Request for Proposals

In-Home Intervention Program – Children

Issued by: Anne Arundel County Mental Health Agency, Inc.

Issue date: July 20, 2020

I. Background

The Maryland General Assembly appropriated funding in FY 2005 to support the expansion of community mental health services in Anne Arundel, Calvert, Charles, Prince George's and St. Mary's Counties, as a result of the closing of Crownsville Hospital Center and a broad-based Task Force Report. The five counties identified the need for in-home intervention services for children and adolescents at risk for admission to institutional care (hospitals and/or Residential Treatment Centers) covered by Medical Assistance and determined to be "high users" of the Public Behavioral Health System (PBHS). The youth targeted for this voluntary in-home intervention program are eligible for and/or are receiving services through the PBHS. This program is based on a Psychiatric Rehabilitation Program (PRP) platform, with additional grant funded activities that are outside the services covered under PRP.

The Anne Arundel County Mental Health Agency, Inc. (AACMHA), a 501 (c) 3 private non-profit organization, is the Core Service Agency (CSA), designated with lead responsibility for this five-county collaborative project. Lead Agency responsibilities include funding, coordination, planning and monitoring of the project.

The AACMHA intends to contract via this RFP with a qualified provider or provider(s) to deliver an In-Home Intervention Program for Children to Anne Arundel and Prince George's Counties. However, a provider may propose to serve one, or both jurisdictions participating in this RFP. **Preference will be given to a provider who can serve both jurisdictions (see proposal scoring for more information).** The AACMHA, on behalf of Anne Arundel and Prince George's Counties will oversee and monitor compliance with all contract conditions. Services are expected to commence on November 2, 2020 or upon the effective date of the contract between Offeror and AACMHA.

II. Goals and Brief Service Description

The goals of the In-Home Intervention Program for Children (IHIP-C) are to:

1. Provide effective, family focused, multi-jurisdictional community-based in-home intervention services for children and adolescents with mental illnesses at risk of out of home placement;
2. Deliver services that are individualized, culturally and linguistically competent, family focused, coordinated and built on strengths and resilience; and
3. Either reduce admissions to more costly and more restrictive institutional placements or assist the family with reunification following an out-of-home placement.

The IHIP-C Program intervenes immediately when there is an emergent or crisis/emergency situation, provides brief and intensive interventions, strengthens family functioning, teaches coping skills, links the youth and family to mental health and other community support services, and averts visits to costly local emergency departments and/or admissions to a hospital or residential treatment center.

III. Offeror's Eligibility

To be eligible for this contract, all the following criteria must be met:

1. Be an approved Psychiatric Rehabilitation Program (PRP) under COMAR 10.63

Preference is given to the provider currently serving both Anne Arundel and Prince George's Counties or those providers who are willing to serve both counties and that can demonstrate the ability to build capacity in the county they are not located. (Please see bonus points at the end of the scoring sheet.)

2. Assurance must be made to become a 1915(i) provider under COMAR 10.08.89.
3. Able to serve a team of 12 youth. For each team of 12 youth, the Offeror will have at a minimum a 0.5 FTE Masters Level licensed mental health clinician and 2.0 FTE Bachelor's level staff with greater than two years of experience. (An offeror who provides services to both Anne Arundel and Prince George's County would be responsible for staffing two teams of 12.)
4. Each IHIP-C team shall have qualified staff on-call and available for home visits 24 hours a day, seven days a week to handle crisis/emergency situations and to accommodate the schedules of program participants.

IV. Scope of Work

Service Expectations

1. Assists with generating appropriate referrals that are sent to the CSA/ LBHA for approval. (Referrals may come from a variety of sources Behavioral health therapist or psychiatrist; Care Coordination Organization; Local Care Team (LCT) members; Inpatient hospital, RTC or community program such as Therapeutic Foster Care or Therapeutic Group Home; or CSA/LBHA identified high cost user or potential high cost user.)
2. Be expected to accept 90 percent of the referrals received from the CSA/LBHA.
3. Serve a daily maximum caseload of 12 youth in Anne Arundel County and/ or 12 youth in Prince George's County.
    a. Average length of service is nine months and a maximum of fifteen months. Service extensions are reviewed and approved by the CSA/LBHA in each jurisdiction on a monthly basis thereafter;
4. For the first 45 days of service, provide at a minimum average of 7 to 10 clinical contact hours per case per week; and a minimum of two clinical contact hours per week after the initial 45-day period.
5. IHIP-C programming includes the following basic components:
    a. Evaluation and assessment (including the CANS, strengths-based family assessment & family systems theory-based skills);
    b. Youth and family directed Individualized Service Planning (ISP);
    c. Brief intervention, crisis intervention and stabilization;

