Front Desk. National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Centers for Excellence in Developmental Disabilities. Accessed at <http://gucchd.georgetown.edu/nccc>.

Mental Health: Culture, Race, Ethnicity  
Supplement to Mental Health: Report of the Surgeon General  
<http://www.mentalhealth.org/cre/default.asp>

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, Office of Minority Health Resource Center.  
<http://www.omhrc.gov/CLAS>

Cultural Competency. A Practical Guide for Mental Health Service Providers. (2001). The Hogg Foundation for Mental Health.  
[www.hogg.utexas.edu/PDF/Saldana.pdf](http://www.hogg.utexas.edu/PDF/Saldana.pdf)

The California Endowment

[www.calendow.org](http://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](http://cecp.air.org/cultural/Q_howstart.htm)

The Cross Cultural Health Care Program

[www.xcultre.org](http://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](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](http://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>

68

City of Philadelphia

Department of Behavioral Health and Mental Retardation Services

Community Behavioral Health

Request for Proposals – Family Based Mental Health Services

- Cultural Competence Works: Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements. <http://www.hrsa.gov/financeMC/ftp/cultural-competence.pdf>

U.S. Surgeon General.

- Mental Health: A Report of the Surgeon General. (Washington, D.C.: US Department of Health and Human Services, 1999). <http://www.surgeongeneral.gov/library/mentalhealth/>
- Culture, Race, and Ethnicity -- A Supplement to the Report <http://www.surgeongeneral.gov/library/mentalhealth/cre/>

# Appendix I

## Department of Behavioral Health and Mental Retardation Services

### 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 & Fallot, 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).

### D. 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 provider agreement with the Center for Mental Health Services (DMHS), Substance abuse  
and Mental Health Services Administration (SAMHSA),

U.S. Department of Health and Human Services (HHS)

<http://www.annafoundation.org/MDT.pdf>

**References**

Blanch, A. (2003). *Developing trauma-informed behavioral health systems*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York, NY: Routledge.

Browne, A. (1992). Violence against women: Relevance for medical practitioners. Council on Scientific Affairs, American Medical Association Report. *JAMA*, 257 (23).

Clark, H., McClanahan, T., & Sees, K. (1997). Cultural aspects of adolescent addiction and treatment. *Valparaiso University Law Review*, 31(2).

Covington, S. S. (2003). *Beyond trauma: A healing journey for women*. Hazelden.

Cusack, K., Frueh, B., Hiers, T., Suffoletta-Maierle, S., Bennett, S. (in press). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health*.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245-258.

Foa, E., Keane, T., & Friedman, M. (2000). *Effective treatment for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.

Ford, J., Courtois, C., Steele, K., van der Hart, O., & Nijenhuis, E. (2004). *Treatment of the complex sequelae of psychological trauma*. Manuscript submitted for publication.

Frueh, B. C., Buckley, T. C., Cusack, K. J., Kimble, M. O., Grubaugh, A. L., Turner, S. M., Keane, T. M. (2004). Cognitive-behavioral treatment for PTSD among people with severe mental illness: A proposed treatment model. *Journal of Psychiatric Practice*, 10(1), 26-38.

Frueh, B., Cousins, V., Hiers, T., Cavanaugh, S., Cusack, K. I., & Santos, A. (2002). The need for trauma assessment and related clinical services in a state public mental health system. *Community Mental Health Journal*, 38, 351-356.

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

Frueh, B., Dalton, M., Johnson, M., Hiers, T., Gold, P., Magruder, K., Santos, A. (2000). Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health*, 28, 147-154.

Giller, E. (1999). *What is psychological trauma?* Sidran Institute.

Goodman, L., Dutton, M., & Harris, M. (1997). The relationship between violence dimensions and symptom severity among homeless, mentally ill women. *Journal of Traumatic Stress*, 10(1), 51-70.

Goodman, L., Rosenberg, S., Mueser, K., & Drake, R. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin*, 23, 685-696.

Harris, M., & Fallot, R. (2001). Using trauma theory to design service systems. *New Directions for Mental Health Services*, 89. Jossey Bass.

