

REQUEST FOR APPLICATIONS

For

**PARTICIPANTS IN THE BECK COMMUNITY
INITIATIVE COGNITIVE THERAPY TRAINING FOR
ADULT DRUG AND ALCOHOL INTENSIVE
OUTPATIENT PROGRAMS**

Issued by

COMMUNITY BEHAVIORAL HEALTH

Date of Issue

August 31, 2017

Applications must be received no later than 2:00PM on September 22, 2017.

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

Gerard Holmes at gerard.holmes@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 Cognitive Therapy (CT). The Beck Community Initiative is a public academic partnership among Dr. Aaron T. Beck, the founder of Cognitive Therapy (CT), his research group at the University of Pennsylvania, and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). Since 2007, this innovative, team-oriented approach has been used to advance the quality of care provided to individuals in the DBHIDS system by placing tangible, empirically-based tools in the hands of the clinicians who serve them. 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 one adult drug and alcohol intensive outpatient program (IOP) through this RFA.

B. Organizational Overview

The City of Philadelphia contracts with the Commonwealth of Pennsylvania Department of Human Services (PA-DHS) 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 Community Behavioral Health to administer the HealthChoices program.

CBH was established as a non-profit organization by the City in 1997 to administer behavioral health care services for the City's approximately 600,000 Medicaid recipients. As a result, CBH manages a full continuum of medically necessary and clinically appropriate behavioral health services. CBH employs more than 400 people and has an annual budget of approximately \$800 million.

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 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**. It is essential that providers who apply for this RFA follow population health approaches as they apply.

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

The Beck Community Initiative (BCI) partners with community behavioral health providers to implement cognitive therapy (CT), an evidence-based practice with demonstrated positive treatment outcomes for many people with complex and challenging behavioral health needs. For example, CT has been successfully used to help people with problematic alcohol and other drug use, anxiety, depression, anger and externalizing disorders, trauma histories, interpersonal conflicts, and other challenges to build new skills and achieve their own unique goals.

CT, also referred to as cognitive behavioral therapy (CBT), is based on the cognitive model that describes the connection between an individual's thoughts, emotions, and behaviors. Each person's unique history and past experiences lead them to develop core beliefs about themselves, others, and the world. Those beliefs, in turn, become the lens through which new experiences are seen and understood. When we see a new situation through the lens of these past experiences, we have immediate, almost reflexive reactions (thoughts, emotions) that influence our behavior in those situations. Some of our thoughts and beliefs (cognitions) may be less accurate or helpful than they may at first seem to us, leading to distress and problematic behavior. CT helps people to identify the cognitions (based on past experiences) that are connected to the distress and unhelpful behavior in their lives, evaluate how accurate or helpful those cognitions may be, and shift to more accurate or helpful cognitions. Those changes in thinking, in turn, lead to less distress, more desirable behavior, and progress toward meaningful life goals. CT also fits well within the recovery movement, helping individuals to identify their own goals and then resolve the obstacles that may be in their path, such as addiction, depression, trauma, chronic stress, and more. CT can be delivered individually or in groups, and is supported by substantial research evidence, including almost 300 meta-analyses.

Programs that partner with the BCI will receive in-depth training followed by consultation for applying their new CT skills individually or in groups with people receiving services in the IOP program. The program will collaboratively retool their services to successfully implement and sustain CT throughout their IOP services. To date, the BCI has partnered with more than 55 programs to integrate CT into their ongoing services. These

trainings have involved a wide range of disciplines including drug and alcohol counselors, social workers, psychologists, psychiatrists, therapists, and peer specialists.

II. Cognitive Therapy (CT) Training and Implementation

A. Training and Implementation Opportunity

CBH is sponsoring an innovative training and implementation program provided by the University of Pennsylvania (Penn) via the BCI for applicants interested in implementing CT in a recovery-oriented framework in their adult drug and alcohol intensive outpatient programs; this RFA will result in the selection of one provider for the CT training opportunity. The training program is scheduled to begin in November, 2017 and will include an active training phase through June, 2018. Integration of CT into the IOP services is then expected to be expanded and sustained over time.

The selected provider will partner with BCI and CBH to implement CT into the adult drug and alcohol intensive outpatient program. Clinicians will participate in an intensive workshop process to build their knowledge of the principles and strategies of cognitive therapy, and then practice the application of those skills during six months of group consultation meetings with cognitive therapy experts. Clinicians will receive training in both individual and group interventions. Agency leaders will engage in planning meetings to support the implementation and sustainability of CT within the agency.

B. Overview of Training and Implementation Program

1. Training Program Goals

The goal of the Beck Community Initiative Training and Implementation program is to successfully integrate and sustain CT as an evidence-based practice within adult IOP services to support individuals with behavioral health challenges and strengthen their recovery in their family, work, home and community.

Training will be offered to clinicians and supervisors, occurring in four (4) phases:

- I) Intensive Workshops
- II) Six-month Consultation
- III) Transition to Internal CT Supervision
- IV) Sustained Practice of CT

The intensive portion of the training program (phases I and II) takes approximately seven months to complete. By the end of the intensive training, clinicians will have the opportunity to demonstrate competency in CT with a recovery-oriented focus. After the intensive training portion ends, the drug and alcohol intensive outpatient program will be expected to support and sustain the ongoing practice of CT with individuals and groups (phases III and IV). Certified clinicians will be expected to be recertified after two years, the internal supervision group will be expected to continue to meet on an ongoing weekly or bi-weekly basis, and additional clinicians and supervisors will be expected to complete a web-based training and join the internal consultation group to spread CT throughout the organization.