d. Skills training (preventative maintenance);
e. Services coordination and monitoring.

6. Provide services in the home or in mutually agreed upon location- services should not be delivered in an office setting. However, have the ability to provide a combination of telehealth and in- home services should the need arise.
7. Provide treatment that builds on the youth, family and community strengths.
8. Promote culturally and linguistically competent services to meet the youth and family's needs.
9. Assure the youth and family participate as a full partner and are actively involved in individual service planning.
10. As needed assist with access to and provide ongoing collaboration with behavioral health, educational and community supports services.

Case Timeline

1. Once referrals are approved by the CSA/LBHA, assure timely initiation of services. Within 2 business days of receiving a completed referral:
   a. Render a decision of acceptance or denial.
   b. Communicate with caregiver to initiate services.
   c. Submits authorization for PRP to ASO.
2. Utilize the CANS within fifteen days of admission, at 9 months and 12 months of service and upon discharge.
3. Develop, with full participation of the youth and family, an initial Individualized Service Plan (ISP) within 30 days of admission to the IHIP-C; update plan whenever necessary but at a minimum every 45 days.
4. Continue services based on the following criteria:
   a. More time is needed to meet ISP goals;
   b. The CANS indicate moderate to serious problems remain; and/or
   c. A significant event in the youth's life requires continuation of services for a specific time period.
5. Transition family/ youth to other services based on the following criteria:
   a. Successful completion of goals listed on the ISP or,
   b. Realistic meeting of goals within the stated period of time; and
   c. Child and Adolescent Needs and Strengths (CANS) indicates significant improvement.
6. Assure aftercare plan is completed prior to discharge delineating referral to other resources as appropriate.

Quality Assurance Expectations

1. Maintain standards under COMAR and accrediting body. The offeror is expected to bill through the PBHS Fee for Service System for PRP services.
2. Hire and verify the credentials of the licensed mental health professionals and complete background checks on all project staff directly involved with youth and their families.

3. Provide ongoing training to staff to ensure competency and continued skill building.
4. Assure each mental health clinician has a minimum of an hour of clinical supervision each week by a qualified mental health professional privileged and approved by the appropriate Licensing Board.
5. Demonstrate adherence to IHIP-C Fidelity Scale and achieve at a minimum a monthly score of 4.2 and overall average of 4.5 for the year (see attached). Maintaining treatment fidelity is tied to payment. These standards include and are not limited to:
   a. Maintaining small case load of 2.5 to 12 youth,
   b. Meeting at least weekly to review each case, and
   c. Team leader provides services directly related to IHIP-C cases 50% of the time
6. Submit IHIP-C monthly performance measures that include but are not limited to: IHIP-C model fidelity adherence, number of admissions and discharges, psychiatric hospitalizations, out of home placements and status at discharge.
7. Submit annual consumer satisfaction surveys.
8. Use Credible Behavioral Health, the project approved Electronic Health Record to document assessments, ISPs, visits, collateral contacts, monthly summaries, and discharge planning.

V. Proposal Submission

Form of Proposal

Proposals must be submitted by each Offeror in separate sealed packages, grouped and marked as follows:

1. In-Home Intervention Program - Children – Offeror Qualifications
   Offeror's name and date of offer
2. In-Home Intervention Program - Children – Technical Proposal
   Offerors name and date of proposal
3. In-Home Intervention Program - Children – Budget Analysis
   Offerors name and date of analysis

VI. Offeror Qualifications

Offeror Qualification Format

Each Offeror's submission must bear the Offeror's name, the closing date for proposals and "In-Home Intervention Program for Children – Offeror Qualifications" on the outside of the package. Inside this package (one original and one electronic copy) shall be the Offeror's Qualification submission.

