REQUEST FOR APPLICATIONS

For

PARTICIPANTS IN THE PARENT-CHILD INTERACTION THERAPY (PCIT) TRAINING FOR CHILD OUTPATIENT PROGRAMS

Issued by

COMMUNITY BEHAVIORAL HEALTH

Date of Issue
June 29, 2016

Applications must be received no later than 2:00PM on July 27, 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 Parent-Child Interaction Therapy (PCIT) as part of an ongoing effort to increase the availability of high-quality, evidence-supported treatments for young children and their families. CBH would like to increase capacity for PCIT across the city, with particular focus on spreading geographic access, engaging child welfare involved families, and strengthening existing PCIT programs. Responses from all applicants who meet RFA qualifications will be considered, with added emphasis on providers serving the child welfare population, providers seeking to expand current PCIT capacity, and providers in zip codes where a gap in PCIT exists: 19153, 19112, 19145, 19148,19139, 19104, 19151, 19131, 19121, 19128, 19125, 19133, 19134, 19124, 19137, 19135, 19149, 19136, 19152, 19111, 19114, 19115, 19154, 19116, 19141, 19126, 19132, 19127, 19138, 19150, 19129, 19120. There will be no cost to providers for this training, but 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 outpatient 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 ten years. This 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 responsibility for their sustained health, wellness, and recovery from behavioral health challenges. System transformation takes place in an environment of self-determination and is individualized, comprehensive, flexible, person-first (culturally responsive), and designed to support health and wellness across the lifespan. In administering behavioral health services for Philadelphia's Medicaid recipients, CBH has been actively involved in the support and implementation of this system transformation. As DBHIDS looks to the future, by implementing a population health approach, it will increase its focus on strategies such as prevention, early intervention and building better community capacity.

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

In 2005, DBHIDS initiated a system transformation to change service delivery for people who live with behavioral health challenges. Transformation in Philadelphia moves beyond the field's historical focus on pathology and disease processes to a model directed by the person in recovery's needs, wants and desires and that emphasize the individual's culture, resilience and unique recovery processes. A recovery/resilience-oriented system attends to the issues of symptom reduction but ultimately provides access to services, supports, environments and opportunities that help individuals restore a positive sense of self and rebuild a meaningful and fulfilling life in their community. Through the implementation of recovery/resilience-oriented, innovative, evidence-based, evidence-informed and promising practices, the system transformation holds the potential to improve quality of care and the lives of service recipients and their families. The core values of the transformation can be found in the Practice Guidelines for Recovery and Resilience Oriented Treatment.

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

Parent-Child Interaction Therapy (PCIT) is an internationally recognized, evidence-based parent training program for families who have children with challenging behaviors, including hitting, yelling, and defiance. In addition, PCIT is an effective intervention for families with a history of child physical abuse. Caregivers are actively supported by a PCIT clinician to apply specialized skills to decrease these challenging behaviors, increase positive child behaviors, such as sharing and following directions, and improve parent-child interactions. The program is unique in that it involves coaching caregivers in specific skills as they interact with their young children (ages 2.5 to 7 years). PCIT is tailored to individual needs and designed to help caregivers gain mastery in techniques taught during sessions. Upon completion of the program, the family graduates from treatment equipped to continue using the skills independently, thus sustaining child behavioral improvements.

According to the Child Welfare Information Gateway, a growing body of research supports the effectiveness of PCIT, including studies examining application for various populations. Over 40 clinical studies have found PCIT to be useful in treating at-risk families and children with behavioral problems. Research findings include positive outcomes for mother-child dyads exposed to interpersonal violence, reductions in the risk of child abuse, improvement in parenting skills, reduction in caregiver stress, improvements in child behavior, and effectiveness in treating multiple issues, including separation anxiety, self-injurious behavior, and attention deficit hyperactivity disorder. Research has demonstrated outcomes across genders and ethnic groups, as well as treatment gains being maintained over time.

Based on systematic reviews of available research, the following expert groups have highlighted PCIT as a model program or promising treatment practice: The California Evidence-Based Clearinghouse for Child Welfare; The National Child Traumatic Stress Network; and National Crime Victims Research and The Center for Sexual Assault and Traumatic Stress, Office for Victims of Crime, U.S. Department of Justice (Child Welfare Information Gateway, 2013 https://www.childwelfare.gov/pubPDFs/f_interactbulletin.pdf).