2. Training Model: Overview of Training and Implementation

The typical BCI Training and Implementation consists of the following four (4) phases:

Phase I: Intensive Workshop (22 hours over four/five weeks)

The 22-hour workshop takes place in four or five weekly meetings held over one month. Beginning with core concepts, clinicians and supervisors will learn to use a semi-manualized approach to cognitive therapy that targets skills training and acquisition related to 1) structuring an individual or group session, 2) motivational enhancement through a goal-directed framework, 3) identifying and shifting inaccurate or unhelpful thinking patterns, 4) coping with urges and cravings, 5) shifting behavior patterns to those that foster wellness, and 6) preventing relapse. The training will focus on the integration of the CT strategies and principles into both individual and group treatment settings.

This training program will enhance clinicians' "toolboxes"; they will learn to form cognitive case conceptualizations, tailor CT interventions to an individual's strengths and needs, consider how those strengths and needs can be addressed through individual or group treatment, and pursue recovery and other meaningful goals set by that individual. CT consultants will collaboratively support agencies to integrate CT interventions into existing individual and group treatment.

The instructors teach through experiential learning, didactics, role plays, audio examples, practices and more. In addition to the core clinical participants (clinicians and supervisors), additional staff including administrators, supervisors, and others are strongly encouraged to attend the Phase I workshop to be best able to support the integration of CT into the drug and alcohol intensive outpatient program. The workshop series is held at the Penn 3535 Market Street location in Philadelphia.

Phase II: CT 6-Month Consultation

Immediately following the close of Phase I, the participants (participating supervisor[s] who are pursuing certification and all participating clinicians) will begin to apply their new CT knowledge and skills to treatment with individuals receiving services; these participants should be able to deliver CT to at least two individuals, as well as to one group pending consent of all group members. In order to receive support and extend their learning, clinicians will meet for two hours weekly at Penn for group CT consultation. During the CT group consultation, the participants will develop and refine case conceptualizations, role play and plan interventions for upcoming sessions, offer and receive feedback, and review the use of structured tools to assess response to treatment. Between meetings, clinicians will practice integrating session structure and CT skills into the services they typically deliver in the drug and alcohol intensive outpatient program.

Every eight weeks throughout the six-month consultation phase, key project personnel from Penn, CBH, and the agency will meet to discuss the progress of the training program, identify potential issues or challenges, and plan for sustainability (see Phase IV). In addition, supervisors who are not participating in Phase II will be expected to come to consultation meetings at least monthly, to facilitate their familiarity of CT and CT-informed supervision. At the close of the active training program, successful core participants will become eligible for certificates to reflect their achievements (see below).

Phase III: Transition to Internal CT Supervision and Sustained Practice (first 2 years after Phase II ends)

Toward the end of the six-month consultation phase, a group facilitator and a CT liaison will be selected from the training group. One person may serve both roles, or the roles may be divided across two people. The group facilitator will be required to have met the certification requirements (see Certification below for details) and be willing to serve as a facilitator. They may be, but are not required to be, supervisors at the program. The CT liaison is required to have participated in the training process, but is not required to have met the certification criteria, nor do they have to be

supervisors at the program. The group facilitator is a clinical role, and the identified individual will receive specialized training in CT group facilitation and specific guidance about supporting the other CT clinicians as the program is sustained over time. The CT liaison will provide an administrative role and will play a key part in sustaining CT in the drug and alcohol intensive outpatient program over time. The CT liaison will receive specific guidance about on-boarding new staff into the BCI through the web-based training, monitoring recertification requirements, and uploading session recordings for additional support from Penn, and other responsibilities related to supporting the requirements for enrollment and credentialing in the BCI.

Immediately following the close of the six-month consultation, the group of graduates will transition to ongoing weekly or bi-weekly meeting to maintain ongoing skill development, prevent drift from the CT model, and to support the learning of subsequent clinicians who join the group through the web-based training. During this two-year Phase, the BCI instructors will provide additional support approximately every 8 weeks by participating in the consultation group, and providing feedback to the Group Facilitator / CT Liaison as needed. The BCI instructors will also provide detailed feedback on the Cognitive Therapy Rating Scale (CTRS) of any additional clinicians pursuing certification through the web-based training during this phase. In addition, agency supervisors will receive additional instruction and support from available online BCI training and webinars to foster growth and development of CT among their supervisees. Training program graduates, supervisors, and administrators from the partner agencies will attend Beck Community Initiative Annual Meetings at CBH.

Over time, it is expected that the agency will increase capacity to deliver the CT model by adding more trained clinicians through the available web-based training. New clinicians will join the existing internal CT supervision group at the agency to receive continued support and learning. All BCI participants will also be invited to Annual Meetings held at CBH, as well as additional training opportunities.

A sustainability plan will be developed in collaboration with the provider's administration, CBH, and Penn, including identifying measurable goals and specific dates for meeting those goals. Goals will include having agency leadership fully engaged in the implementation and sustainability of CT over time, supporting an EBP-infused culture, maintaining capacity among trained clinicians, building capacity to address turnover and increase penetration of CT in the organization, navigating competing demands, integrating policies and practices with CT, building stakeholder involvement, and evaluating outcomes. More detail on each of these domains will be provided in a Sustained Implementation Plan (SIP), with instruction for how to proceed and details on support from the BCI team. The plan will be discussed in detail in the third key personnel meeting (approximately four months into the six-month consultation phase), finalized in the fourth key personnel meeting (near the end of the six-month consultation phase), and placed into action in Phase IV (after the six-month consultation phase). Administrators will continue to provide support to the ongoing internal CT groups within their agencies.

At the end of this phase, participants will be offered the opportunity to be recertified, earning a non-expiring certificate (see Certification below).