Qualification Content

The proposal should clearly label responses and address all points outlined below.

1. Eligibility Requirements – Offeror must demonstrate ability to meet eligibility requirements set forth in the proposal. (For example, provide resumes for proposed staffing, copy of PRP license, etc.), or describe in detail how the requirement will be met before commencement of the project on or about November 2, 2020. Preference is given to the provider currently serving both Anne Arundel and Prince George's Counties or those providers who are willing to serve both counties and that can demonstrate the ability to build capacity in the county they are not located. (Please see bonus points at the end of the scoring sheet.)
2. Documentation of Corporate Structure
    a. Current legal status (e.g. Articles of Incorporation).
    b. Board resolution approving submission of proposal.
3. Financial Capability to Perform
    a. Description of Offeror 's financial capability to carry out work of RFP.
    b. Audited financial statements for the last two years.
    c. Summary of Relevant Experience-References and descriptions of previous similar engagements should be provided (All references should include a contact person familiar with the Offeror's work and the appropriate telephone number, with authorization for AACHMA to contact any reference provided.).
    d. Specific documentation of experience with other similar projects.
4. Organization Structure/Chart
    a. Description of organizational structure.
    b. Explanation of how project will relate to the whole.
    c. Table of Organization/organizational relationships.
5. Staffing - The Offeror shall clearly identify the proposed project team, the assignment of work activities, and the experience, qualifications, and education of the staff to be assigned. The Offeror should explain to what extent backup professional personnel are available to substitute for loss of professional personnel identified as necessary in the proposal.
    a. Names and Resumes of administrative/supervisory staff and direct care staff who will be assigned to the program.
    b. Description of staff assigned.
    c. Description of duties and qualifications.

VII. Technical Proposal Criteria

Technical Proposal Format

Each Offeror's submission must bear the Offeror's name, the closing date for proposals and "In-Home Intervention Program for Children – Technical Proposal" on the outside of the package. Inside this package (one original and one electronic copy) shall be the Offeror's Technical Proposal. The proposal should be typed in 12-point font; each page numbered and should not exceed ten (10) pages of narrative. Appendices and budget do not count as part of the ten pages.

A transmittal letter on the Offeror's stationary should accompany the technical proposal. The sole purpose of this letter is to transmit the technical proposal. It should be brief and signed by an individual who is authorized to commit the Offeror to the services and requirements as stated in this RFP.

Technical Proposal Content

The proposal should clearly label responses and address all points outlined below.

1. Executive Summary- The Offeror shall condense and highlight the contents of the RFP. The brief summary shall provide a description of the objectives of the RFP, the scope of work, the contents of the proposal, and any related issues which should be addressed.
   a. Demonstrate an understanding of the goals of the RFP.
   b. Demonstrate an understanding of the Scope of Work required which includes service expectations, timeline for cases and quality assurance for the program and its relation to payment.
2. Philosophy and Approach to Service Delivery - Offeror shall describe the organization's:
   a. Basic values and beliefs about mental health services.
   b. Knowledge of population.
   c. Knowledge of public behavioral health system.
   d. Approach to working with youth and families.
3. Scope of Work - The Offeror shall provide a detailed discussion of their ability to carry out the duties under the Scope of Work section in the RFP. Offeror will describe their approach, methods, techniques, tasks, work plan for addressing the requirements under:
   a. Service expectations
   b. Timeline for cases

   Offeror may provide examples of current practices that can demonstrate their ability to meet expectations such as current clinical supervision documents, treatment plans, crisis intervention plans.