In addition, PCIT has been identified as a key component in Philadelphia's Department of Human Services Child Welfare Demonstration Project (CWDP). The CWDP is a program in Pennsylvania (and other selected states) that funds interventions to improve safety, permanency, and well-being of children. CWDP funding represents an alternative and supplemental program to the per placement reimbursement process that is

traditional in child welfare. Philadelphia chose PCIT as one of several Evidence-Based Programs to implement and expand in the city's continued efforts to improve outcomes for children.

II. PCIT (PCIT) Training and Implementation

A. Training and Implementation Opportunity

CBH is sponsoring an innovative training and implementation program for child outpatient providers. The training will be provided by Amy Herschell, Ph.D and her team. Dr. Herschell is a PCIT International Master Trainer and as Associate Professor at the University of Pittsburgh and West Virginia University. She has conducted extensive research on evidence-based practice implementation, and she recently conducted a federally-funded trial through the University of Pittsburgh to understand the effectiveness of specific training strategies (Cascading, Distance Education, and Learning Collaborative) for implementing PCIT.

The training will include a pre-work / launch phase when agencies prepare to deliver PCIT, three face-to-face training series (also known as Learning Sessions, each lasting two or three days), and consultation with the trainers during active implementation between learning sessions.

The training program is scheduled to begin in September 2016 and will include an active training and implementation phase through October 2017. Integration of PCIT into 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

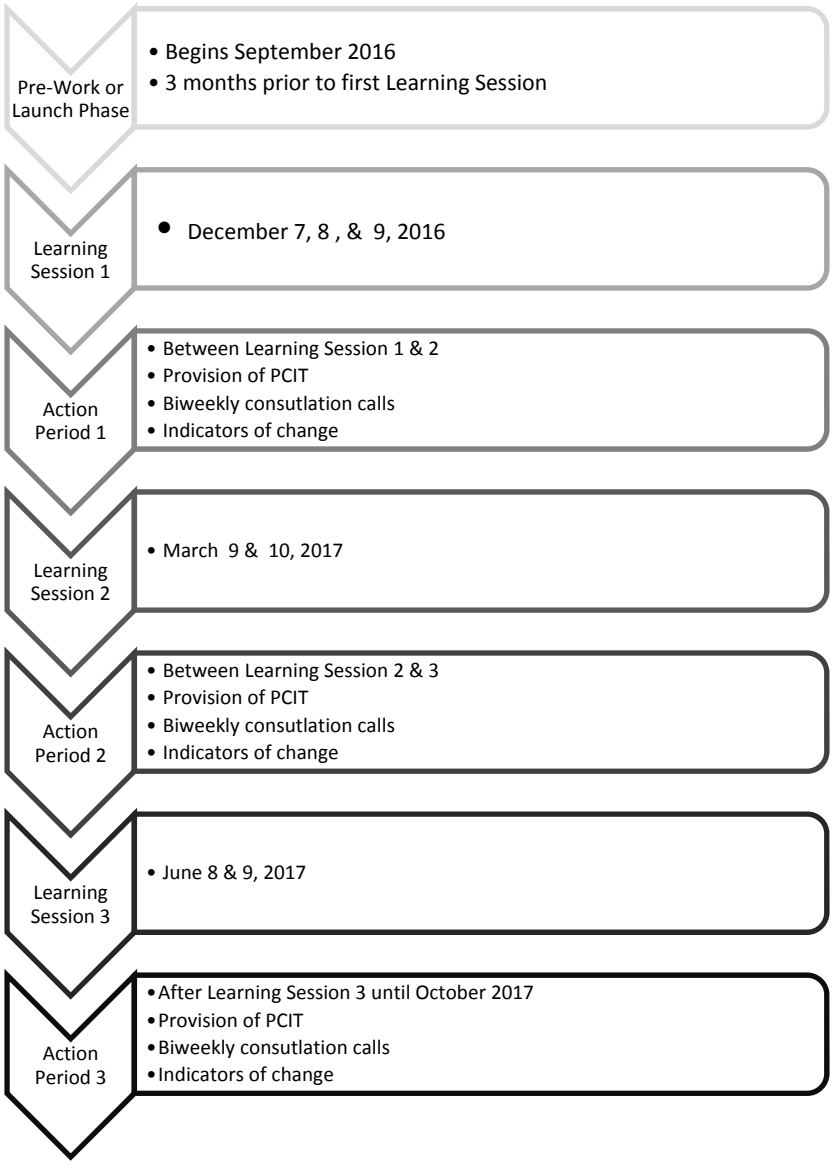
The goal of this training and implementation program is to successfully integrate and sustain PCIT within child outpatient services in Philadelphia for the purpose of strengthening the resilience and functioning of young children in home, school, and community settings. Following the training and implementation program, providers should be able to demonstrate the capacity to identify and engage appropriate children and families with the service, deliver the model to fidelity, and sustain the model long term. CBH would like to increase capacity for PCIT across the city, with particular focus on spreading geographic access, engaging child welfare involved families, and strengthening existing PCIT programs.

