REQUEST FOR APPLICATIONS

For

PARTICIPANTS IN THE Dialectical Behavior Therapy (DBT) TRAINING FOR OUTPATIENT PROGRAMS AND RESIDENTIAL TREATMENT FACILITIES

Issued by

COMMUNITY BEHAVIORAL HEALTH

Date of Issue
November 4, 2016

Applications must be received no later than 2:00PM on December 9, 2016.

Questions related to this RFA should be submitted via E-mail to:

Carrie Comeau at carrie.comeau@phila.gov

EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER – WOMEN, MINORITY INDIVIDUALS AND PEOPLE WITH DISABILITIES ARE ENCOURAGED TO RESPOND

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I. Overview

A. Introduction/Statement of Purpose

Community Behavioral Health (CBH) is soliciting participants for a training and implementation program to build clinical capacity in Philadelphia to provide Dialectical Behavior Therapy (DBT) as part of an ongoing effort to increase the availability of high-quality, evidence-based treatments for adults and adolescents. CBH would like to increase capacity for DBT across the city in outpatient programs for adults and adolescents and residential treatment facilities for adolescents. Please note application responses should be separate for each level of care and clearly indicate adult or adolescent for outpatient programs. Responses from all applicants who meet RFA qualifications will be considered. There will be no cost to providers for this training, aside from the purchasing of manuals for identified clinicians. A significant organizational commitment will be required to successfully implement and sustain this Evidence-Based Practice (EBP). CBH expects to support training for up to ten programs through this RFA.

B. Organizational Overview

The City of Philadelphia contracts with the Commonwealth of Pennsylvania Department of Public Welfare for the provision of behavioral health services to Philadelphia's Medicaid recipients under Pennsylvania's HealthChoices behavioral health mandatory managed care program. Services are funded on a capitated basis through this contractual agreement. The City of Philadelphia, through the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), contracts with CBH to administer the HealthChoices program.

CBH was established by the City in 1997 to administer behavioral health care services for the City's approximately 550,000 Medicaid recipients. As a result, CBH manages a full continuum of medically necessary and clinically appropriate behavioral health services. CBH employs more than 350 people and has an annual budget of approximately $800 million.

DBHIDS has been actively transforming Philadelphia's behavioral health system for the last eleven years. The Department's system transformation is rooted in approaches that promote recovery, resilience and self-determination and build on the strengths and resilience of individuals, family members and other allies in communities that take ownership for their sustained health, wellness, and recovery from behavioral health challenges. As a next wave of its transformative efforts, DBHIDS is now putting emphasis on quality community-level health outcomes using a population health approach. A population health approach seeks to promote health and wellness in all, not just to address challenges for persons with diagnoses. The DBHIDS population health approach builds upon many years of focus on community health; thus, the approach is consistent with a public health framework. The essence of DBHIDS' population health approach is based on the following principles: attend to the whole population, not just to those seeking services; promote health, wellness and self-determination; provide early intervention and prevention; address the social determinants of health; and empower individuals and communities to keep themselves healthy.

It is essential to assure that the proposed services meet the standards of the DBHIDS Practice Guidelines as well as using a population health approach to behavioral health services. The Practice Guidelines are based on the core values of the DBHIDS transformation. The transformation initiative was drawn from the earlier work of the Recovery Advisory Committee and from the values identified in the report issued by the Mayor's Blue

Ribbon Commission on Children's Behavioral Health. The Practice Guidelines for Recovery and Resilience Oriented Treatment can be found at (http://www.dbhids.org/practice-guidelines/).

DBHIDS is committed to developing a system of care that is grounded in Evidence-Based Practices. In 2013, DBHIDS created Evidence-based Practice and Innovation Center (EPIC) to support the alignment of resources, policies and technical assistance to support the ongoing transformation of the system to one that promotes and routinely utilizes evidence-based, empirically-supported, and outcomes-oriented practices.

C. DBHIDS System Transformation

Because of the successful DBHIDS transformation initiative over the last decade (2005-2015), people with behavioral health conditions and intellectual disabilities now not only live in communities but are *a part of* their communities. As the natural continuation of the transformation of Philadelphia's behavioral health and intellectual disability service system, DBHIDS has now adopted a population health approach.

Population health refers to the health of an entire community. Traditional approaches to health care center around individuals who are already experiencing a health-related condition. Population health approaches take a much broader view, seeking to improve the health status of everyone in a community, not just those who are sick. By providing excellent clinical care as well as community-level interventions and services, **population health approaches help to create communities in which every member—not just those who seek out health services—can thrive**.

As DBHIDS worked in communities to help them better support people in its system, it became clear that many communities are themselves distressed, grappling with violence, poverty, inadequate housing, and other threats to health, well-being, and self-determination. It also has become clear that many people in need of support are not being reached or being reached too late. As a result, DBHIDS has initiated a population health approach to increase capacity within the community to deliver highly effective clinical care supports and services so that over time, communities experience less illness and its associated consequences.