4. Quality Assurance - The offer shall describe how they will ensure that high-quality treatment will be provided to youth and families. Offeror should incorporate the following:
   a. Clearly state desired clinical outcomes.
   b. Clearly lists how progress will be measured and recorded.
   c. Hire and verify the credentials of the licensed mental health professionals and complete background checks on all project staff directly involved with youth and their families.
   d. Provide ongoing training to staff to ensure competency and continued skill building.
   e. Assurance of weekly clinical oversight of cases by a licensed clinician.

f. Monthly Performance measures
g. Assurance of treatment fidelity scale usage
h. Participant Satisfaction measures

5. Implementations and Operation Strategy - The Offeror shall demonstrate the capability to successfully manage and complete the contract. Describe what organizational processes are in place to support successful implementation of the program from start up to maintenance. These might include including an outline of the overall management concepts and methodologies to be employed by the Offeror, a project management plan including project control mechanisms, and description of the quality control procedures of the Offeror. The Offeror may also address the transition and employment of existing staff to the team(s). Key management individuals responsible for coordinating with the respective local Core Service agency should be identified as the Offeror must meet periodically with respective local Core Service Agency or Local Behavioral Health Agency staff and render periodic progress reports for the purpose of administering the contract. The Offeror shall also participate in the client tracking process approved by the BHA, collecting and submitting relevant data as required by BHA.
   a. Clear and concise timelines.
   b. Clear and concise work plan.
   c. Staff adequate for tasks.
   d. Orientation, training and supervision.
   e. Report requirements.
   f. Problem solving if encountered.
   g. Grievance procedures.

VIII. Budget

Submit a budget using MDH Form 432 (one original and one electronic copy). The budget should be based on the provider's estimated billing to the Maryland Public Behavioral Health System for the Psychiatric Rehabilitation Program, grant funding and other sources of income. In FY 19, the total budget for this program was approximately $400,000, which includes grant and Medicaid billing revenue. Please note, under the Human Services Agreement Manual, contracts totaling over $100,000 will require an independent audit of those grant funds received. The awarded agency will need to furnish this audit to the AACMHA annually.

Start-up Costs: Although there is no funding for start-up costs, start-up costs are anticipated, and they should be submitted on a separate budget and supported with supplement schedules of start-up costs. All costs should be detailed on a separate MDH 432 packet.

The MDH packet can be downloaded at www.aamentalhealth.org, click RFP/RFI under the News menu.

Attachment 1

IN-HOME INTERVENTION PROGRAM – CHILDREN (IHIP-C)

RATING SHEET

Transmittal Letter should include:

1. Letter signed by authorized official.
2. Letter on Offeror's stationary.

I. QUALIFICATIONS OF OFFEROR AND PROPOSED STAFF (15%)

a. DOCUMENTATION OF CORPORATE STRUCTURE
   i. Current legal status (e.g. Articles of Incorporation).
   ii. Board resolution approving submission of proposal.

b. FINANCIAL CAPABILITY TO PERFORM
   i. Description of Offeror's financial capability to carry out work of RFP.
   ii. Audited financial statements for the last two years.

c. SUMMARY OF RELEVANT EXPERIENCE
   i. Specific documentation of experience with other similar projects.

d. ORGANIZATION STRUCTURE/CHART
   i. Description of organizational structure.
   ii. Explanation of how project will relate to the whole.
   iii. Table of Organization/organizational relationships.

e. STAFFING
   i. Resumes of administrative/supervisory staff.
   ii. Description of staff assigned.
   iii. Description of duties and qualifications.
   iv. Names and resumes for all staff and consultants, if to be reassigned or already committed to the project.

All elements of the Offeror Qualifications are being rated equally.

II. TECHNICAL PROPOSAL

a. PHILOSOPHY AND APPROACH TO SERVICE DELIVERY (10%)
   i. Basic values and beliefs about mental health services.
   ii. Knowledge of population.
   iii. Knowledge of public mental health system.
   iv. Importance of youth and family involvement.

b. QUALITY IMPORVEMENT AND REPORTING (10%)
    i. Clearly stated outcomes.
    ii. Listed mission, goals, and objectives.
    iii. Clearly lists how progress will be measured and recorded.
    iv. Efforts or method to ensure youth/family involvement.
    v. Confidentiality and record security.

c. IMPLEMENTATION AND OPERATIONS STRATEGY (35%)
    i. Clear and concise timelines.
    ii. Clear and concise work plan.
    iii. Staff adequate for tasks.
    iv. Orientation, training and supervision.
    v. Process and content of Individualized Service Plans.
    vi. Report requirements.
    vii. Problem solving if encountered.
    viii. Grievance procedures.