The training and implementation program will use a learning collaborative structure that includes didactic training and workshop learning activities. Participating staff will receive regular phone consultation with a PCIT trainer in order to obtain support in maintaining fidelity to the PCIT model, supporting successful application of learning, and determining any modifications needed to ensure optimal progress for families receiving the treatment. Throughout the training and implementation program, teams and trainers will focus on the overall goal of promoting changes in practices that enhance care for children and families. These changes will be measured by indicators of improvement within an identified timeframe. This measure is to enable outpatient programs to sustain PCIT independently over time.

2. Training Model

Identified clinicians, supervisors, and administrators from selected agencies will participate in a training and implementation program lasting approximately one year. This period will include preparation for implementation, training in the PCIT model, and the provision of PCIT to a caseload of identified children and their caregivers. To ensure optimal success in application, trained staff will receive biweekly consult with a PCIT trainer throughout the training year. Also with the support of the training team, or "faculty," agencies will track progress by administering structured change measurements throughout the implementation process.

An overview of the training:



The above training phases will unfold as follows:

PRE-WORK PHASE

The "Pre-Work" or Launch Phase of training occurs over the three months prior to the first in-person training session (i.e., Learning Session). Goals of this phase include to: (1) provide participants with exposure to the treatment model, (2) promote knowledge acquisition regarding the intervention, (3) support teams in ensuring readiness for treatment implementation (e.g., room set-up, equipment), and (4) familiarize teams with core components of the training and implementation model. Pre-Work activities include reading and reviewing introductory materials related to the treatment (such as the treatment manual, relevant articles) as well as the

training model, assessing team readiness for implementation of a new EBT, and participating in collaborative calls with team members and affiliate groups. These activities will be customized to agencies depending on existing capacity to deliver PCIT. During the Pre-Work Phase, agencies will be expected to obtain the required technology and physical room changes to be prepared to begin PCIT immediately following the first learning sessions (see Technology Capabilities). Agencies will also be expected to identify young child referral pathways and sources of referrals. Additionally, agency clinicians will be expected to complete pre-requisite training in early childhood development (unless prior training is verified) so that face-to-face learning session time is optimized.

LEARNING SESSIONS

Throughout the course of the training and implementation, teams will participate in three sessions of face-to-face trainings, also known as Learning Sessions. Each Learning Session will last either two or three days and will occur three to four months apart throughout the year. During each Learning Session, participants engage in a variety of activities targeting agency teams as well as individual affiliate tracks (senior leader, supervisor, and clinician). Goals of the learning sessions include to: (1) provide exposure and skill practice related to the intervention, (2) support teams in engaging with one another to build collaborative network, and (3) support understanding of the training and implementation methodology (such as the use of metrics, focus on local expertise, and embedding practices).

ACTION PERIODS

Following each Learning Session, agency teams participate in Action Periods. During Action Periods, teams implement and study the knowledge and skills acquired during training as they administer PCIT to caseloads of child-caregiver dyads. Teams evaluate the impact of their efforts through Plan, Do, Study, Act (PDSA) cycles. PDSA cycles allow teams to measure the effect of techniques/ideas implemented to improve implementation/sustainability of the intervention. Throughout the Action Periods, faculty support teams and encourage collaboration through consultation calls, affiliate group calls, agency team meetings, and use of technology to encourage sharing. Teams also complete monthly Metric Reports during each Action Period which provide ongoing monitoring of key outcomes (such as the number of referrals and hours of supervision). Additionally, Action Periods include assignments for completion prior to upcoming Learning Sessions.