Phase IV:

Independent Practice of CT (after the conclusion of Phase III, beginning approximately 32 months after the start of the implementation process)

In this final phase of participation, which lasts indefinitely, the internal consultation group will continue meeting weekly or bi-weekly meeting to maintain ongoing skill development, prevent drift from the CT model, and to support the learning of subsequent clinicians who join the group through the web-based training. However, the BCI instructors will no longer provide the additional bi-monthly support that was received in Phase III. The BCI instructors will continue to provide CTRS scores for any additional clinicians pursuing certification through the web-based training during this phase, but no written feedback will be provided. Instead, detailed feedback should be provided by other group members after recording review in the supervision group. In addition, agency supervisors will receive additional instruction and support from available online BCI training and webinars to foster growth and development of CT among their supervisees. Training program graduates, supervisors, and administrators from the partner agencies will continue to attend Beck Community Initiative Annual Meetings at CBH.

There remains an ongoing expectation that the agency will continue to maintain or increase capacity to deliver the CT model by adding more trained clinicians through the available web-based training. New clinicians will join the existing internal CT supervision group at the agency to receive continued support and learning. If the group becomes too large for there to be time for adequate feedback from other groups members (more than approximately eight members), the groups will be encouraged to split into smaller independent groups. All BCI participants will continue to be invited to Annual Meetings held at CBH, as well as additional training opportunities.

Overview of BCI Training and Implementation

BCI Activity	Time/ Frequency	Content	Related Requirements	Participants
BCI Orientation (PHASE I)	2 hours	Overview of BCI for participating staff	N/A	All staff participating directly, or providing support roles, in BCI
CT Workshop (PHASE I)	22 hours over 4-5 weeks	Core CT training; workshop will focus on the integration of the CT strategies and principles into both individual and group treatment settings.	N/A	REQUIRED: <ul style="list-style-type: none"> • Core Clinical Participants • Data Liaison • Group Facilitator ENCOURAGED: <ul style="list-style-type: none"> • Administrative Leadership • Data Liaison/ Evaluation Team
Meetings of Key Personnel (PHASE I and II)	Approximately every 8 weeks until end of Penn-led CT Group Consultation phase (below)	Training program progress will be discussed. Key personnel will identify potential issues or challenges, and plan for sustainability Topics of discussion will include barriers to consistent delivery of CT, data collection, participant progress, supervision, enrollment of new clinicians, or other components of sustainable implementation addressed.	Key personnel will follow up on areas of the initiative needing support as determined in meetings.	REQUIRED: <ul style="list-style-type: none"> • Administrative Leadership, other agency leadership as determined • Supervisor (s) pursuing certification • Supervisor (s) not pursuing certification • Group Facilitator • CT Liaison • Participant representative
Penn-led CT	2 hours weekly for	Clinicians and supervisors	•Deliver CT to at	REQUIRED:

Group Consultation (PHASE II)	six months following CT Workshop (consults will occur at Penn)	delivering CT will receive support and coaching from BCI trainers to develop and refine case conceptualizations, role play and plan interventions for upcoming sessions, offer and receive feedback, and review the use of structured tools to assess response to treatment. Teams will be prepared for transitioning to internal (without BCI) CT Supervision (below) to sustain CT within their agencies independently.	least two individuals. • Deliver CT to group if groups are typically within participants' scope of work.	<ul style="list-style-type: none"> • Core Clinical Participants • Supervisor (s) pursuing certification • Supervisor (s) not pursuing certification must attend consults on a monthly basis at least. • Group Facilitator
Sustained Implementation Plan (SIP) Operationalized (PHASE II and III)	For 2 years following close of 6-month Group Consultation (Phase II)	The SIP is operationalized, with includes having agency leadership fully engaged in the implementation and sustainability of CT over time, maintaining capacity among trained clinicians, building capacity to address turnover and increase penetration of CT in the organization, integrating policies and practices with CT, building stakeholder involvement, and evaluating outcomes.	N/A	<p>REQUIRED:</p> <ul style="list-style-type: none"> • Administrative Point Person, other agency leadership as determined • Supervisor (s) pursuing certification • Supervisor (s) not pursuing certification • Group Facilitator • CT Liaison • Participant representative •
Transition to Internal CT Supervision and Sustained Practice (PHASE III)	Weekly or biweekly For 2 years following close of 6-month Group Consultation (Phase II)	Internal group supervision will continue to maintain ongoing skill development, prevent drift from the CT model, and to support the learning of subsequent clinicians who join the group through the web-based training. BCI will provide bi-monthly support and detailed CTRS feedback for new participants. Participants will be recertified at the end of the two years (with a certificate that does not expire)	<ul style="list-style-type: none"> • Deliver CT to at least two individuals. • Deliver CT to group groups are typically within participants' scope of work. 	<p>REQUIRED:</p> <ul style="list-style-type: none"> • Core Clinical Participants • New participants trained through web-based training • Supervisor (s) pursuing certification • Group Facilitator
Independent Practice of CT (PHASE IV)	Ongoing	Internal group supervision will continue to meet to maintain ongoing skill development, prevent drift from the CT model, and to support the learning of subsequent clinicians who join the group through the web-based training. BCI will provide CTRS scores for new participants.		<p>REQUIRED:</p> <ul style="list-style-type: none"> • Core Clinical Participants • New participants trained through web-based training • Certified supervisor (s) • Group Facilitator
Annual BCI Meeting (MAY BE IN ANY PHASE)	Yearly	Annual meeting among CT graduates, supervisors, administrators from participating providers, CBH, and BCI staff to discuss status of BCI and goals for next year and to celebrate participant achievements in the past year.	N/A	<p>REQUIRED:</p> <ul style="list-style-type: none"> • Core and WBT Clinical Participants • Supervisor (s) pursuing certification • Supervisor (s) not pursuing certification • Group Facilitator <p>ENCOURAGED: All staff participating directly, or providing support roles, in BCI</p>

C. Continuing Education Credits

If they choose to do so, participants in the intensive workshop can receive continuing education credits (CEs) from the American Psychological Association (APA). In order to receive CEs, the individual must complete 100% of the workshop and submit feedback forms, then pay a \$25 processing fee for the CEs, with a check made out to the Trustees of the University of Pennsylvania.