The current national attention to population health confirms that Philadelphia's population health approach is appropriate. The U.S. healthcare environment is already moving in this direction in an effort to contain costs and achieve better outcomes. Acknowledgement is growing locally, nationally, and internationally that promoting optimum health among a whole population can't be achieved within a narrow paradigm built primarily to manage diagnosed conditions. To break the cycle of escalating costs, health systems are increasingly focusing resources on prevention and early intervention. Because of DBHIDS' longstanding commitment to promoting recovery, resilience, and self-determination, Philadelphia is well positioned to be a leader in the nation's next health transformation. The thrust of Philadelphia's behavioral health initiatives are shifting from addressing illness and disability one person at a time to promoting optimum health, wellness, and self-determination throughout the population.

The population health approach challenges us to continue to enhance efforts to improve the health of all Philadelphians. This approach challenges us to expand our efforts beyond pilot projects and special initiatives and embed these principles into the culture of our entire system. It challenges us to consistently broaden our scope to include *all* people in a population, not just those seeking our services. It challenges us to prevent behavioral health conditions and developmental delays from developing or progressing, to equip individuals with the skills and opportunities to make their own choices and build meaningful lives in their communities, and to move even more out of program settings and deeper into the community to address the social and environmental circumstances that have shaped people's lives. We must learn from the innovative work the city has already started and be even bolder, shifting the *intention* of our work from addressing illness and disability

one person at a time to promoting optimum health, wellness, and self-determination throughout the whole population.

Health providers and payers use a variety approaches to improve the health of a population. Some approaches, known as population health management, prioritize identifying and providing services to members of a population who have complex, chronic, or very costly conditions. A key goal of population health management efforts is to control costs, often through existing managed care strategies such as reducing avoidable emergency department visits. Other population health approaches are more akin to public health interventions in that they include broad-based interventions (such as flu shots) that benefit *all* members of a defined population, not just those seeking health services. These two major population health frameworks both use data-driven decision making and focus on health outcomes. DBHIDS's approach to population health builds on many years of focus on community health; thus, our approach is consistent with a public health framework.

The essence of the DBHIDS population health approach is as follows:

1. **Attend to the needs of the whole population, not just those seeking services.** Population health approaches emphasize community-level outcomes, not just outcomes for individuals with particular diagnoses. A key benefit of a population health approach is its focus on keeping people well so that, over time, communities experience less illness and its associated consequences.
2. **Promote health, wellness and self-determination.** Health is much more than the absence of illness or management of symptoms. There is a fundamental difference between providing targeted interventions to address illness versus promoting wellness and quality of life.
3. **Provide early intervention and prevention.** There will always be a need for access to high –quality clinical care, supports, and services. A population health approach provides such care and also works to screen for and prevent the onset or progression of conditions which improves outcomes and better utilizes resources.
4. **Address the social determinants of health.** Poor health and health disparities don't result from medical conditions alone. Chronic stress, toxic environments, limited access to nutritious foods, inadequate housing, social isolation, and numerous other nonmedical factors contribute to poor outcomes. A population health approach seeks to address these factors to reduce health disparities and safeguard everyone's right to optimum health and self-determination.
5. **Empower individuals and communities to keep themselves healthy.** Healthcare providers can't shoulder the entire responsibility for healthy communities. A population health approach not only educates but also empowers and motivates people to take responsibility for promoting their own health and wellness.

D. General Disclaimer

This RFA does not commit CBH to award a training opportunity to any program. This RFA and the process it describes are proprietary and are for the sole and exclusive benefit of CBH. No other party, including any Respondent, is intended to be granted any rights hereunder. Any response, including written documents and verbal communication, by any Applicant to this RFA, shall become the property of and may be subject to public disclosure by CBH.

E. Project Background

DBT is an evidence-based treatment designed specifically for individuals with significant challenges stemming from emotion dysregulation. Randomized trials have associated DBT with a reduction in target behaviors and symptoms, namely suicidal behavior, self-injury, depression, substance dependence, eating disorder behaviors, hopelessness, anger, impulsiveness, with increases in social adjustment and positive self-esteem. DBT has

been developed over the last 25 years by Dr. Marsha Linehan; initially designed to treat individuals with borderline personality disorder (BPD), DBT has been applied more generally to individuals with severe and chronic, multi-diagnostic challenges.

DBT is rooted in Cognitive Behavior Therapy (CBT), with a focus on helping individuals change emotions, thoughts, and actions that are interfering with a "life worth living." DBT expands on traditional CBT interventions and includes validation strategies to sustain the engagement of individuals whose struggles with emotion regulation can manifest during sessions, as they work through vulnerable material. Validation strategies help keep the therapeutic relationship intact as well as keep the client (and therapists) regulated enough for treatment to work. DBT also applies mindfulness strategies to promote acceptance as an individual is simultaneously working toward change. Dialectics are used to reconcile the disparate theories of change and acceptance, help move the therapy when it reaches an impasse, and model fluidity in thinking.

DBT is offered in a variety of settings from outpatient (standard DBT) to inpatient, intensive outpatient, partial hospitalization, residential, schools, forensics and corrections. Standard DBT is provided in six month or one year programs and requires weekly individual psychotherapy, psychoeducational skills training group, and coaching outside of session via approved privacy-protected means of communication (for example, telephone and electronic communication as appropriate). In addition, anyone providing any mode of DBT (individual psychotherapy, skills training, coaching, case management and/or prescribing) attends weekly consultation team meetings, considered "therapy for the therapists" to support those working with individuals with emotion regulation challenges.