SUSTAINED PRACTICE

Following the completion of the full training and implementation program, agencies will be expected to independently sustain PCIT, including facilitating ongoing referrals and engagement, maintaining case load, and ensuring supportive supervision, leadership, and policy. Having an agency's leadership (e.g., CEO, supervisors, and other decision-makers) directly involved in the implementation of an EBP is key to its long-term success. Strategies of an engaged leadership include the CEO being knowledgeable about PCIT and directly involved in: 1) supporting clinicians and supervisors in maintaining fidelity to PCIT, 2) recruiting staff to participate in learning and using the EBP, 3) integrating the EBP into the culture of the agency, and 4) demonstrating commitment to the EBP through follow-through with the implementation plan.

In addition, each agency should also consider how their policies may support or conflict with EBP practice and identify ways to integrate PCIT into their policies and procedures, for example 1) considering an applicant's knowledge of (or openness to) EBPs in hiring decisions and integrating information about PCIT into new employee orientations, 2) setting participation in EBP supervision as a regular requirement, 3) creating processes to track fidelity and measures in electronic medical records, 4) integrating PCIT into clinical documentation, and 5) recognizing EBP clinicians formally in performance reviews and merit raises and informally in newsletters, websites etc.

C. Monitoring and Reporting Requirements

The tracking of change is an integral part of PCIT, as well as essential to understanding what is working well within the training and implementation. CBH and PCIT faculty 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 PCIT faculty. Programs that are selected through this RFA process will be required to meet the following monitoring and reporting requirements:

- Data related to delivery of PCIT, including number of therapists, volume of service delivery, fidelity indicators

- Evidence of the regular collection and use of clinical data (e.g. Eyberg Child Behavior Inventory (ECBI) and the Dyadic Parent-Child Interaction Coding System (DPICS), each of which will be carefully reviewed during training). Documentation may be reviewed or requested to demonstrate use in progress monitoring, treatment planning, supervision, and quality improvement.

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

The University of Pittsburgh has been contracted by the state to conduct CWDP evaluation. Agencies may also be asked to submit data to the University of Pittsburgh CWDP evaluation team. The University of Pittsburgh CWDP evaluation team is not directly affiliated with the PCIT Training Team. For questions about the CWDP evaluation, please contact the study Principal Investigator, Dr. Mary Beth Rauktis (mar104@pitt.edu).

D. Technology Capabilities

Applicants must have the technological capabilities required to perform the proposed activities in this RFA. Start-up funding to assist with physical and technological requirements for PCIT will be allocated on an as-needed basis, up to the amount of $2000. Selected providers will be given the opportunity to submit a budget and receive reimbursements for these costs.

The following space details and tools are necessary for an agency to maintain in order to provide PCIT:

1. **PCIT room**: This includes a one-way mirror between an observation room and a therapy office large enough to accommodate a play area and timeout chair (see layout below). Agencies that do not currently have this set-up should have the capabilities to implement, for example, ability to construct a one-way mirror between two existing rooms.

2. **Time-out space:** This is a space in addition to the timeout chair. It can be a room adjoined to or near the PCIT room that can accommodate the child alone. In keeping with PA Policy on Seclusion/ Restraint, the room should be childproof, of a recommended size of 5’x5’, no smaller than 4’x4’, and must allow the caregiver and child to be able to see one another throughout the timeout. If the timeout space is within the PCIT room, one of the four walls defining the space must be between 4’ and 5’2” in height, again allowing for caregiver and child to see one another. Agencies that do not currently have this set-up should have the capabilities to implement.