III. Eligibility Requirements and Expectations

A. **Licensure and Good Standing:** Eligible applicants must be current drug and alcohol intensive 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 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' Medisearch List <http://www.dhs.state.pa.us/publications/medisearch/>

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.

B. **Program Requirements:** Participating providers will be expected to make a serious, sustained commitment to full and continuing implementation of CT, both for the duration of the training cycle and for the long-term. Participation represents a willingness to transform the drug and alcohol intensive outpatient services, rather than just a brief training initiative. As such, agencies will be expected to sustain CT Supervision Groups and increase capacity to build CT across the program.

C. **Sustained Practice:** Following the completion of the full training and implementation program (see II.B.), agencies will be expected to independently sustain CT, including facilitating ongoing referrals and engagement, delivery CT to an adequate volume of individuals, maintain proper documentation and use of measures, developing strategies to support staff through supervision and to address staff attrition.

DBHIDS is currently developing an EBP Program Designation to identify providers that are sustaining high quality EBP Programs. The criteria for EBP Program Designation include:

1. Training and consultation
 - a. intensive training by qualified treatment expert

- b. case-specific consultation to translate knowledge to practice
- 2. EBP service delivery
 - a. strategies for receiving referrals, assessment, and connecting individual with EBP-trained counselor
 - b. maintaining EBP service volume to meet referral needs and maintain proficiency with the practice
- 3. EBP quality assurance (see also requirements listed in Monitoring section below)
 - a. documentation of use of EBP in treatment plans and notes
 - b. supervision of the EBP, including use of EBP specific tools or checklists
 - c. collection of clinical outcome measures appropriate for the EBP
 - i. including measures of improved function or quality of life improvement
 - ii. developing systems for ongoing collection and reporting

Providers who participate in this initiative are expected to develop these capacities and procedures during the course of the initiative and to pass the EBP Program Designation at the end of the CT Initiative via an EBP Program Designation application. Providers are expected to demonstrate sustained capacity for the CT program via annual resubmission of the EBP Program Designation Application. Achieving and maintaining EBP Program Designation status will be required for inclusion in DBHIDS rosters in EBP providers and for any financial incentives that may become available to EBP providers.

Other strategies to support sustainability include engagement and support from agency leadership and integrating EBP in the organizational culture and operations. This includes but is not limited to:

- Recruiting staff to participate in learning and using the EBP
- Considering an applicant's knowledge of (or openness to) EBPs in hiring decisions and integrating information about ESFT and family systems care into new employee orientations
- Recognizing EBP clinicians formally in performance reviews and merit raises and informally in newsletters, websites etc.
- Planning to educate all relevant staff on the CT model and principles, including for example, drug and alcohol intensive outpatient psychiatrists, intake coordinators, and support/ administrative staff
- Selecting an individual who will take the lead on integration of CT skills throughout the program (or agency)

D. Monitoring and Reporting Requirements:

The Beck Community Initiative considers the tracking of change to be an integral part of the CT process, as well as essential to understanding what is working well within the Initiative. Therefore, CBH and Penn will partner with the selected agency to develop an outcomes monitoring plan. Support will be given in the development of the operational procedures for collecting and regularly reporting/reviewing data with CBH and Penn. Programs that are selected through this RFA process will be required to meet the following monitoring and reporting requirements.

- Submission of measures related to the agency (completed by supervisors, administrators, and clinician prior to the workshop) and clinician information (prior to beginning training, at the completion of the workshop, three months post-workshop, six months post-workshop, and bi-annually).
- Collection and submission of clinical measures that will be integrated into clinical care and consultation as well as aggregated to inform program-level outcomes and areas for quality improvement. Measures will be selected collaboratively with the agencies. Examples of measures include the WHO Quality of Life, the Beck Depression Inventory, the Beck Anxiety Inventory, the Patient Health Questionnaire-9, and the Generalized Anxiety Disorder 7.

- Submission of data and/or chart review to verify CT program components (e.g. delivery of CT groups, supervision and team approaches that support CT, development of policies supporting new staff in CT, ongoing collection of data related to fidelity and outcomes).

To this end, each participating agency will identify an Evaluation Team, comprised of agency staff and supported by the Beck Community Initiative team. As noted above, measures will be selected collaboratively and will be clinically applicable throughout the intake, treatment, and discharge processes. The clinical data from the assessment at intake and discharge, as well as clinical data collected during treatment, will inform both individual treatment planning and, in aggregate, the development of the training program. Team members should be nominated based on their willingness to participate and familiarity with the current services provided. Key evaluation team participants may include clinical / program leadership, clinical staff members, quality assurance or compliance staff members, and Information Services/ Information Technology or data management staff.

In conjunction with identifying an Evaluation Team, each agency will identify a Data Liaison who will serve as part of the Evaluation Team and function as a point person for issues pertaining to evaluation of outcomes. The Data Liaison will be responsible for coordinating regular updates pertaining to data collection, management, and sharing at the individual client level. The Data Liaison will work closely with BCI staff regarding collection of data at the individual level during the course of BCI training. Programs will also be expected to provide individual client level data for a one- year period prior to BCI involvement and for at least one year following BCI training to facilitate evaluation of the impact of CT implementation on the delivery of clinical services.

In addition, providers will be expected to maintain the necessary documentation for the EBP Program Designation (some of these requirements overlap/ repeat those listed in the beginning of section 4.above, and are being listed in full here for the purposes of aligning with other EBP Program Designation guiding documents):

- Roster of counselors / supervisors, documentation of their training in CT and tracking of caseload
- Documented processes for accepting referrals/ assessing appropriateness of EBP / scheduling with EBP counselors
- Documentation of delivery of EBP components
- 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 CT model. If programs do not adequately sustain the model, they may no longer be included in the Beck Community Initiative or on DBHIDS rosters of CT providers.