Hien DA, Cohen LR, Litt LC, Miele GM, Capstick C (in press). Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry*. For information on this article, email the first author's assistant: idisla@chpnet.org; if you do not get a response, then contact: seekingsafety@netzero.com.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

Jennings, A. (in press). *Trauma informed mental health service systems: Blueprint for action*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Jennings, A. (2004). *The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system*. Alexandria, VA: Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

LeBel J, Stromberg N. (2004) *State Initiative to Reduce the Use of Restraint and Seclusion and Promote Strength-Based Care Powerpoint*, Massachusetts Department of Mental Health, Boston MA

Maine Department of Behavioral and Developmental Services. (1998). *Augusta Mental Health Institute consent decree class member assessment*.

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

Moos, R.H. (1996). *Community oriented program scale: Sampler set manual, test booklets, and scoring key (3rd Ed)*. Redwood City, CA: Mindgarden

Moos, R.H. (1997). *Evaluating treatment environments: The quality of psychiatric and substance abuse programs*. New Brunswick, NJ: Transaction Publishers.

Mueser, K., Goodman, L., Trumbetta, S., Rosenberg, S., Osher, F., Vidaver, R., Anciello, P., & Foy, D. (1998). Trauma and Posttraumatic Stress Disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66, 493-499.

Mueser, K., Rosenberg, S., Goodman, L., & Trumbetta, S. (2002). Trauma, PTSD, and the course of schizophrenia: An interactive model. *Schizophrenia Research*, 53, 123-143.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. The Guilford Press.

Najavits LM, Gallop RJ, Weiss RD (under review). *Seeking Safety* therapy for adolescents with PTSD and substance abuse: A randomized controlled trial. (Email seekingsafety@netzero.com to obtain

National Association of State Mental Health Program Directors (NASMHPD). (1999). *Position statement on services and supports to trauma survivors*. Retrieved from the Internet at [http://www.nasmhpd.org/general\\_files/position\\_statement/posstmb.htm](http://www.nasmhpd.org/general_files/position_statement/posstmb.htm) on September 16, 2004.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: DHHS

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry*, 64(4), 319-345.

Rosenberg, S., Mueser, K., Friedman, M., Gorman, P., Drake, R., Vidaver, R., Torrey, W., & Jankowski, M. (2001). Developing effective treatments for posttraumatic disorders among people with severe mental illness. *Psychiatric Services*, 52, 1453-1461.

Russell, D. (1986). *The secret trauma: Incest in the lives of girls and women*. New York, NY: Basic Books Inc.

Saakvitne, K., Gamble, S., Pearlman, S., & Tabor Lev, B. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Sidran Institute.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York, NY: Guilford Press.

## Appendix J

### Department of Behavioral Health and Mental Retardation Services

#### 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.

## References

### *Internet*

Bernard, Bonnie (1996) from Research to Practice. In Resiliency In Action, Winter 1996 Premiere Issue. Available 1/7/97 at <http://www.resiliency.com>

Freire ,Paulo Excerpts from Pedagogy of Freedom at <http://userwww.service.emory.edu>  
Report of the Surgeon General's Conference on Children's Mental Health.

Available at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>

Psychotherapy Networker, The Magazine for Today's Helping Professional

[http://www.psychotherapynetworker.org/interviews\\_seligman.htm](http://www.psychotherapynetworker.org/interviews_seligman.htm)

Spencer, Margaret at [http://www.dubois.gse.upenn.edu/miscFiles/margaret\\_beale\\_spencer.htm](http://www.dubois.gse.upenn.edu/miscFiles/margaret_beale_spencer.htm)

Teaching Resiliency to our Children

Available at <http://a2zgorge.info/prevention/resiliency.htm>

Bernard, Bonnie (1992) Corner on Research, Western Center News, Vol.5,No.3

Focal Point, Research, Policy and Practice in Children's Mental Health, Vol.19, No. 1 entitled Resilience and Recovery

Frey, Katie (1998) Introduction to Resiliency

Gilligan, Carol( 1985) In a Different Voice

Werner, E.E.& Smith, R.S. (1992) Overcoming the odds: High-risk children from birth to adulthood. Ithaca, N.Y. Cornell University Press.

## **APPENDIX K**

### **CBH - PROVIDER AGREEMENT**

This Agreement is made as of January 1, 2008, 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](http://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" thereunder or, where the term "Provider" is used, as the "Provider" thereunder; (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" thereunder 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. In addition, Provider may disclose Confidential Information to CBH which is proprietary and valuable to Provider. Each party 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 either party by or on behalf of the other party or created by either party pursuant to this Agreement, including but not limited to data and/or information relating to either party’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 the receiving party can demonstrate (i) is generally available to or known by the public other than as a result of disclosure by the receiving party or (ii) was obtained by the receiving party from a source other than the disclosing party, provided that such source is not bound by a duty of confidentiality to CBH, Provider or another person or entity with respect to such information.