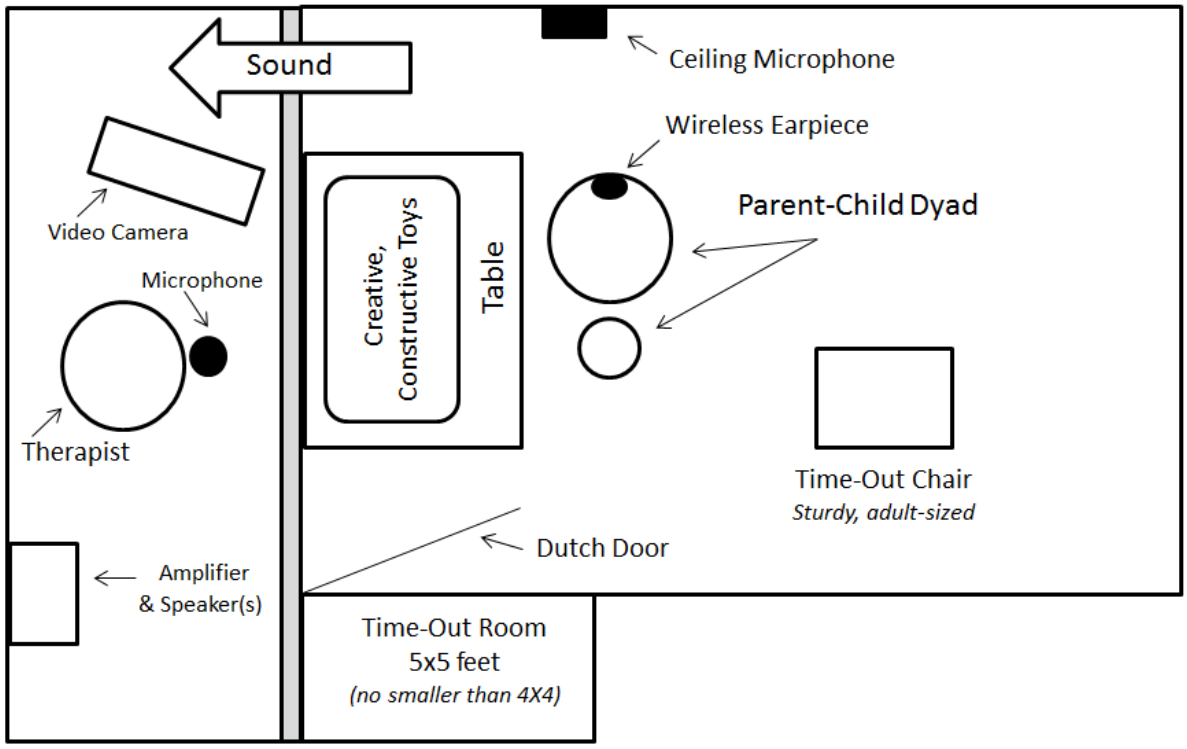
3. **Communication and sound devices:** Bug-in-ear, microphone, cable, speaker, amplifier.

4. **Recording equipment:** Video camera and privacy- protected space to store media.

5. **Assessment tools:** ECBIs, ECBI Manual, DPICS

6. **Creative and constructive toys:** Toys that can be easily handled and described, for example, Mr./ Ms. Potato Head, foam building blocks, wooden train and track, plastic play figures with terrain/ play mats, such as animals and barn/ silo.

Example of PCIT room setup*:*



E. Continuing Education Credits

Continuing Education Credits are not guaranteed at this time; however, CBH is collaborating with the trainers to develop capacity to provide credit for the learning sessions.

III. Application and Selection Process

A. Eligibility Requirements and Expectations

Applicants must meet the following eligibility requirements.

1) Eligible applicants must be a current child outpatient 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 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) Participating providers will be expected to make a serious, sustained commitment to full and continuing implementation of PCIT, both for the duration of the training cycle and for the long-term. Please note that participation represents a willingness to transform outpatient services, rather than just a temporary training initiative (See “Sustained Practice” in section B.2. above). Applicants must be willing and able to meet the expectations indicated below.

3) Priority will be given to:

- Applicants in the following zip codes: 19153, 19112, 19145, 19148,19139, 19104, 19151, 19131, 19121, 19128, 19125, 19133, 19134, 19124, 19137, 19135, 19149, 19136, 19152, 19111, 19114, 19115, 19154, 19116, 19141, 19126, 19132, 19127, 19138, 19150, 19129, 19120.
- Applicants with identified child welfare connections, including those with an identified plan to support access from their current sites for CUA affiliated families.
- Current PCIT providers seeking to expand capacity to deliver PCIT.