E. Participating Staff:

At a minimum, the following will be required:

1. **Core Clinical Participants (six-eight)**, who hold at least a bachelor's degree and are providing individual or group therapy who will:
 - a) Attend a Beck Community Initiative Orientation Meeting (two hours).

- b) Submit a baseline audio recording of a treatment-as-usual session and complete background and training program evaluation measures prior to the start of the workshop.
 - c) Attend and participate in all 22-hours of intensive workshop.
 - d) Attend and participate in at least 85% of the six months of weekly consultation group meetings.
 - e) Throughout the training period (beginning during Phase II/Six-month Consultation Group), deliver CT to two individuals who agree to have their therapy sessions audio recorded for training purposes. Participants are also encouraged to identify at least one ongoing therapy group in which they will practice and grow their CT skills. In these groups, consent to record will be required in order to submit audio for feedback; when consent is not possible from all group members, the clinician will practice the skills in the group but not submit audio for review of this portion of their work. In addition, clinicians will practice CT during their broader clinical practice throughout the six-month consultation phase, and beyond to support recertification and the internal consultation group.
 - f) Submit audio recordings to demonstrate emerging CT skills, with at least one recorded session submitted at the end of the workshop, and at months three and six of consultation (for certification) and a total of 30 months after the end of the workshop (for recertification) with written client consent to record. Also, complete training program evaluation measures at each of these time points.
 - g) Follow through with consultation group assignments on most consultation group weeks.
 - h) Complete weekly clinical assessment measures designed to improve and guide care, and report responses on those measures to the Penn team to guide consultation.
 - i) Continue to meet with the training cohort and consult with peers to increase skills and prevent drift, indefinitely as an internal CT supervision group on at least a bi-weekly basis beyond the close of the seven-month intensive training period.
2. **Supervisor (at least one)**, who holds at least a bachelor's degree and supervises the clinicians providing therapy will participate in the BCI. If the supervisor(s) would like to be eligible for CT certification, they will complete the same requirements as a core trainee listed above, which will include the requirement to consistently practice CT treatment sessions. Even if the supervisor(s) would not like to be eligible for the certification in Section II, supervisor(s) will be required to:
- a) Attend a Beck Community Initiative Orientation Meeting (two hours).
 - b) Complete background and training program evaluation measures prior to the start of the workshop.
 - c) Attend and participate in all 22 hours of intensive workshop.
 - d) Submit post-program evaluation measures at the completion of the workshop.
 - e) View the online Cognitive Therapy Supervisor Webinar (six hours).

- f) Attend and participate in the consultation group meeting at least once monthly during the six months of weekly consultation group meetings.
 - g) Complete training related assessments and questionnaires designed to improve the training and implementation of CT.
 - h) Continue to meet with the training cohort indefinitely as an internal CT supervision group on at least a bi-weekly basis beyond the close of the seven-month intensive training period.
3. **CT Liaison** will be identified. The CT liaison is required to have participated in the training process, but is not required to have met the certification criteria, nor do they have to be supervisors at the program. The CT liaison will:
- a) Attend a Beck Community Initiative Orientation Meeting (two hours).
 - b) Submit a baseline audio recording of a treatment-as-usual session and complete background and training program evaluation measures prior to the start of the workshop.
 - c) Attend and participate in all 22-hours of intensive workshop.
 - d) Provide an administrative role and will play a key part in sustaining CT in the drug and alcohol intensive outpatient program over time.
 - e) On-board new staff into the BCI through the web-based training.
 - f) Monitor recertification requirements.
 - g) Upload session recordings for additional support from Penn.
 - h) Complete other responsibilities related to supporting the requirements for enrollment and credentialing in the BCI.
 - i) Attend key personnel and BCI annual meetings.
4. **Group Facilitator** will be identified from the group of clinicians/ supervisor(s) who are pursuing entire training and certification. In addition to completing all requirement of the Core Clinical Participants listed, the Group Facilitator must be willing to fill this role and will:
- a) Facilitate internal CT group supervision that begins after the six-month Penn-led group consultation.
 - b) In addition to supervisor (if this role is being filled separately), support the other CT clinicians as the program is sustained over time.
 - c) Attend key personnel and BCI annual meetings.

5. **Data Liaison and other members of Evaluation Team**, which may include clinical / program leadership, clinical staff members, quality assurance or compliance staff members, and information services/ information technology or data management staff, all of whom are willing to participate and familiar with the BCI, and who will:
 - a) Assist with selecting clinical tools to be administered at intake, throughout treatment, and at discharge.
 - b) Assist in collecting data to inform individual treatment planning and in aggregate, the development of the training program.
 - c) In conjunction with identifying an Evaluation Team, each agency will identify a Data Liaison who will serve as part of the Evaluation Team and function as a point person for issues pertaining to evaluation of outcomes. The Data Liaison will be responsible for coordinating regular updates pertaining to data collection, management, and sharing at the individual client level. The Data Liaison will work closely with BCI staff regarding collection of data at the individual level during the course of BCI training.
 - d) Provide individual client level data for a one- year period prior to BCI involvement and for at least one year following BCI training to facilitate evaluation of the impact of CT implementation on the delivery of clinical services.
- a) Attend key personnel and BCI annual meetings.
6. **Agency leadership**, including Executive Director and Clinical Director,, must be willing to participate actively in the effort to successfully establish and sustain CT as a treatment option within their organizations. The following commitments will be required of organizational/agency leaders:
 - a) Assure that the agency's staff members selected to participate in the Beck Community Initiative are informed and aware that their participation in the training program is voluntary and these clinicians were not the subject of coercion by any level of leadership within the organization.
 - b) Identify an administrative point person within the agency who will serve as the main point of contact for CBH and Penn throughout and beyond the active training period. This point person must attend regular coordination and review meetings with CBH and Penn to track the progress of this initiative on an ongoing basis. Meetings will occur approximately every eight weeks throughout the seven-month active training period.
 - c) Identify at least one supervisor whose supervisees will be involved in CT and their involvement in the Beck Community Initiative. Supervisors are required to participate in the 22 hours training, all key personnel meetings, monthly group consultation meetings, a supervisor webinar, and Annual Meetings.
 - d) Identify and oversee an Evaluation Team to inform the implementation of clinical assessment measures that guide treatment and program development as well as a Data Liaison who will serve as part of the Evaluation Team and function as a point person for issues pertaining to evaluation of outcomes.