(3) The parties agree that they:

(i) shall use Confidential Information solely in the course of their relationship hereunder;

(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 the other party. Either party 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 the other party, 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. Each party 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 either party at any time, the other party shall promptly return to the first party 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 either party, and that the other party 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 either party to enforce this Agreement or to obtain money damages for the breach hereof, the suing party shall be entitled upon demand to reimbursement from the other party 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. Effective July 1, 2008, Provider shall submit a Clean Claim no more than ninety (90) days following the date of service. 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 within the timeframes 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, 2008, 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 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 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.

I. *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  
Attn: Nancy Lucas, CEO  
801 Market Street  
Seventh Floor  
Philadelphia, PA 19107

**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.

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»

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

**COMMUNITY BEHAVIORAL HEALTH**

By: \_\_\_\_\_  
NANCY LUCAS

Its CHIEF EXECUTIVE OFFICER

«Contract\_Name»

110  
City of Philadelphia  
Department of Behavioral Health and Mental Retardation Services  
Community Behavioral Health  
Request for Proposals – Family Based Mental Health Services

EXHIBIT A

**Joinder Agreement**

By executing this document, \_\_\_\_\_ (ASubcontractor@) represents and warrants that he/she has reviewed the terms of the CBH-Provider Agreement for 2008 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 for 2008, 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. Notwithstanding the foregoing, Subcontractor shall only be liable for Subcontractor's own acts or omissions, and not for any failures or acts of Provider.

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 L

## MINORITY BUSINESS ENTERPRISE COUNCIL LANGUAGE

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

#### SECTION 3. The Minority Business Enterprise Council and Advisory Board

##### H. Nonprofit Organizations

The City annually spends a substantial percentage of its provider agreement dollars with nonprofit organizations and expects these organizations to share the City's commitment to diversity. Although City Provider agreements with nonprofit organizations are not subject to the City's M/W/DSBE participation ranges, all City Provider agreements 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 provider agreement 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 provider agreements with the City.

## **APPENDIX M - 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](http://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.dqs.state.pa.us/cabd.htm](http://www.dqs.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](mailto: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 [dced@state.pa.us](mailto:dced@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](http://www.sba.gov) and click on *PRO-Net*.

City of Philadelphia  
Department of Behavioral Health and Mental Retardation Services  
Community Behavioral Health  
Request for Proposals – Family Based Mental Health Services

## **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](mailto: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](mailto:cjumba@state.pa.us) or call 412-442-5872.

# APPENDIX N

## 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 resiliency for individuals and families with behavioral health issues.

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.

Area # 5: Understanding and competence in providing family systems theory.

Area # 6: Understanding and acquisition of Evidenced Based Family Therapy techniques.

### 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 and supervision will continue according to CBH credentialing and state regulations.

# **APPENDIX O**

## **Family Based License Packet**

**APPENDIX P**  
**Chapter 5260 FBMH Regulations**

**APPENDIX Q**  
**OMHSAS FBMH Bulletins**

# **APPENDIX R**

## **OMHSAS FBMH Policy Clarifications**

**APPENDIX S**  
**FBMH Proposed Draft Regulations**

# APPENDIX T

## City of Philadelphia Disclosure Forms

### Disclosure Forms

#### **Directions:**

1. Please read the following information regarding the completion of these disclosure forms. Please review the definitions prior to completing any form.
2. Date and initial the top of each form after you have completed it and sign the form on the last page.
3. NOTE: There are two different types of campaign contribution disclosure forms: one for those who are applying as individuals and one for those applying as businesses. Only fill out one type of form. (If you have used a consultant with respect to applying for this non-competitively bid contract you will have to fill out a campaign contribution disclosure form for them as well.)