4) At a **minimum**, the following will be required:

- 1 Administrator who will:
    - Provide oversight of day-to-day activities of core team members (i.e. the supervisor and clinicians participating in trainings
    - Receive PCIT training in full
    - Participate in one-hour consultation calls with PCIT trainer once per month
    - Participate in quarterly meetings of key personnel
    - Complete monthly metrics and Continuous Quality Improvement

- 1 Supervisor who holds a master’s or doctoral degree (with preference for licensed or licensed-eligible staff) who will:
    - Supervise/ work directly with clinicians receiving PCIT training
    - Receive PCIT training in full
    - Participate in one-hour clinical consultation calls with PCIT Trainer twice per month and one-hour supervision consultation calls with PCIT Trainer once per month
    - Participate in quarterly meetings of key personnel
    - Carry a caseload of 5-7 child-caregiver dyads
    - Complete monthly metrics and Continuous Quality Improvement

- 3-5 Clinicians who hold a master’s or doctoral degree (with preference for licensed or licensed-eligible staff) who will:
    - Work directly at the target site with young children
    - Receive PCIT training in full
    - Participate in one-hour clinical consultation calls with PCIT trainer twice per month
    - Participate in quarterly meetings of key personnel
    - Carry a caseload of 5-7 child-caregiver dyads
    - Complete monthly metrics and Continuous Quality Improvement

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 PCIT training and signed by the Executive Director.
- Appendix B is the Trainee Information Form, to be completed by each potential participant.
- Appendix C is the DBHIDS Funding for Training and Education Policy, for applicant review.

Completed application documents must be submitted to Carrie Comeau by **2:00PM on July 27, 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 July 13, 2016. Answers to all questions will be posted on the CBH section of the DBHIDS website (www.dbhids.org) by July 18, 2016.

D. Notification

Applicants will be notified via email by **August 26, 2016** about their acceptance for training. Applicants who have been accepted will be given additional information about the training and expectations via an orientation session.

E. Certification

All licensed clinical staff who complete the PCIT training will be eligible for certification through PCIT International through a separate process coordinated directly with PCIT International. The identification of

licensed or licensed-eligible clinical staff for the training is strongly recommended so that these staff can pursue PCIT certification. This RFA does not, however, preclude applicants who are not licensed or licensed-eligible.

F. Cost Information

There will be no cost to providers for this training but a significant organizational commitment will be required to successfully implement and sustain this evidence-based family therapy model.

Start-up funding to assist with physical and technological requirements for PCIT will be allocated on an as-needed basis, up to the amount of $2,000. Selected providers will be given the opportunity to submit a budget and receive reimbursements for these costs. Agencies will be expected to cover costs in excess of $2000.

CBH is currently developing a strategy to provide an enhanced billing rate for PCIT that will be dependent on completion of all training requirements and the demonstration of sustained delivery of PCIT to model 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

PCIT Training
Request for Applications (RFA)

Agency: _____

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

Address: _____

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

Agency Contact: _____

Title: _____

Telephone: _____

Email: _____

Fax: _____

PCIT Contact: _____

List all personnel applying for PCIT training: master's or doctoral level staff to include 3-5 clinicians, 1 supervisor, 1 administrator (additional details of participating staff to be included in Appendix B)

Name	Role (Clinician, Supervisor, Administrator)

DBHIDS is looking to understand your agency's interest and motivation in integrating PCIT 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 PCIT from the onset of engaging in the PCIT 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 PCIT.

2. Population Served: Describe the geographic area (including zip codes) and population served at your agency. Include the number of individuals served, numbers of children ages 2.5 to 7 currently served, approximate percentage of children engaged in child welfare system and any unique characteristics of the population (e.g., primarily Spanish speaking).

   Describe the need in your community for specialized treatments and interventions for young children with emotional and behavioral challenges and their families, as well as families with history of harsh parenting practices. Explain here 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 child referrals).