In residential settings, all staff members have the potential to fill coaching roles to help instill new behaviors. When enrolled in DBT, adolescents attend skills training group to learn new behaviors aimed to help them regulate their emotions and their relationships and to tolerate crises and stress. When emotions escalate, often those new skills are difficult for individuals to access. Coaches help to remind DBT participants to practice new behaviors during challenging moments. Line staff, education staff, case managers, and psychiatrists, all play critical roles in helping transfer what is learned in a DBT skills group into day to day life. Effective coaching helps everyone as it decreases crises and stress on the individual and his or her environment. (It should be noted that similar opportunities may exist in outpatient settings for staff to support skills, the specifics of which can be discussed during planning phases).

Additionally, DBT for adolescents often includes establishing multifamily skills groups to support skill acquisition and generalization. Family members are taught along with the adolescent and expected to complete weekly practice of the behavioral skills in their own lives. Family engagement, especially in skills training, will be a necessary aspect of establishing DBT programs for adolescents. While the adolescent in the program is the primary client for all programming, participation of at least one family member or significant adult in skills training group with the adolescent has demonstrated improved treatment outcomes.

CBH recognizes a need to provide high-quality, evidence-based treatment to its population of adolescents and adults who are experiencing the high-risk and complex symptoms targeted by DBT. As such, CBH is committed to increasing capacity for the provision of DBT within its network. As CBH is also aware of the challenges faced by agencies in implementing and sustaining evidence-based clinical programs, this initiative includes both DBT training and the development of sustainable DBT programs.

II. DBT Training and Implementation

A. Training and Implementation Opportunity

CBH is sponsoring an innovative training and implementation program for adult and adolescent outpatient providers and adolescent residential treatment providers. The training will be provided by the Treatment

Implementation Collaborative (TIC), LLC, a group of experienced DBT clinicians, trainers, and consultants who specialize in DBT training and program implementation. The TIC team includes DBT research therapists and supervisors on DBT randomized control trials, the Chairperson of the Work Sample Committee on Marsha Linehan's Board of Certification (DBT-LBC), certified DBT therapists, DBT authors and the developer of DBT Accepting the Challenges of the Existing System. TIC possesses over 20 years of DBT training and implementation experience within various systems serving many different populations, including schools, correctional facilities, and all levels of behavioral health care.

The training will include a pre-work / launch phase when agencies prepare to deliver DBT, five training sessions (each lasting three days), and consultation with the trainers during active implementation between learning sessions. Additional training will be scheduled for ancillary staff (not on the core clinical team or attending the core clinical trainings), focused on learning DBT skills and effective DBT skills coaching. The training program is scheduled to begin in March 2017 and will include an active training and implementation phase through February 2018. Integration of DBT into residential and outpatient services is then expected to be sustained and expanded over the long-term.

B. Overview of Training and Implementation Program

1. Training Program Goals

The goal of this training and implementation program is to successfully integrate and sustain DBT services in Philadelphia for the purpose of strengthening the resilience, recovery, and functioning of adolescents and adults across settings. Following the training and implementation program, providers should demonstrate the capacity to identify and engage appropriate individuals for DBT, deliver the model to fidelity, and sustain comprehensive DBT programs long term (which includes maintaining a census of individuals engaged in DBT).

The training and implementation program will use a comprehensive learning structure that teaches skill coaching, treatment delivery engagement in consultation teams to competency, and supporting program implementation. Participating staff will receive regular consultation with a DBT trainer in order to master and maintain fidelity to the DBT model, apply DBT learning to meet the needs of diverse individuals within their unique service setting, and determine how to apply the model with flexibility and fidelity to ensure optimal progress for individuals receiving the treatment. In addition to developing mastery of the clinical model, teams and trainers will focus on program implementation, including development of referral and intake processes, operational policies, and organizational supports to ensure that individuals who could benefit are engaged in the model and receive comprehensive DBT, and that the program is sustained.

2. Training Model: Overview of Training and Implementation

ACTIVITY	PARTICIPANTS	TIME	PROGRAM DEVELOPMENT BETWEEN SESSIONS
Needs Assessment Identifying provider agencies, goals, relevant programs, structural supports and needs for potential and selected teams.	Administrative and clinical leadership for each identified program	1-2 hours per agency (to be scheduled)	Complete preparation steps as needed, to be determined among trainers, agency, and CBH.
Overview of DBT 2-day overview of treatment and training plan.	All staff whose roles connect them to DBT programming (team leaders, clinicians, all other relevant staff)	2 days: March 27 and 28	Identify clinicians and roles, establish consultation team meetings, begin reading treatment manuals, review policies with leadership, identify entrance and exit criteria. Specific team and practice homework assigned at training.
Leadership Planning 1-Day Leadership Planning Session to address goals, barriers, data, sustainment including DBHIDS expectations for EBP Programs.	Administrative and clinical leadership for each identified program	1 day: March 29	Develop DBT programming.
Skills Training 3-Day overview of the four modules of DBT Skills Training – Emotion Regulation, Distress Tolerance, Mindfulness and Interpersonal effectiveness. Structuring and leading groups, therapy interfering behavior, coaching in different contexts (in person, phone, case management, etc.).	All staff	3 days: June 5, 6, 7	Define and develop skills group plan – Personal practice with skills, content, language. Specific team and practice homework assigned at training.
Residential Milieu Staff Training (RTF only) Overview of DBT skills and a clear, concise method of coaching new behavior.	RTF Milieu staff	6 days (2 3-day trainings): TBD	Coach DBT skills in daily life.
Core Clinical Training (CCT) 1 Following the initial Skills Training, DBT teams (clinicians and team leaders) will participate in three series of three-day Core Clinical Trainings (a total of nine days). Core Clinical Trainings will teach DBT to competency and will occur approximately three months apart to allow time for reading, practicing, completing homework, and delivering DBT.	Team leaders and clinicians (DBT teams)	3 days August 7, 8, 9	Continued practice using (self) and teaching skills (others), continued reading of treatment manuals, strengthen and refine consultation team. Specific team and practice homework assigned at training.