#### **Getting Started**

There are five sets of disclosure forms enclosed in this packet. You must provide information for each disclosure form. The information you must disclose includes:

1. Any contributions (defined as a provision of money, in-kind assistance, discounts, forbearance or any other valuable thing) made during the two years prior to the application deadline for this non-competitively bid contract opportunity;
2. The name of any consultant(s) you used to help in obtaining the non-competitively bid contract and any campaign contributions they have made during the two years prior to the application deadline;
3. Any subcontractors you are planning to use if awarded this contract;
4. Whether a City of Philadelphia or Community Behavioral Health employee or official asked you to give money, services, or any other thing of value to any individual or entity; and
5. Whether a City of Philadelphia or Community Behavioral Health employee or official gave you any advice on how to satisfy any minority, women, disabled or disadvantaged business participation goals.

#### **More information on Disclosing Campaign Contributions**

Applicants for contract opportunities must disclose any contributions they made to:

- A candidate for nomination or election in any public office in the Commonwealth of Pennsylvania
- An incumbent in any public office in the Commonwealth of Pennsylvania
- A political committee or state party in the Commonwealth of Pennsylvania
- A group, committee, or association organized in support of any candidate, office holder, political committee or state party in the Commonwealth of Pennsylvania

*Attribution Rules.* In addition to disclosing contributions made directly by the applicant, the applicant will be asked to supply information on other types of contributions. The campaign contribution disclosure forms will include questions that specifically ask for information on these other types of contributions. These contributions will be attributed to the individual or business and will be used to determine the applicant's eligibility to be awarded a contract.

Businesses (i.e. corporation, limited liability company, partnership association, joint venture, or any other legal entity) have to disclose contributions made by the following:

- Applicant business
- Parent, subsidiary, or otherwise affiliated entity of the applicant business (“affiliate”)
- An individual or business that is then reimbursed by the applicant business or affiliate
- Officers, directors, controlling shareholders, or partners of the for-profit applicant business or for-profit affiliate
- Political action committee controlled by applicant business or affiliate
- Political action committee controlled by officer, director, controlling shareholder, or partner of the for-profit applicant business or for-profit affiliate

Individuals have to disclose contributions made by the following:

- Applicant individual
- Member of individual's immediate family (i.e., spouse, life partner, or dependent child living at home), when contributions are in excess of \$2500

In addition to direct contributions to candidates, incumbents, or political committees in the Commonwealth of Pennsylvania, applicants are also required to disclose:

1. Contributions not directly given to a candidate, incumbent, or political committee but made with the intent that the contribution will benefit the candidate, incumbent, or political committee;
2. Solicitation of contributions on behalf of a candidate, incumbent, or political committee, including the hosting of or solicitation at fundraising events (required to disclose details regarding the date of event and amount raised); and
3. Contributions not made directly by the individual/business to a candidate, incumbent, or political committee but furnished by the individual / business (as an “intermediary”).

**Eligibility Restrictions**

If an individual makes contributions totaling over \$2,500 in one calendar year to a candidate for City elective office or to an incumbent, the individual is not eligible to receive a non-competitively bid contract during that candidate’s or incumbent’s term of office.

If a business makes contributions totaling over \$10,000 in one calendar year to a candidate for City elective office or to an incumbent, the business is not eligible to receive a non-competitively bid contract during that candidate’s or incumbent’s term of office.

Although individuals and businesses have to disclose campaign contributions made during the two years prior to the deadline for completing these forms, the eligibility restrictions take into consideration only those contributions made on or after January 1, 2006.

Definitions

Affiliate	A parent, subsidiary, or otherwise affiliated entity of a business
Applicant	An individual or business who has filed an application to be awarded a non-competitively bid contract
Business	A corporation, limited liability company, partnership, association, joint venture or any other legal entity (including non-profit organizations) that is not an Individual
Candidate	Any individual who seeks nomination or election to public office, other than a judge of elections or inspector of elections, whether or not such individual is nominated or elected. An individual shall be deemed to be seeking nomination or election to such