III. BUDGET ANALYSIS (30%)
    a. Overall budget
    b. Personnel Detail Page
    c. Collections

IV. BONUS POINTS
    a. Up to 5% bonus points will be given to an Offeror who can provide services in both Anne Arundel and Prince George's County.

Attachment 2

IN-HOME INTERVENTION PROGRAM – CHILDREN (IHIP-C) PROPOSAL TIMELINE

Steps to Completion	Completion Date
Advertise/E-Mail/Webpage	July 20, 2020
Register for Pre-Bid Conference RSVP to Chelsea Bednarczyk at cbednarczyk@aamentalhealth.org	August 14, 2020
Pre-Bid Conference 10 am via Zoom Meeting (please register for invitation information)	August 18, 2020
Deadline for Questions by 4 PM Answers will be posted to AACMHA website within 5 days	August 25, 2020
Proposal Submission Deadline by 3 PM EST Deliver to: AACMHA Attn: CCO RFP 1 Truman Pkwy, Ste. 101 Annapolis, MD 21401	September 11, 2020
Review Committee Packet Pick Up/Distribution	September 14, 2020
Review Committee 10 am via Zoom Meeting	October 5, 2020
Contract Committee 1 pm via Zoom Meeting	TBD
Core Service Agency's Board of Directors' Approval	By October 27, 2020
Contract Award Announcement Email/call to successful bidder and notice to be placed on the AACMHA website	October 30, 2020
Work to begin on or about	November 2, 2020

Attachment 3

	IHIP-C FIDELITY SCALE-BASED UPON CASELOAD OF 12						
	Provider Name:_____			MONTH:_____			
Start	CRITERION	1	2	3	4	5	Score
9/1/14	**1. SMALL CASELOAD: STAFF/CASE RATIO 2.5:12 (All staff and direct supervision time spent on cases)**	Less than 1.75 staff : 12 youth	1.75 staff : 12 youth	2.0 staff : 12 youth	2.25 staff : 12 youth	2.5 staff : 12 youth	
3/1/05	**2. PROGRAM MEETING: Team meets frequently to plan & review services for direct services.**	Program meets <1x/mo. to review ea. case.	Program meets at least 1x/mo. to review ea. case.	Program meets at least 2x/mo. to review ea. case.	Program meets at least 3x/mo. to review ea. case.	Program meets at least 1x/week to review ea. case.	
9/1/14	**3. PRACTICING TEAM LEADER: Team Leader of front line IHIP-C Specialists provides services directly related to cases.**	Team Leader provides no services.	Team Leader provides services on rare occasions as backup.	Team Leader provides services routinely as backup, or <25% of the time.	Team Leader provides services 25 - 49% of the time.	Team Leader provides services at least 50% of the time.	
1/1/07	**4. CONTINUITY OF STAFF: Program maintains same staffing over time.**	>80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20%-39%turnover in 2 years.	<20% turnover in 2 years.	
3/1/06	**5. STAFF CAPACITY: Program operates at full staffing.**	Program has operated at <50% of full staffing in past 12 mos.	Program has operated at 50-64% of full staffing in past 12 mos.	Program has operated at 65-79% of full staffing in past 12 mos.	Program has operated at 80%-94% of full staffing in past 12 mos.	Program has operated at >95% of full staffing in past 12 mos.	
3/1/05	**6. EXPLICIT ADMISSION CRITERIA: Program has clearly identified population to serve & has & uses measurable & operationally defined criteria to screen out inappropriate referrals.**	W/i 12 mo. program accepts <80% of referrals from CSA that comply w/ explicit admission criteria.	W/i 12 mo. program accepts 80-84% of referrals from CSA that comply w/ explicit admission criteria.	W/i 12 mo. program accepts 85-89% of referrals from CSA that comply w/ explicit admission criteria.	W/i 12 mo. program accepts 90-95% of referrals from CSA that comply w/ explicit admission criteria.	W/i 12 mo. program accepts >95% of referrals from CSA that comply w/ explicit admission criteria.	
7/1/14	**7. STANDARDIZED ASSESSMENT: CANS administered within 15 days of admission.**	<85% of cases CANS administered within 15 days.	85-89% of cases CANS administered within 15 days.	90-94% of cases CANS administered within 15 days.	95-99% of cases CANS administered within 15 days.	100% of cases CANS administered within 15 days.	
7/1/14	**8. STANDARDIZED ASSESSMENT: CANS re-administered within 15 days of discharge.**	<85% of cases CANS administered within 15 days of discharge.	85-89% of cases CANS administered within 15 days of discharge.	90-94% of cases CANS administered within 15 days of discharge.	95-99% of cases CANS administered within 15 days of discharge.	100% of cases CANS administered within 15 days of discharge.	
9/1/14	**9. STAFF CREDENTIALS & TRAINING: Program has clearly defined educational, experiential, and on-going training expectations for staff.**	<.5 staff are MA, +/or any of 2.0 <BA, +/or w/<2 yrs. experience. Less than 50% receive > 15 hrs. cont. ed./yr. avg.	<.5 staff are MA, +/or 2.0 BA with <2 yrs. experience. 50% receive >15 hrs. cont. ed/yr.	.5 staff are MA, & 2.0 BA with >2 yrs. Experience. 75% receive > 15 hrs. cont. ed./yr.avg.	.5 staff are MA, & 2.0 BA with >2 yrs. experience. 85% receive >15 hrs. cont. ed/yr.	.5 staff are MA, & 2.0 BA with >2 yrs. experience. All receive >15 hrs. cont. ed/yr.	