ACTIVITY	PARTICIPANTS	TIME	PROGRAM DEVELOPMENT BETWEEN SESSIONS
Core Clinical Training (CCT) 2	Team leaders and clinicians (DBT teams)	3 days November 6, 7, 8	All individual clinicians take on clients, complete pretreatment with all clients, start group for all clients, continued reading of treatment manuals. Specific team and practice homework assigned at training.
Clinical Core Training (CCT) 3	Team leaders and clinicians (DBT teams)	3 days February 26, 27, 28	Increase DBT case load, adding groups as needed, finish reading treatment manuals. Specific team and practice homework assigned at training. Program sustainment, train new therapists as needed, expand to additional locations or populations as needed.
Monthly Phone Consultation Typically, each team receives 1 hour per month for a period of 12 months.	Teams and leadership for each provider	1 hour per month	Develop/ support DBT programming.
Quarterly Meetings Key Personnel will meet quarterly to discuss progress and barriers related to implementation.	Key personnel in implementation to be determined	Quarterly	Develop/ support DBT programming.

C. Continuing Education Credits

Continuing Education Credits (CEUs) will be provided through the Behavioral Health Education and Training Network (BHTEN). See below for the types of credits offered.

- International Association for Continuing Education and Training (IACET) credits will be provided as BHTEN is an Accredited Provider.
- Pennsylvania Certification Board (PCB) credits awarded through the PCB.
- Social Work (SW) credit hours awarded. This conference is co-sponsored by Bryn Mawr College Graduate School of Social Work and Social Research (GSSWSR) for a maximum of 5 credit hours. Bryn Mawr College GSSWSR, as a Council of Social Work Education (CSWE) accredited School of Social Work, is a pre-approved provider of continuing education for Social Workers in PA and many other states.
- CE credit hours for Psychologists awarded. BHTEN is approved by the American Psychological Association to sponsor continuing education for psychologists. BHTEN maintains responsibility for the program and its content.

- Certified Psychiatric Rehabilitation Practitioners (CPRP) CEUs—BHTEN is approved by the United States Psychiatric Rehabilitation Association (Provider #011190) to sponsor continuing education for CPRPs. BHTEN maintains responsibility for the program and its content.

Participants must attend entire presentation to receive CEUs and must submit a completed course evaluation. Additionally, participants must attend both days of the 2-day DBT Overview to receive CEUs for this section of the training plan. CEUs will not be provided for the 1-day Leadership Planning session. For the remaining 4 3-day trainings (Skills Training and Core Clinical Training I-III), participants must attend the entire series to receive CEUs. No partial credit will be given.

III. Application and Selection Process

A. Eligibility Requirements and Expectations

Applicants must meet the following eligibility requirements.

1. **Licensure and Good Standing:** Eligible applicants must be a current outpatient or residential treatment services provider located in Philadelphia County under contract with Community Behavioral Health. These services must also have current licenses from the Pennsylvania Department of Human Services and be a service provider in good standing with the City and CBH. CBH will determine if a provider is in good standing by reviewing information gathered through various departments across the DBHIDS. A determination is based on, but not limited to, the following criteria: re-credentialing status history, compliance error rate history, quality improvement plan status, and financial solvency. When applicable, state licensure status will also be reviewed and taken into consideration and discussed with Department of Human Services (state division). Examples of findings from these oversight functions that could disqualify a provider from being in good standing may include but are not limited to: a. Level II Quality Improvement Plan (QIP) (CBH); b. Consecutive Network Improvement and Accountability Collaborative (NIAC) credentialing statuses of 1 year or less (DBHIDS); c. Provisional licensure (State). In addition, CBH will evaluate other commitments between the provider and CBH that may render a provider unable to dedicate the necessary time and resources to this project. Finally, neither the vendor nor its staff, subcontractors, or vendors may be on any of the three Excluded Individuals and Entities lists:
   - List of Excluded Individuals and Entities (LEIE) http://oig.hhs.gov/fraud/exclusions.asp;
   - System for Award Management (SAM) *(formerly Excluded Parties List System (EPLS))* https://www.sam.gov;
   - Department of Human Services' Medicheck List http://www.dhs.state.pa.us/publications/medichecksearch/

   In each case, CBH will review the findings and make a final determination of standing for the purpose of the provider's eligibility to apply for the RFA.