	office if he or she has (1) received a contribution or made an expenditure or has given his consent for any other person or committee to receive a contribution or make an expenditure, for the purpose of influencing his or her nomination or election to such office, whether or not the individual has made known the specific office for which he or she will seek nomination or election at the time the contribution is received or the expenditure is made; or (2) taken the action necessary under the laws of the Commonwealth of Pennsylvania to qualify himself or herself for nomination or election to such office.
Consultant	A person used by an applicant to assist in obtaining a non-competitively bid contract through direct or indirect communication by such individual or business with any City agency or City officer or employee or any Community Behavioral Health officer or employee, if the communication is undertaken by such individual or business in exchange for, or with the understanding of receiving, payment from the applicant; provided, however, that "Consultant" shall not include a full-time employee of the applicant.
Contributions	The provision of money, in-kind assistance, discounts, forbearance or any other valuable thing, during the two years prior to the deadline for the filing of the application for the contract opportunity, to any of the following: <ul style="list-style-type: none"> <li>– a candidate for nomination or election to any public office in the Commonwealth of Pennsylvania;</li> <li>– an incumbent in any public office in the Commonwealth;</li> <li>– a political committee or state party in the Commonwealth; or</li> <li>– a group, committee or association organized in support of any candidate, office holder, political committee or state party in the Commonwealth.</li> </ul>
Immediate family	A spouse or life partner residing in the individual's household or minor dependent children
Incumbent	An individual who holds elective office
Intermediary	A person, who, other than in the regular course of business as a postal, delivery or messenger service, delivers a contribution from another individual or business to the recipient of such contribution
Non-Competitively Bid Contract	A contract for the purchase of goods or services to which the City or City Agency is a party that is not subject to the lowest responsible bidder requirements of Section 8-200 of the Home Rule Charter, including, but not limited to, a Professional Services Contract, and any renewal of such a contract (other than a renewal term pursuant to an option to renew contained in an executed contract)
Person	An individual, corporation, limited liability company, partnership, association, joint venture, or any other legal entity
Political committee	Any committee, club, association or other group of persons which receives money or makes expenditures for purposes of influencing any election
Professional Services Contract	A contract to which the City or a City Agency is a party that is not subject to the lowest competitive bidding requirements of Section 8-200 of the Home Rule Charter because it involves the rendition of professional services, including any renewal of such a contract (other than a renewal term pursuant to an option to renew contained in an executed contract)

Solicit a  
Contribution

Requesting or suggesting that a person make a contribution. The sponsoring or hosting of a fundraising event is considered soliciting a contribution from the attendees of the event. Any contributions raised at such event are counted as a contribution made by the host of the event.

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

Initials: \_\_\_\_\_

If Applying as an Individual:  
Campaign Contribution Disclosure Form

Please read through the directions and definitions before filling out this disclosure form to make sure that each question is answered appropriately and thoroughly. Note that you must provide information for the two years prior to the application deadline.

	Yes	No
Have you made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you solicited or served as an intermediary for any contributions?	<input type="checkbox"/>	<input type="checkbox"/>
Has a member of your immediate family made any contributions over and above \$2,500?	<input type="checkbox"/>	<input type="checkbox"/>
Has a member of your immediate family solicited or served as an intermediary for contributions over and above \$2,500?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Check here to certify that no contributions were made.</i>	<input type="checkbox"/>	

Additional information on every contribution must be disclosed.  
Please use the table provided on the next page.



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

Initials: \_\_\_\_\_

If Applying as a Business:  
Campaign Contribution Disclosure Form

Please read through the directions and definitions before filling out this disclosure form to make sure that each question is answered appropriately and thoroughly. Where “non-profit” is an option, indicate whether the business is a non-profit; non-profits are not required to disclose contribution information on these questions. Note that you must provide information for the two years prior to the application deadline.

	Yes	No	Non-Profit
Has the business made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the business solicited or served as an intermediary for any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of the business made any contributions? <i>See note below.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has an officer, director, controlling shareholder, or partner of the business solicited or served as an intermediary for any contributions? <i>See note below.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has an affiliate of the business made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an affiliate of the business solicited or served as an intermediary for any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of a for-profit affiliate of the business made any contributions? <i>See note below.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of a for-profit affiliate of the business solicited or served as an intermediary for any contributions? <i>See note below.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Has the business or an affiliate of the business reimbursed another individual or business for a contribution that the individual or business has made?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of a for-profit business, or of a for-profit affiliate of the business, reimbursed another individual or business for a contribution that the individual or business has made?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a political committee controlled by the business or by an affiliate of the business made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a political committee controlled by an officer, director, controlling shareholder, or partner of the for-profit business, or of a for-profit affiliate of the business, made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Check here to certify that no contributions were made.</i>		<input type="checkbox"/>	

Note: Applicants must disclose all contributions to candidates or incumbents which are attributed to an immediate family member of an officer, director, controlling shareholder or partner of the for-profit Applicant or the for-profit affiliate of the Applicant. Please disclose the full amount of the contribution, although only the amount above \$2500 will be attributed to the officer, director, controlling shareholder or partner (and, by extension, the Applicant business).