- e) Assist in oversight of all facets of this initiative, including the implementation plan, development and execution of a sustainability plan, and resolution of any operational challenges.
- f) Executive Directors and Clinical Directors will be required to sign an agreement confirming that they will continue to fully support and accommodate post-training program sustainability and implementation of CT within their agency.
- g) Provide operational and administrative support on a continuing basis to the cohort of CT graduates at the close of the intensive training program as they meet as an internal group on a bi-weekly basis indefinitely to support adherence to the CT model. Ensure they meet regularly, address operational challenges the group may experience, and support the growth of the CT model across the agency through ongoing use of the Beck Community Initiative's Web-based Training (Web-Based Training) program.
- h) Provide feedback to the BCI instructors on the selection of a group facilitator and / or CT liaison, and then support people in those roles as CT champions for the internal group.
- i) Submit a proposal delineating how the organization plans to sustain the CT practice at the time of application. During the intensive seven-month training cycle, a detailed plan will be developed, including how the agency is prepared to continue to sustain the CT model beyond the close of the training program. Agency leaders will be specified to ensure the implementation of this plan.
- j) Ensure that assessment and tracking measures are being completed by the clinicians, submitted on a regular basis, and used to guide treatment planning and delivery.
- k) Agency leadership and participating clinicians are expected to complete a variety of assessment instruments administered by Penn and CBH before, during and after the intensive seven-month training cycle. These instruments will be used to explore such things as relations between reported readiness to adopt EBPs and the subsequent ability to effectively institute these practices, and to help identify what, if any, impact CT training has on clinicians, client, provider variables and the behavioral health system as a whole.
- l) Attend key personnel and BCI annual meetings.

Overview of Activities and Requirements of Participating Staff

Staff	Qualifications	Role in BCI	Requirements/ Meetings/ Trainings
Core Clinical Participants (6-8)	<ul style="list-style-type: none"> • Holds bachelor's degree or higher in a human services field (e.g., social work, psychology) • Delivers individual and group therapy 	Deliver CT	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Complete CT Workshop (22 hrs over 4-5 weeks). • Deliver CT to at least 2 individuals and if possible, 1 group (includes gathering and submitting baseline and ongoing clinical measures, audio recordings, and training evaluations). • Participate in at least 85% of the six months of weekly consultation group meetings (includes completing assignments, and practicing/ delivering CT between meetings). • Participate in ongoing biweekly/ weekly internal CT supervision following seven-month intensive training.
Supervisor (at least 1)	<ul style="list-style-type: none"> • Holds bachelor's degree or 	Supervise	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs).

	<p>higher in a human services field (e.g., social work, psychology)</p> <ul style="list-style-type: none"> • Holds current supervisor position 	CT Clinicians	<ul style="list-style-type: none"> • Complete CT Workshop (22 hrs over 4-5 weeks). • Complete Cognitive Therapy Supervisor Webinar (6 hours). • Participate at least monthly in the six months of weekly consultation group meetings (includes completing assignments, and practicing/ delivering CT between meetings). • Attend regular coordination and review meetings with CBH and Penn to track the progress of initiative (approximately every 8 weeks during seven-month intensive training period). • Attend BCI Annual Meetings at CBH. • Participate in ongoing biweekly/ weekly internal CT supervision following seven-month intensive training phase. • If pursuing CT certification, supervisor must complete all components required of Core Clinical Participants.
CT Liaison	<ul style="list-style-type: none"> • Holds bachelor's degree or higher in a human services field (e.g., social work, psychology) • Delivers individual and group therapy • Can be supervisor, though not required • Can be same individual who fills role of Group Facilitator 	Play key role in sustaining CT	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Complete CT Workshop (22 hrs over 4-5 weeks). • On-board new staff into BCI through web-based training. • Monitor recertification. • Upload recorded sessions for support from Penn. • Manage other responsibilities related to supporting the requirements for enrollment and credentialing in the BCI. • Attend regular coordination and review meetings with CBH and Penn to track the progress of initiative (approximately every 8 weeks during seven-month intensive training period).
Group Facilitator	<ul style="list-style-type: none"> • Holds bachelor's degree or higher in a human services field (e.g., social work, psychology) • Delivers individual and group therapy • Can be supervisor, though not required • Can be same individual who fills role of CT Liaison 	Facilitates CT groups following intensive training phase	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Complete CT Workshop (22 hrs over 4-5 weeks). • Deliver CT to at least 2 individuals and if possible, 1 group (includes gathering and submitting baseline and ongoing clinical measures, audio recordings, and training evaluations). • Participate in at least 85% of the six months of weekly consultation group meetings (includes completing assignments, and practicing/ delivering CT between meetings). • Receive specialized training in CT group facilitation and specific guidance about support the other CT clinicians as the program is sustained over time. • Facilitate internal biweekly/ weekly group supervision, beginning after seven-month intensive training phase. • Participate in ongoing biweekly/ weekly internal CT supervision following seven-month intensive training. • Attend regular coordination and review meetings with CBH and Penn to track the progress of initiative (approximately every 8 weeks during seven-month intensive training period).
Administrative Leadership	<ul style="list-style-type: none"> • Holds leadership role in the agency 	Serves as leadership point of contact for CBH and Penn	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Strongly encouraged to complete CT Workshop (22 hrs over 4-5 weeks). • Attend regular coordination and review meetings with CBH and Penn to track the progress of initiative (approximately every 8 weeks). • Attend BCI Annual Meetings at CBH. • Ensure leadership engagement and oversight of the