3. Treatment Program: Describe the programming in your Child Outpatient Program and current treatments offered in your agency. Please be certain to include information about each of the following:
   For child outpatient services describe:
   a) Primary theoretical model(s) of treatment currently offered
   b) How families, schools and other social supports are engaged in the treatment process
   c) Other services, supports provided to support engagement of families in treatment, for example, childcare for siblings, meals, tokens, transportation
   d) Process for monitoring symptom change and treatment progress, including the use of standardized measures in intake, treatment planning or program evaluation. Describe any application of measures in program development and/ or system changes.

4. Referral Pathways: Describe current sources of referrals for your child outpatient program, including methods to provide education about current services and assist in identifying appropriate referrals.

   Identification of PCIT family: The participating therapists and supervisors will need to have at least two families ready to participate in PCIT immediately following the first Learning Session in December 2016 and a plan to build and sustain capacity to deliver PCIT to 5-7 families per therapist.
   a) Describe plan to develop and sustain additional referral pathways for children ages 2-7 appropriate for PCIT, (e.g. connections with child welfare, pediatricians, and/or childcare facilities.)
   b) Explain your plan to have families ready to participate in PCIT immediately following the first training

5. Child Welfare System, expertise and collaboration: Providing PCIT to children and families referred from Community Umbrella Agencies (CUA) is a priority for this RFA.
   a) Describe experience/ expertise with children and families from the child welfare population;
   b) Describe current collaboration with your local CUA;
   c) Describe your location in relation to your local CUA;
   d) Describe how you could support increased referral and engagement from CUAs,

e) Applicants may include letters of support from local CUAs.

6. Requirements of participating staff: Participating clinicians and supervisor will dedicate time to training and implementation of PCIT, including commitment to 7 full days of training through the training year, monthly and/or biweekly PCIT consultation, and participation in meetings as needed to support implementation and sustainability of PCIT program. The participating administrator will provide leadership and oversight of implementation, which will include full training in PCIT 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.

7. PCIT space: Describe current room setup where PCIT can be provided or capacity to build/ establish space to accommodate an observation room, a one-way mirror, an office space large enough to include a play area and timeout chair, and a separate timeout room/ space (see Section D).

8. 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). (For example, Evidence-Based Practices may be used in your agency, outside of the OP.) Describe some of the specific successes and challenges with these approaches. 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.

9. Sustainability As noted, the capacity to sustain the implementation of PCIT in a child outpatient setting will be strongly considered in the RFA selection. Sustainability requires the full engagement of leadership, policies that support rather than conflict with EBP practice, and efficient staff retention methods, among other strategies. Please describe your plan to ensure that the implementation of PCIT can be sustained long term in the child outpatient setting, addressing the commitment of CEO and other agency leaders, policies, and staff retention.

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

License from DHS _____

The following signature is required to confirm your agency's interest in applying for PCIT training slated to begin in September, 2016.

EXECUTIVE DIRECTOR NAME (Print) _____

EXECUTIVE DIRECTOR SIGNATURE _____

DATE _____

APPENDIX B

PCIT TRAINEE INFORMATION FORM

Parent-Child Interaction Therapy (PCIT) is an internationally recognized, evidence-based parent training program for families who have children with challenging behaviors, including hitting, yelling, and defiance. In addition, PCIT is an effective intervention for families with a history of child physical abuse. Caregivers are actively supported by a PCIT clinician to apply specialized skills to increase positive child behaviors, such as sharing and following directions. The program is unique in that it involves coaching caregivers as they interact with their young children (ages 2.5 to 7 years). PCIT treatment is tailored to individual needs and skill-based, with a goal of helping parents to gain mastery in techniques taught during sessions. Upon completion of the program, the family graduates from treatment equipped to continue using the skills independently, thus sustaining child behavioral improvements.

The training will target up to ten agencies currently providing psychiatric outpatient services. Each agency will identify one administrator, one supervisor, and up to five clinicians to participate in the PCIT training. Participants will be expected to:

- Attend one three-day and two two-day PCIT trainings, scheduled at 3-4 month intervals through the training year (December 2016, March 2017, and June 2017).
- Participate in one-hour biweekly PCIT consults through the training year.
- Begin providing PCIT following the first three day training. Build to and sustain case load of 5-7 (clinicians and supervisors only).
- Participate in quarterly meetings of key personnel.

In order to be trained in PCIT, clinicians must have a master's degree or higher in a human services field (e.g., social work, psychology) and be licensed or license eligible.