Additional information on every contribution must be disclosed.  
Please use the table provided on the next page.



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

Initials: \_\_\_\_\_

### Use of Consultant Disclosure Form

Please list all consultant(s) used in the year prior to the application deadline for this contract opportunity and the corresponding information for that consultant in the space provided below.

Please note that a Consultant, for the purposes of the required disclosures, is defined as an individual or business used by an applicant or contractor to assist in obtaining a non-competitively bid contract through direct or indirect communication by such individual or business with a City agency or City employee or official or Community Behavioral Health or any Community Behavioral Health officer or employee, if the communications is undertaken in exchange for, or with the understanding of receiving, payment from the applicant or contractor or any other individual or business (however, "Consultant" shall not include a full-time employee of the Applicant or Contractor).

Check here to certify that no consultant(s) was used in the year prior to the application deadline for this contract opportunity.	<input type="checkbox"/>
Consultant Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid	
Consultant Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid	
Consultant Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid	
Consultant Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid	

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

Initials: \_\_\_\_\_

Consultant: Individual Campaign Contribution Disclosure Form

Use this form if the Consultant used is an Individual. Please read through the directions and definitions before filling out this disclosure form to make sure that each question is answered appropriately and thoroughly. Note that you must provide information for the two years prior to the application deadline.

	Yes	No
Has the Consultant made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>
Has the Consultant solicited or served as an intermediary for any contributions?	<input type="checkbox"/>	<input type="checkbox"/>
Has a member of the Consultant's immediate family made any contributions over and above \$2,500?	<input type="checkbox"/>	<input type="checkbox"/>
Has a member of the Consultant's immediate family solicited or served as an intermediary for contributions over and above \$2,500?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Check here to certify that no contributions were made.</i>	<input type="checkbox"/>	

Additional information on every contribution must be disclosed.  
Please use the table provided on the next page.



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

Initials: \_\_\_\_\_

Consultant: Business Campaign Contribution Disclosure Form

Use this form if the Consultant used is a Business. Please read through the directions and definitions before filling out this disclosure form to make sure that each question is answered appropriately and thoroughly. Where “non-profit” is an option, indicate whether the business is a non-profit; non-profits are not required to disclose contribution information on these questions. Note that you must provide information for the two years prior to the application deadline.

	Yes	No	Non-Profit
Has the Consultant business made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the Consultant business solicited or served as an intermediary for any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of the Consultant business made any contributions? <b>See note below.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has an officer, director, controlling shareholder, or partner of the Consultant business solicited or served as an intermediary for any contributions? <b>See note below.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has an affiliate of the Consultant business made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an affiliate of the Consultant business solicited or served as an intermediary for any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of a for-profit affiliate of the Consultant business made any contributions? <b>See note below.</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of a for-profit affiliate of the Consultant business solicited or served as an intermediary for any contributions? <b>See note below.</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Has the Consultant business or an affiliate of the business reimbursed another individual or business for a contribution that the individual or business has made?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an officer, director, controlling shareholder, or partner of the for-profit Consultant business, or of a for-profit affiliate of the Consultant business, reimbursed another individual or business for a contribution that the individual or business has made?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a political committee controlled by the Consultant business or by an affiliate of the business made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
Has a political committee controlled by an officer, director, controlling shareholder, or partner of the for-profit Consultant business, or of a for-profit affiliate of the Consultant business, made any contributions?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Check here to certify that no contributions were made.</i>		<input type="checkbox"/>	

Note: Consultants must disclose all contributions to candidates or incumbents which are attributed to an immediate family member of an officer, director, controlling shareholder or partner of the for-profit Consultant or the for-profit affiliate of the Consultant. Please disclose the full amount of the contribution, although only the amount above \$2500 will be attributed to the officer, director, controlling shareholder or partner (and, by extension, the Consultant business).

Additional information on every contribution must be disclosed.  
Please use the table provided on the next page.



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

Initials: \_\_\_\_\_

Use of Subcontractor Disclosure Form

Please list all subcontractor(s) you are planning to use if awarded this non-competitively bid contract by filling out the appropriate information in the space provided below.