			BCI, particularly regarding sustainability.
CT Point Person	• Any	Serves as main point of contact for CBH and Penn	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Strongly encouraged to complete CT Workshop (22 hrs over 4-5 weeks). • Attend regular coordination and review meetings with CBH and Penn to track the progress of initiative (approximately every 8 weeks). • Attend BCI Annual Meetings at CBH. • Ensure agency engagement of the BCI, through coordination, liaising, and championing CBT.
Data Liaison	• May be clinical / program leadership, clinical staff member, quality assurance or compliance staff members, and information services/ information technology or data management staff.	Serves as point person for outcomes evaluations and liaises among Evaluation Team, BCI, and CBH	<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Strongly encouraged to complete CT Workshop (22 hrs over 4-5 weeks). • Function as point person for issues pertaining to evaluation of outcomes. • Coordinate regular updates regarding data collection, management, and sharing at the individual client level. • Attend regular coordination and review meetings with CBH and Penn to track the progress of initiative (approximately every 8 weeks during seven-month intensive training period).
Evaluation Team	• May comprise clinical / program leadership, clinical staff member, quality assurance or compliance staff members, and information services/ information technology or data management staff.		<ul style="list-style-type: none"> • Participate in BCI Orientation (2 hrs). • Strongly encouraged to complete CT Workshop (22 hrs over 4-5 weeks). • Assist in selecting data measures, ensuring consistent data collection through all phases of treatment, aggregating data, preparing for regular reporting to BCI and CBH, and addressing barriers that may arise to any phase of data collection and reporting.

6. Technology Capabilities:

Applicants must have the technology capabilities required to perform the proposed activities in this RFA. At a minimum, agency applicants must have the capabilities for new clinicians to access the webinar of the initial training (Phase IV), electronic data submission, and required reporting. Participating clinicians will be required to have the ability to transfer materials and measures to Penn’s secure, HIPAA compliant server for Penn’s retrieval and review. If needed, digital audio recorders will be lent to clinicians and returned at the end of Phase III. Participating agencies will need to make arrangements with their IT departments to ensure that this transfer of data is able to occur on a regular basis. In addition, clinicians will need access to an appropriate setting to deliver group and individual CT (i.e., a quiet, private space for individual sessions) and obtain member consent for recording sessions.

III. Application Process

The application consists of Appendices A and B as well as a set of measures to be completed online (found at <https://redcap.med.upenn.edu/surveys/?s=KLYJ3DRNHX>). These Appendices must be completed and submitted by the agency applying for CT training.

1. Appendix A is the main portion of the application, to be completed by an official at the agency requesting participation in CT training and signed by the Executive Director.
2. Appendix B is the Trainee Information Form, to be completed by each potential participant.
3. Appendix C is the web link for the Organizational Readiness for Change measure that should be completed by at least one administrator, one supervisor, and two counselors in order to provide multiple perspectives about the agency’s areas of strength, as well as areas in which the Beck Community

Initiative could offer additional supports. In order to complete the ORC, please go to <https://redcap.med.upenn.edu/surveys/?s=KLYJ3DRNHX>. There, each individual will answer a set of brief background questions which will then direct the user to the appropriate version of the form to be completed. Each individual should plan to spend 30-45 minutes to complete the measure.

Completed application documents must be submitted to Gerard Holmes by **2:00PM on September 22, 2017**. 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: Gerard Holmes

Submissions should be marked “BCI 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).
- The survey completed (Appendix C) online by at least 1 administrator, 1 supervisor, and 2 clinicians (at <https://redcap.med.upenn.edu/surveys/?s=KLYJ3DRNHX>)
- 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.

A. Questions about the RFA

All questions regarding the RFA must be sent via email and directed to Gerard Holmes at Gerard.Holmes@phila.gov. No phone calls will be accepted. The deadline for submission of questions is **September 15, 2017**. Answers to all questions will be posted on the CBH section of the DBHIDS website (www.dbhids.org) by September 19, 2017.

Information Session

CBH will hold a CT Information Session for all interested agencies. If you are interested in applying, your agency should plan to have a representative in attendance at the CT overview event. Details regarding the date and time of the information session will be posted on the CBH section of the DBHIDS website.

B. 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.

C. Notification

Applicants will be notified via email by **October 13, 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.

D. Certification

All clinicians/supervisors who also attend at least 85% of the 6-month consultation meetings will receive a certificate of completion. Clinicians/supervisors who participate in the workshop, attend at least 85% of the consultation meetings, complete program evaluation measures, and demonstrate competency in CT (as measured by adherence to CT session structure and review of CT skill adherence and competency) will receive a certificate of Competency in CT in a Drug and Alcohol Intensive Outpatient Setting. Counselors will recertify after 2 years to demonstrate that they have continued to practice and build their skills. The recertification certificates do not expire. To be recertified, a clinicians/supervisor must attend at least 85% of the ongoing internal group meetings, earn at least 3 continuing education credits (CEs) related to CT or CBT, submit new materials demonstrating competency in CT, and complete program evaluation measures.

E. Cost Information

There will be no cost to providers for this training.