2. **Program Requirements:** As DBT programs are established, programmatic census levels will be determined and maintained, with thoughtful approach to caseloads. Teams will be expected to work collaboratively with CBH to be available to receive CBH members identified by CBH. In order to be eligible for the DBT Training, Residential Treatment Facilities must on average have 50% of their census be CBH members and outpatient programs must demonstrate an adequate number of CBH members will benefit from implementation of a DBT program at the proposed location.

3. **Sustained Practice:** Following the completion of the full training and implementation program, agencies will be expected to independently sustain DBT, including facilitating ongoing referrals and engagement,

maintaining a DBT program census and individual clinician case load, and ensuring supportive supervision, leadership, and policy and addressing staff attrition. Having an agency's leadership (e.g., Executive Direcor, **C**EO, supervisors, and other decision-makers) directly involved in the implementation of an EBP is key to its long-term success. Sustainability is supported when administrative and clinical leadership are knowledgeable about the EBP and directly involved in setting policies that support the model. This may include staff recruitment and training policies such as 1) recruiting staff to participate in learning and using the EBP, 2) considering an applicant's knowledge of (or openness to) EBPs in hiring decisions and integrating information about DBT into new employee orientations, 3) recognizing EBP clinicians formally in performance reviews and merit raises and informally in newsletters, websites etc., 4) planning to educate all relevant staff on the DBT model and principles, including for example, outpatient psychiatrists, intake coordinators, and RTF milieu staff, and 5) selecting an individual (in addition to the DBT team) who will take the lead on integration of DBT skills throughout the program (or agency). In addition sustainability can be supported through integrating the EBP into the culture and operations of the organization by: 1) supporting clinicians and supervisors in maintaining fidelity to the EBP, 2) integrating the EBP into the culture of the agency, 3) demonstrating commitment to the EBP through follow-through with the implementation plan, 4) creating processes to track fidelity and measures in electronic medical records, 5) integrating DBT into clinical documentation.

4. **Monitoring and Reporting Requirements:** The tracking of change is an integral part of DBT, as well as essential to understanding what is working well within the training and implementation. TIC will partner with the selected agencies to develop an outcomes monitoring plan. Support will be provided in the development of the operational procedures for collecting and regularly reporting/reviewing data with CBH and TIC. A single point person within each agency will be responsible for DBT monitoring and reporting. At a minimum, programs that are selected through this RFA process will be required to meet the following monitoring and reporting requirements:

    - Documented processes for accepting referrals/ assessing appropriateness of EBP / scheduling with EBP therapists
    - Roster of therapists / supervisors and tracking of caseload
    - Documentation of delivery of EBP components (e.g. DBT skills groups, individual therapy and team consultation, phone coaching, session structure)
    - Documented supervision to the model and / or peer supervision
    - Documented use of EBP specific fidelity tools
    - Integration of model into treatment plan and session documentation
    - Documented use of clinical measures appropriate to EBP

    These reporting requirements may be used to determine if programs are sustaining the DBT model. If programs do not adequately sustain the model, they may no longer be eligible for an enhanced DBT rate, where applicable, and/or included on DBHIDS rosters of DBT providers.

5. **Technology Capabilities:** Applicants must have the technology capabilities required to perform the proposed activities in this RFA. Additionally, selected agencies may need to have the capacity to audio or video record sessions to support expert consultation. Details will be determined with trainers.

6. Participating Staff:

Staff	Degree/ Employment Status	Role in DBT implementation	Trainings to Attend
1 Executive Leader	Salaried / full-time equivalent Staff member in position of leadership with clinical and administrative decision making authority	Ensure the implementation and sustained delivery of comprehensive DBT; Identify specific roles and responsibilities among all staff to manage DBT implementation.	Overview of DBT Quarterly Meetings
1 Team Leader*	Master's or doctoral degree (with preference for licensed or licensed-eligible staff)/ and Salaried full-time equivalent	Oversee the clinical team; Address implementation issues; Ensure fidelity and sound clinical decision-making throughout training and implementation; Maintain access to agency leadership to coordinate DBT implementation and address potential challenges; Implement comprehensive DBT including individual therapy, skills group, team consultation and phone coaching; Carry a caseload of at least two DBT recipients during training and expand DBT caseload to an average of four to five DBT cases as expertise grows.	All components of DBT training: Needs Assessment, Overview of DBT, Skills Training, Core Clinical Trainings, Monthly Consultation, Quarterly Meetings
4-8 Clinicians*	Master's or doctoral degree (with preference for licensed or licensed-eligible staff) / preference for salaried, full time equivalent staff	Implement comprehensive DBT including individual therapy, skills group, team consultation and phone coaching; Carry a caseload of at least two DBT recipients during training and expand DBT caseload to an average of four to five DBT cases as expertise grows.	Skills Training, Core Clinical Trainings, Monthly Consultation.
1 DBT Skills Lead (Residential only)	Individual for this position will be selected based on agency structure and ability to fulfill role in DBT implementation	Take the lead on integration of DBT skills throughout the program (or agency), supporting a DBT culture throughout the program among staff regardless of clinical expertise grows.	DBT overview and 2 3-day trainings for milieu staff
Residential Milieu Staff (Residential only)	Any milieu staff member	Help transfer DBT skills to daily life	2 3-day trainings for milieu staff focused on DBT skills, principles that increase the chances that individuals engaged in DBT will respond to coaching, and a clear, concise method of coaching new behavior. Participate in ongoing education and training related to coaching DBT skills.