Check here to certify that no subcontractor(s) are to be used.	<input type="checkbox"/>
Subcontractor Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid, or Percentage to be Paid	
Subcontractor Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid, or Percentage to be Paid	
Subcontractor Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid, or Percentage to be Paid	
Subcontractor Name	
Address 1	
Address 2	
City, State, Zip	
Phone	
Amount Paid or to be Paid, or Percentage to be Paid	

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

Initials: \_\_\_\_\_

Employee Request Disclosure Form

Please list any City of Philadelphia or Community Behavioral Health employees or officers who have asked you (the Applicant), any officer director, or management employee of the Applicant, or any person representing the Applicant to give money, services, or any other thing of value (other than contributions as defined above) during the two years prior to the application deadline for this contract opportunity.

Check here to certify that no City of Philadelphia or Community Behavioral Health employees or officers who have asked you (the Applicant), any officer director, or management employee of the Applicant, or any person representing the Applicant to give money, services, or any other thing of value (other than contributions as defined above) during the two years prior to the application deadline for this contract opportunity.	<input type="checkbox"/>
<b>Name of Employee/Officer</b>	
<b>Title</b>	
<b>Money Services, or Thing of Value Requested</b>	
<b>Money, Services, or Thing of Value Given (If none, write "none")</b>	
<b>Date Requested</b>	
<b>Date of Payment</b>	
<b>Name of Employee/Officer</b>	
<b>Title</b>	
<b>Money Services, or Thing of Value Requested</b>	
<b>Money, Services, or Thing of Value Given (If none, write "none")</b>	
<b>Date Requested</b>	
<b>Date of Payment</b>	
<b>Name of Employee/Officer</b>	
<b>Title</b>	
<b>Money Services, or Thing of Value Requested</b>	
<b>Money, Services, or Thing of Value Given (If none, write "none")</b>	
<b>Date Requested</b>	
<b>Date of Payment</b>	

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

Initials: \_\_\_\_\_

Employee Participation Advice Disclosure Form

Please list any City of Philadelphia or Community Behavioral Health employees or officers who gave you (the Applicant), any officer director, or management employee of the Applicant, or any person representing the Applicant advice that a particular individual or business could be used by the Applicant to satisfy any goals established in the contract for the participation of minority, women, disabled, or disadvantaged business enterprises during the two years prior to the application deadline for this contract opportunity.

Check here to certify that no City of Philadelphia or Community Behavioral Health employees or officers gave you (the Applicant), any officer director, or management employee of the Applicant, or any person representing the Applicant advice that a particular individual or business could be used by the Applicant to satisfy any goals established in the contract for the participation of minority, women, disabled, or disadvantaged business enterprises during the two years prior to the application deadline for this contract opportunity.	<input type="checkbox"/>
Name of Employee/Officer	
Title	
Date of Advice	
Individual or Business Recommended to Satisfy Participation Goals	
Name of Employee/Officer	
Title	
Date of Advice	
Individual or Business Recommended to Satisfy Participation Goals	
Name of Employee/Officer	
Title	
Date of Advice	
Individual or Business Recommended to Satisfy Participation Goals	
Name of Employee/Officer	
Title	
Date of Advice	
Individual or Business Recommended to Satisfy Participation Goals	

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

Signature Page

In order for the submission of these disclosure forms to be considered valid, they must be properly signed below by the respondent. Disclosure forms **that are not signed will be rejected**. By signing your name and title in the signature space below, you, as the applicant, signify your intent to sign these disclosure forms. The signatory hereby declares and certifies themselves to be the applicant, declares and certifies that they are properly authorized to execute these disclosure forms, and represents and covenants that all of the information and disclosures provided to the best of their knowledge are true and contain no material misstatements or omissions. Breach of such representation and covenant may render any subsequent contract voidable, and entitle Community Behavioral Health to all rights and remedies provided by law or equity.

If these disclosure forms are being submitted by an INDIVIDUAL, PARTNERSHIP, LIMITED LIABILITY COMPANY OR MANAGED LIMITED LIABILITY COMPANY, sign the forms here:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

If these disclosure forms are being submitted by a CORPORATION, sign the forms here, with signatures by (a) President or Vice-President of the corporation AND (b) Secretary, Assistant Secretary, Treasurer or Assistant Treasurer of the corporation. If the disclosure forms are not signed by the above mentioned, you hereby certify that you are authorized pursuant to a certified corporate resolution to sign in place of such officers.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
*President/Vice President, if other, please specify*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
*Secretary/Asst. Secretary/Treasurer/Asst. Treasurer  
If other, please specify*