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
CT Training
Request for Applications (RFA)**

Agency: _____

Site Proposed to Receive CT Training: _____

Organizational Type: ___ **For Profit** ___ **Not For Profit**

Address: _____

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

Administrative Leadership: _____

Title: _____

Telephone: _____

Email: _____

Fax: _____

CT Point Person Contact: _____

List all personnel applying for CT training: bachelor's, master's or doctoral level staff to include 6-8 Clinicians, at least 1 Supervisor, 1 Administrative Leadership (additional details of participating staff to be included in Appendix B). Data Liaison and Evaluation Team Members should be included in chart below.

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

List members of the Evaluation team, including Data Liaison:

Name	Role (Supervisor, Clinician, Admin, Leadership, QA, IT/ IS, etc.)	Salaried or Contract

DBHIDS is looking to understand your agency's interest and motivation in integrating CT 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 CT from the onset of engaging in the CT 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 CT.
2. **Population Served:** Describe the population served at your agency. Include the number of individuals served. Indicate any unique characteristics of the population (e.g., primarily Spanish speaking, geographic location, etc.) On average what % of individuals served in your program are CBH members?
3. **Treatment Program:** Describe the programming in your 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) Type and frequency of individual, group, and family therapy (if applicable) in your program
 - c) Role of families/social supports in the treatment process
 - d) Process for monitoring symptom change and treatment progress, including the use of standardized measures in intake, treatment planning or program evaluation

Discuss how CT will be incorporated into your existing array of services.

4. **Supervision:** Developing the skills of supervisors is a key element of the CT training. Describe current supervisory practices in the program and how supervisors will be supported in CT training and implementation.

5. **Evidence-Based Practice:** Please describe any additional EBP Initiatives or Research Activities your organization (not just the level of care being applied for in this RFA) has been involved in or is currently enrolled in (both DBHIDS sponsored and independent enrollments).

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

6. **Requirements of participating staff:** Participating clinicians and supervisors will dedicate time to training and implementation of CT for the initial intensive seven months as outlined above. The training cohort will continue to meet indefinitely as an internal CT supervision group on at least a bi-weekly basis beyond the close of the seven-month intensive training period, Describe proposed methods to support staff in managing these responsibilities and ensuring time to engage in key activities.
7. **Sustainability:** Describe in detail your plans to support sustainability in the following ways:
- a) Leadership's role in ensuring a culture that integrates CT into standard practices
 - b) Strategies to address turn over and increase penetration of CT into the organization
 - c) Integration of CT into policies and practices
8. **License:** Please indicate if your agency has a current license from the Department of Human Services (DHS) for drug and alcohol intensive outpatient care. Please submit copies of your most recent licensure certificates. Providers with provisional licenses may not be eligible for CT Training.

License from DHS _____

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

EXECUTIVE DIRECTOR NAME (Print) _____

EXECUTIVE DIRECTOR SIGNATURE _____

DATE _____

**APPENDIX B
CT TRAINEE INFORMATION FORM**

The Beck Community Initiative is a public academic partnership among Dr. Aaron T. Beck, the founder of Cognitive Therapy (CT), his research group at the University of Pennsylvania and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). Since 2007, this innovative, team-oriented approach has been used to advance the quality of care provided to persons in the DBHIDS system by placing tangible, empirically-based tools in the hands of the clinicians who serve them.

The Beck Community Initiative (BCI) partners with community behavioral health providers to implement cognitive therapy (CT), an evidence-based practice with demonstrated positive treatment outcomes for many people with complex and challenging behavioral health needs. For example, CT has been successfully used to help people with problematic alcohol and other drug use, anxiety, depression, anger and externalizing disorders, trauma histories, interpersonal conflicts, and other challenges to build new skills and achieve their own unique goals.

Programs that partner with the Beck Community Initiative will receive in-depth training followed by consultation for applying their new CT skills with people receiving services in the IOP program. The program will collaboratively retool their services to successfully implement and sustain CT throughout their IOP program.

Training will be offered to clinicians and supervisors, occurring in four phases:

- 1) **Intensive Workshops:** The 22-hour workshop takes place in four or five weekly meetings held over one month.
- 2) **Six-month Consultation:** Clinicians will meet for two hours weekly at Penn for group CT consultation and will begin to deliver CT.
- 3) **Transition to Internal CT Supervision:** The group will transition to an ongoing weekly or bi-weekly meeting to maintain ongoing skill development, prevent drift from the CT model, and to support the learning of subsequent clinicians who join the group.
- 4) **Sustained Practice of CT:** Weekly or biweekly internal supervision will continue, along with continued delivery of CT and practice of skills.

In order to be trained in CT, clinicians must have a bachelor's degree or higher in a human services field (e.g., social work, psychology).

This questionnaire is to be completed by each potential participant. Please note your participation in the CT training is voluntary.

Your full name: _____

Your title: _____

Your email address: _____

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

Please note any languages spoken in addition to English _____

Approximately what percentage of your clinical time is devoted to individual treatment ? _____% Group treatment? _____% Family-focused treatment? _____?

Are you trained in any other evidence-based practice (EBP)? Y N

If yes, which EBPs? _____

Are you currently providing any other EBPs? Y N

If yes, which EBPs? _____

Please describe your interest in learning about CT: _____

APPENDIX C

Organizational Readiness for Change Measure (ORC)

The Organizational Readiness for Change measure should be completed by **at least** one administrator, one supervisor, and two counselors in order to provide multiple perspectives about the agency's areas of strength, as well as areas in which the Beck Community Initiative could offer additional supports.

To complete the ORC, please go to <https://redcap.med.upenn.edu/surveys/?s=KLYJ3DRNHX>. There, each individual will answer a set of brief background questions which will then direct the user to the appropriate version of the form to be completed, based on your role in your organization. Each individual should plan to spend 30-45 minutes to complete the measure.