*Applicants can propose larger team sizes to accommodate larger programs and/ or higher numbers of anticipated DBT referrals. Justification for proposed team sizes must be included in response.

B. Application Process

The application consists of Appendices A and B. These Appendices must be completed and submitted by the agency applying for PCIT training.

- Appendix A is the main portion of the application, to be completed by an official at the agency requesting participation in DBT training and signed by the Executive Director.
- Appendix B is the Trainee Information Form, to be completed by each potential participant.

Completed application documents must be submitted to Carrie Comeau by **2:00PM on December 9, 2016**. Responses submitted after the deadline will be returned unopened. Responses will also be returned unopened to agencies that are ineligible to apply because they do not have a current contract with Community Behavioral Health (CBH) for the level of care noted in section III. A. Submissions are to be addressed as follows:

Community Behavioral Health
801 Market Street
7th Floor
Philadelphia, PA 19107

ATTN: Carrie Comeau

Submissions should be marked "PCIT Training Application." Applications submitted by any means other than mailing, courier, or hand delivery will not be accepted.

Applicants must submit the following:

- An electronic version of the entire application prepared as a PDF document placed onto a compact disc or flash drive (Appendices A and B).
- One (1) clearly marked, signed original hardcopy application.
- Eight (8) additional hardcopies of the complete application (Appendices A and B).

Proposals submitted after the deadline date and time will be returned unopened.

The agency Executive Director must sign Appendix A.

C. Questions about the RFA

All questions regarding the RFA must be sent via email and directed to Carrie Comeau at Carrie.Comeau@phila.gov. No phone calls will be accepted. The deadline for submission of questions is **November 28 2016**. Answers to all questions will be posted on the CBH section of the DBHIDS website (www.dbhids.org) by December 2, 2016.

Information Session
CBH will hold a DBT Information Session for all interested agencies. If you are interested in applying, your agency should plan to have a representative in attendance at the DBT overview event on **November 30, 2016**.

D. Interviews/Presentations

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

E. Notification

Applicants will be notified via email by **January 27, 2017** about their acceptance for training. Applicants who have been accepted will be given additional information about the training and expectations via an orientation session.

F. Certification

DBT certification is coordinated through the DBT-Linehan Board of Certification (see www.dbt-lbc.org for more information about certification). All licensed clinical staff who complete the DBT training may be eligible for certification through the DBT-Linehan Board of Certification. The identification of licensed or licensed-eligible clinical staff for the training is recommended so that these staff have the opportunity to pursue DBT certification, with the understanding that DBT certification requires additional components beyond the scope of what is offered through this RFA. This RFA does not, however, preclude applicants who are not licensed or licensed-eligible.

G. Cost Information

There will be no cost to providers for participating in this training; however, providers will be responsible for purchasing the following manuals for the team leader and clinicians on the DBT team:

- Linehan, M. M. (In Press). DBT® Skills Training Manual: Second Edition New York: Guilford Press.
- Linehan, M. M. (In Press). DBT® Skills Training Handouts and Worksheets: Second Edition New York: Guilford Press.
- Linehan, M. M. (1993a). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York: Guilford Press.

Cost – About $130 per person depending on where the books are sourced.

In addition, a significant organizational commitment will be required to successfully implement and sustain this evidence-based therapy model.

CBH is exploring strategies to provide an enhanced billing rate for outpatient DBT that will be dependent on engagement in all training requirements and demonstrating sustained support of the DBT program and delivery of the DBT model to fidelity.

IV. General Rules Governing RFAs/Applications; Reservation of Rights; Confidentiality and Public Disclosure

A. Revisions to RFA

CBH reserves the right to change, modify or revise the RFA at any time. Any revision to this RFA will be posted on the DBHIDS website. It is the applicant's responsibility to check the website frequently to determine whether additional information has been released or requested.

B. Reservation of Rights

By submitting its response to this notice of Request For Applications as posted on the DBHIDS website, the Applicant accepts and agrees to this Reservation of Rights. The term "notice of request for applications," as used herein, shall mean this RFA and include all information posted on the DBHIDS website in relation to this RFA.

1. Notice of Request For Applications (RFA)

CBH reserves and may, in its sole discretion, exercise any one or more of the following rights and options with respect to this notice of training opportunity:

- to reject any and all applications and to reissue this RFA at any time;
- to issue a new RFA with terms and conditions substantially different from those set forth in this or a previous RFA;
- to issue a new RFA with terms and conditions that are the same or similar as those set forth in this or a previous RFA in order to obtain additional applications or for any other reason CBH determines to be in CBH's best interest;
- to extend this RFA in order to allow for time to obtain additional applications prior to the RFA deadline or for any other reason CBH determines to be in the CBH's best interest;
- to supplement, amend, substitute or otherwise modify this RFA at any time prior to issuing a notice of intent to develop a provider agreement or consultant contract to one or more Applicants;
- to cancel this RFA at any time prior to the execution of a final provider agreement whether or not a notice of intent to develop a provider agreement has been issued, with or without issuing, in CBH's sole discretion, a new RFA for the same or similar services;
- to do any of the foregoing without notice to Applicants or others, except such notice as CBH, in its sole discretion, elects to post on the DBHIDS website.