Attachment 3

Start	CRITERION	1	2	3	4	5	Score
3/1/05	**10. RESPONSIBILITY FOR CRISIS SERVICES; Program has 24-hr. responsibility for covering psychiatric crises.**	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, primarily in consulting role.	Program provides emergency service backup; if called, program makes decision about need for direct program involvement.	Program provides 24 hr. coverage.	
3/1/05	**11. PROVIDES CRISIS SERVICES; Program demonstrates the covering of psychiatric crises by documenting time of responses.**	Documents avg. of <60 minutes or has no call back.	Documents avg. of 60 minutes.	Documents avg. of 50 minutes.	Documents avg. of 40 minutes.	Documents avg. of 30 minutes.	
3/1/05	**12. PROVIDES CRISIS SERVICES; Program demonstrates the covering of psychiatric crises by documenting responses to crisis site.**	When needed, no response documented.	When needed, documents avg. non-regular hrs. face-to-face response time of >1:41 hrs.	When needed, documents avg. non-regular hrs. face-to-face response time of 1:21-1:40 hrs.	When needed, documents avg. non-regular hrs. face-to-face response time of 1:01-1:20 hrs.	When needed, documents avg. non-regular hrs. face-to-face response time of 1 hr.	
3/1/05	**13. RESPONSIBILITY FOR INSTITUTIONAL DISCHARGES; Program is involved in RTC & IP discharges.**	For C&A in the program, <40% or more of discharges are planned jointly with program.	For C&A in the program, 40-49% or more of discharges are planned jointly with program.	For C&A in the program, 50-69% or more of discharges are planned jointly with program.	For C&A in the program, 70-94% or more of discharges are planned jointly with program.	For C&A in the program, 95% or more of discharges are planned jointly with program.	
6/1/06	**14. TIME-LIMITED SERVICES: Program is time-limited and adjunct to therapy.**	All cases are served on a time-limited basis, w/ >33% exceeding 15 mos. In program.	All cases are served on a time-limited basis, w/ 18-32% exceeding 15 mos. In program.	All cases are served on a time-limited basis, w/ 10-17% exceeding 15 mos. In program.	All cases are served on a time-limited basis, w/ 5-9% exceeding 15 mos. In program.	All cases are served on a time-limited basis, w/ <5% exceeding 15 mos. In program.	
2/1/05	**15. IN-VIVO SERVICES: Program works to teach skills in vivo rather than in office.**	<85% of non-crisis visits non-office.	85-89% of non-crisis visits non-office.	90-94% of non-crisis visits non-office.	95-99% of non-crisis visits non-office.	100% of non-crisis visits non-office.	
2/1/05	**16. DURATION OF VISITS BRIEF: Program emphasizes flexibility, frequency & timeliness rather than length.**	<85% of in-home non-crisis visits 1/2-2 hrs. in length.	85-89% of in-home non-crisis visits 1/2-2 hrs. in length.	90-94% of in-home non-crisis visits 1/2-2 hrs. in length.	95-99% of in-home non-crisis visits 1/2-2 hrs. in length.	100% of in-home non-crisis visits 1/2-2 hrs. in length.	
2/1/05	**17. SERVICE INTENSITY-ENGAGEMENT: Multiple service hours per week in 1st 45 days.**	Direct service hours average <2.5/week in 1st 45 days.	Direct service hours average 3/week in 1st 45 days.	Direct service hours average 4/week in 1st 45 days.	Direct service hours average 5-6/week in 1st 45 days.	Direct service hours average 7-10/week in 1st 45 days.	