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: Y N License(s) held in PA _____

Credentialed: Y N 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 children / families / adults?

Do you have training and/or education focused on early childhood development? Yes ___ No ___

Please provide details about your training:

_____

Please describe your theoretical orientation:

_____

Please describe your interest in learning about PCIT:

_____

APPENDIX C
DBHIDS Policy Alert
Funding for Training and Education Services

The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has committed significant resources in the past five years toward ensuring that services provided in the system are evidence-based and informed and that providers have the opportunity to receive training and education around these practices, often with no cost to the provider. Additionally, the Department has frequently taken measures to reimburse for lost revenue as a result of staff attendance at these events.

This policy articulates the rights and responsibilities of both DBHIDS and the provider/agency related to training and education funded either directly or through a reimbursement process. These include specifically:

- receipt of training or other types of educational efforts for which DBHIDS has paid;
- funds received or expected to receive with which to enhance services through training;
- funding for lost wages as a result of training or;
- costs to the agency created as a result of training or other types of education.

Agency Responsibilities

DBHIDS expects that if an agency applies for and receives either training or funding for training (including payment for lost revenue) through a Request For Proposals (RFP), Request For Applications (RFA), Request For Qualifications (RFQ) or other procurement/grant process, that the agency will follow through on all commitments related to this training/funding. This includes but is not limited to:

- attendance at all training that is mandatory in order to complete the requirements for the skills being sought;
- attendance/participation in all follow-up, booster or supervision sessions or phone calls related to the training;
- prompt invoicing for all expenses related to the training/educational services being received, including documentation of lost revenue;
- accurate record-keeping related to numbers of staff receiving the training/educational services and requirements for achieving the desired skill set; and the appropriate number of staff (based on the size of the agency) to be trained that will ensure that the skill set is embedded in the practice of the agency;
- immediate notification to DBHIDS in the event that, for unforeseen reasons, there is an obstacle to completing the training and/or follow-up activities as agreed.

Please note that the responsibilities associated with this policy are not program specific but apply to the entire agency.

DBHIDS Responsibilities

DBHIDS commits to the agency that we will:

- provide information in the RFP or request for participation that details, as clearly as possible, expectations including time frames, follow-up meetings, supervision, and costs to be borne by the provider for implementation;
- ensure the highest quality of training/education by contracting with the leaders in the field around evidence-based, evidence-informed practices to provide training/education;
- process invoices in the most expedient manner possible;
- maintain a database of providers with specific skills to ensure that agencies with staff trained in specific evidence-based or evidence-informed practices are acknowledged for their work.
- Work collaboratively with providers(s) should unforeseen obstacles arise that preclude completion of training and/or follow-up activities determine that training and/or follow-up activities should be suspended.

Default of Responsibilities

Because of the major costs associated with bringing no-cost, evidence-based and informed training and education to our provider community, should a provider/agency fail to meet the conditions set herein, the entire agency will be considered in default of this policy and the following remedies may be sought by DBHIDS:

- ineligibility (as an agency) to apply for any RFP, RFA or RFQ or other opportunity that would enhance or expand services for a period of eighteen months;
- ineligibility(as an agency) to receive any reimbursement for any costs (including payment for lost revenue) related to the training/education for which the agency has not billed up to the point of the default and beyond;
- ineligibility (as an agency) to receive any reimbursement for any costs (including payment for lost revenue) for any part of the training that has been completed if the training requires that it be fully completed in order to be considered certified, accredited or otherwise credentialed;
- ineligibility (as an agency) for reimbursement of any costs related to the purchase of any equipment or supplies related to this training/education;

DBHIDS will work collaboratively with individual providers to evaluate whether or not an agency that has defaulted will need to return funds that have been expended for training/education. Agencies lacking the numbers of staff with the time and/or credentials necessary to ensure an embedding of the skill set or evidence-based or informed practice within its service structure **should not** apply for training/education through an RFP, RFA, RFQ or other procurement process.

Should there be instances where attendance or participation in training or education activities are interrupted or otherwise precluded due to extenuating circumstances, DBHIDS will evaluate these situations on a case-by-case basis.

A database of all agencies that have defaulted or otherwise failed to complete education or training initiatives will be maintained.