2. Miscellaneous

Interpretation; Order of Precedence: In the event of conflict, inconsistency or variance between the terms of this Reservation of Rights and any term, condition or provision contained in any RFA, the terms of this Reservation of Rights shall govern.

Headings: The headings used in this Reservation of Rights do not in any way define, limit, describe or amplify the provisions of this Reservation of Rights or the scope or intent of the provisions, and are not part of this Reservation of Rights.

C. Confidentiality and Public Disclosure

The successful applicant shall treat all information obtained from CBH and DBHIDS which is not generally available to the public as confidential and/or proprietary to CBH and DBHIDS. The successful applicant shall exercise all reasonable precautions to prevent any information derived from such sources from being disclosed to any other person. The successful applicant agrees to indemnify and hold harmless CBH and DBHIDS, its officials and 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 applicant or any person acquiring such information, directly or indirectly, from the successful applicant.

By submission of an application, applicants acknowledge and agree that CBH, as a quasi-public corporation, is subject to state and local public disclosure laws and, as such, is legally obligated to disclose to the public documents, including applications, to the extent required there under. Without limiting the foregoing sentence, CBH'S legal obligations shall not be limited or expanded in any way by an Applicant's assertion of confidentiality and/or proprietary data.

D. Incurring Costs

CBH is not liable for any costs incurred by applicants for work performed in preparation of a response to this RFA.

E. Disclosure of Application Contents

Information provided in applications will be held in confidence and will not be revealed or discussed with competitors. All material submitted as part of the RFA process becomes the property of CBH and will only be returned at CBH's option. Applications submitted to CBH may be reviewed and evaluated by any person other than competing applicants. CBH retains the right to use any/all ideas presented in any reply to this RFA. Selection or rejection of an application does not affect this right.

F. Selection/Rejection Procedures

Applicants will be notified in writing by CBH as to their selection. Information will be provided in this letter as to any issues within the application that will require further discussion or negotiation with CBH. Applicants who are not selected will also be notified in writing by CBH.

G. Non-Discrimination

The successful applicant, as a condition of accepting training from CBH through this RFA, agrees 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 does not and will not discriminate against any person because of race, color, religious creed, ancestry, national origin, age, sex, sexual orientation, handicap or disability in providing services, programs or employment or in its relationship with other contractors.

APPENDIX A
DBT Training
Request for Applications (RFA)

Agency: _____

Organizational Type: ____ **For Profit** ____ **Not For Profit**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Executive Leader Contact: _____

Title: _____

Telephone: _____

Email: _____

Fax: _____

Team Leader Contact: _____

Indicate the Level of Care in which you plan to integrate DBT: Adult Outpatient (OP), Adolescent OP or Adolescent RTF:

_____

*Applicants can apply to more than one level of care but will need to plan separate DBT teams for each of the three possible levels of care and to provide separate responses to certain questions as noted below. For example, if a provider is applying for DBT for RTF, Adult Outpatient, and Adolescent Outpatient, they would need to propose three separate teams in this application.

List all personnel applying for DBT training: master's or doctoral level staff to include 4-8 clinicians, 1 Team Leader, 1 Executive Leadership (additional details of participating staff to be included in Appendix B). For RTF, include 1 DBT Skills Lead.

Name	Role (Clinician, Supervisor, Leadership)	Credential / Licensed	Salaried or Contract

DBHIDS is looking to understand your agency's interest and motivation in integrating DBT into your agency's services. It is important for providers to engage in a thoughtful process for planning and supporting the long-term sustainability of DBT from the onset of engaging in the DBT Initiative. Please respond to the following sections.

1. **Executive Summary**: Provide a summary of the reasons why your agency should be selected to participate in the training and to provide DBT.

2. **Population Served**: Describe the population served at your agency. Include the number of individuals served. Outpatient agencies who are applying for DBT for their adult population, include numbers of adults served (age 18+); outpatient agencies who are applying for DBT for their adolescent population, indicate numbers of adolescents served (ages 13-17). Agencies applying for both adults and adolescents outpatient, provide these numbers separately. Indicate any unique characteristics of the population (e.g., primarily Spanish speaking, geographic location, etc.) On average what % of individuals served in your outpatient and / or RTF programs are CBH members?

   Describe the need in your community/ population for specialized treatments and interventions for adolescents or adults, particularly those who are experiencing complex symptoms associated with emotion regulation challenges (i.e. the symptoms targeted by DBT).

   Explain your rationale for the number of clinicians you have identified (e.g., requesting training for a higher number of clinicians to support a large number of anticipated referrals).

3. **Treatment Program**: Describe the programming in your outpatient or residential program and current treatments offered in your agency. Please be certain to include information about each of the following:
   a) Primary theoretical model(s) of treatment currently offered
   b) How individuals are engaged in the treatment process, for adolescent outpatient and RTF, strategies currently used or that will be deployed to engage families in DBT
   c) Other services, supports provided to support engagement of individuals / families in treatment,
   d) Process for monitoring symptom change and treatment progress, including the use of standardized measures in intake, treatment planning or program evaluation.