Attachment 3

Start	CRITERION	1	2	3	4	5	Score
4/1/05	**18. SERVICE INTENSITY-SKILL DEVELOPMENT: Gradual reduction of # of hours as problem-solving skills improve.**	Direct service hours average < .75/week after 1st 45 days.	Direct service hours average at least .75/week after 1st 45 days.	Direct service hours average at least 1/week after 1st 45 days.	Direct service hours average at least 1.5/week after 1st 45 days.	Direct service hours average at least 2/week after 1st 45 days.	
2/1/05	**19. FAMILY INVOLVEMENT: Program emphasizes importance of family involvement.**	<85% of in-home visits involve other persons living in the home.	85-89% of in-home visits involve other persons living in the home.	90-94% of in-home visits involve other persons living in the home.	95-99% of in-home visits involve other persons living in the home.	100% of in-home visits involve other persons living in the home.	
3/1/05	**20. INDIVIDUALIZED TREATMENT: Program develops individualized treatment plans based upon assessment of person/family needs.**	<85% of IRP & ISP developed from the CANS within 15 days of admission.	85-89% of IRP & ISP developed from the CANS within 15 days of admission.	90-94% of IRP & ISP developed from the CANS within 15 days of admission.	95-99% of IRP & ISP developed from the CANS within 15 days of admission.	100% of IRP & ISP developed from the CANS within 15 days of admission.	
3/1/05	**21. INDIVIDUALIZED SERVICES PLANS (ISP): Team & family included.**	<85% of ISPs developed, agreed to, & implemented by full team & family.	85-89% of ISPs developed, agreed to, & implemented by full team & family.	90-94% of ISPs developed, agreed to, & implemented by full team & family.	95-99% of ISPs developed, agreed to, & implemented by full team & family.	100% of ISPs developed, agreed to, & implemented by full team & family.	
3/1/05	**22. PERSON IN FAMILY APPROACH: Treatment should be in the community, not institutions whenever possible.**	<50% of youth served have either RTC or IP care during enrollment & 6 mos following d/c.	<40% of youth served have either RTC or IP care during enrollment & 6 mos following d/c.	<30% of youth served have either RTC or IP care during enrollment & 6 mos following d/c.	<25% of youth served have either RTC or IP care during enrollment & 6 mos following d/c.	<20% of youth served have either RTC or IP care during enrollment & 6 mos following d/c.	
						SCORE AVERAGE: (calculated by Project Coordinator)	
	PROVIDER:			**PAYMENT AUTHORIZATION**	**$**	**%**	
	DATE:			**DATE:**			
	LOCAL CSA REVIEWER:		**PROJECT COORDINATOR:**				
	DATE:			**DATE:**			

Attachment 3

A completed fidelity scale is to be attached to each invoice. These must be signed by the Program Monitor. Overall average scale of 4.5 for year is expected.

The following criteria will be used for payment for each element:

A score of:	Will result in :
5	Payment at 100%
4	Discuss with Program Director.
3	If a problem exists; CSA will estimate a cost of element NOT delivered and penalty may apply. Penalty
2	Penalty will apply: Cost of element times two.
1	Penalty will apply: Total withhold on entire month contract amount (all elements).