   Discuss how DBT will be integrated into the service array at agency.

4. **Evidence-Based Practice:** Please describe any additional Evidence-based Practice Initiatives or Research Activities your organization has been involved in or is currently enrolled in (both DBHIDS sponsored and independent enrollments). In EBPs across your organization, not just in the level of care you are applying for DBT.

   Describe some of the specific successes and challenges your agency has had with EBPs. Describe how you plan to support and integrate multiple EBPs. If you have not implemented specific EBPs before, please discuss some of the anticipated challenges associated with this kind of practice change and how you intend to address them.

5. **Referral Pathways /Identification of DBT recipients:** Describe current sources of referrals for your program. Describe proposed strategies for creating and sustaining referral pathways for DBT, ensuring minimum caseloads for clinicians and team leader (e.g. connections with inpatient and partial hospitals, other treatment providers, and adult and child systems, such as child welfare, probation, etc.). Describe strategies to identify DBT recipients, including methods to provide education about the services and screening and intake processes.

6. **Requirements of participating staff:** Participating clinicians and the DBT Team Leader will dedicate time to training and implementation of DBT, including commitment to 15 full days of training through the training year, monthly expert DBT consultation, and participation in meetings as needed to support implementation and sustainability of DBT program. The participating Team Leader and Executive Leader will provide leadership and oversight of implementation, which will include participation in a 2-Day Overview of DBT, 1-Day Leadership Planning and participation in meetings of key personnel. Describe proposed methods to support staff in managing these responsibilities and ensuring time to engage in key activities.

   Although not part of the core DBT team, direct care/ ancillary staff play integral roles in supporting the integration of DBT programming into agency. Outpatient examples include psychiatrists, intake coordinators. RTF examples include direct care staff, education staff, psychiatrists. Describe the proposed method to educate/ train these staff and include them in DBT implementation.

7. **Sustainability:** As noted, the capacity to sustain the implementation of DBT in your setting setting will be strongly considered in the RFA selection. Sustainability requires the full engagement of leadership, policies that support the EBP practice, and efficient staff retention methods, among other strategies. Please describe your current staff retention rate (or turnover rate) and strategies used to support retention of staff. Please describe the plan to ensure that the implementation of DBT can be sustained long term, addressing the commitment of executive director and other agency leaders, policies, staff retention strategies, and continued education/ training for all ancillary staff to maintain model.

8. **License:** Please indicate if your agency has a current license from the Department of Human Services (DHS) for outpatient or residential levels of care. Please submit copies of your most recent licensure certificates. Providers with provisional licenses may not be eligible for DBT Training.

   License from DHS _____

The following signature is required to confirm your agency's interest in applying for DBT training slated to begin in January, 2017.

EXECUTIVE DIRECTOR NAME (Print) _____

EXECUTIVE DIRECTOR SIGNATURE _____

DATE _____

APPENDIX B
DBT TRAINEE INFORMATION FORM

DBT is an evidence-based treatment designed specifically for individuals with self- harm behaviors, such as cutting, suicidal thoughts, urges, and attempts, and for individuals with significant challenges associated with emotion disregulation; many of these individuals meet criteria for borderline personality disorder (BPD). Randomized trials have associated DBT with a reduction in target behaviors and symptoms, namely suicidal behavior, self-injury, depression, substance dependence, eating disorder behaviors, hopelessness, anger, impulsiveness, with increases in general and social adjustment and positive self-esteem. DBT is a comprehensive cognitive-behavioral treatment developed by Dr. Marsha Linehan over the last 25 years. Although it was designed for individuals with BPD, DBT has been applied more generally to severe and chronic, multi-diagnostic individuals. DBT is appropriate for individuals at all levels of severity and complexity of disorder and is delivered via individual psychotherapy, skills groups, telephone consultation, and therapists' consultation meetings. Through DBT individuals develop skills and strategies to commit to creating a "life worth living."

The training will target up to ten agencies currently providing psychiatric outpatient or residential services. Each agency will identify one executive leader, one team leader, and four to eight clinicians to participate in the DBT training. Participants will be expected to participate in some or all of the following (varies depending on role):

- Attend five three-day trainings, scheduled at 3-4 month intervals through the training year (March 2017, June 2017, August 2017, November 2017, and February 2018).
- Participate in one-hour monthly DBT consults through the training year.
- Participate in all aspects of comprehensive DBT
    - Skills Group, Individual Therapy, Team Consultation, Phone Coaching.
- Participate in quarterly meetings of key personnel.

In order to be trained in DBT, clinicians must have a master's degree or higher in a human services field (e.g., social work, psychology). The identification of licensed or license eligible clinicians is strongly encouraged

This questionnaire is to be completed by each potential participant.

Your full name:_____

Your title:_____

Your educational degree(s) and year(s): _____

Your professional discipline:_____

Licensed or Credentialed:: Y N License(s) held in PA _____Credential(s) held in PA_____

Your agency name:_____

Your full agency address (where you are located):_____

Full Time Part-time Fee for Service

Do you primarily provide services to adolescents/adults?_____

Please describe your interest in learning about DBT:_____