

**MADERA COUNTY
BEHAVIORAL HEALTH SERVICES****POLICY NO.: MHP 48:00****SUBJECT: THERAPEUTIC BEHAVIORAL SERVICES****REFERENCE:**

- Therapeutic Behavioral Services Coordination of Care Best Practices Manual 2.0
- Therapeutic Behavioral Services Documentation Manual 2.0
- DMH Letter No. 08-38; DMH Letter No. 09-10; Title 9, Division 1, Chapter 11, "Medi-Cal Specialty Mental Health Services," CLN 09:00 Therapeutic Behavioral Services

POLICY:

Madera County Behavioral Health Services (BHS) shall offer Therapeutic Behavioral Services (TBS) to children and youth who meet the criteria established by the State Department of Mental Health. The Mental Health Plan (MHP) shall authorize all TBS services.

PURPOSE:

To provide a standardized procedure for referring and obtaining TBS services for children and youth with severe emotional disturbance who meet TBS criteria.

PROCEDURE:**I. TBS Definition**

TBS is defined as one-on-one behavioral health services available to children and youth with serious emotional challenges who are under the age of 21 and who are eligible for full scope Medi-Cal benefits without restrictions or limitations. TBS is never a stand-alone therapeutic intervention, but is used in conjunction with other Specialty Mental Health Services (SMHS).

II. Criteria for TBS

The following criteria must be met to establish eligibility for TBS services. If the child/youth does not meet all required criteria, TBS services will not be authorized by MHP and a Notice of Action-B will be sent to the consumer by the Managed Care Coordinator, or designee, with a copy to the provider.

- A. Eligible for TBS services (must meet criteria 1 and 2). Documentation will be maintained in the MHP file.
1. Full-scope Medi-Cal beneficiary under 21 years of age
 2. Meets MHP medical necessity criteria
- B. Member of the Certified Class (must meet criteria 1, 2 or 3)

Approved by:

Janice Melton

Date:

6-8-11

Effective Date:

10-01-03

Revision Date:

1. Are placed in a facility with a Rate Classification Level 12 or above and/or a locked treatment facility for acute psychiatric inpatient hospital services for the treatment of mental health needs (not an IMD). Placement in an IMD disqualifies him/her from receiving federally reimbursed Medi-Cal services; **or**
2. Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the past 24 months; **or**
3. Are being considered for placement in these facilities as a result of behaviors that may benefit from TBS interventions, whether or not such a facility is available.

III. TBS Eligibility

- A. For children and youth identified as meeting the requirements for class membership, the need for TBS is determined based on the following criteria:
 1. The child/youth is receiving other SMHS services; **and**
 2. The clinical judgment of the mental health provider indicates that the short-term support of TBS is needed to:
 - a. Prevent the child or youth from being placed in out of home care, or into a higher level of residential care; **or**
 - b. Address a change in behavior or symptoms that is expected as a child or youth transitions to a home, foster home or lower level of residential placement.

IV. TBS Procedures

- A. The consumer's parent/legal guardian, primary clinician, probation officer or CPS/DSS social worker may initiate a request for TBS services by calling MHP at 559-675-7850 or 1-800-275-9779 (toll free) and completing a Request for Therapeutic Behavioral Services (Attachment 1).
- B. The TBS advisor (MHP staff) will verify Medi-Cal eligibility and complete a Verification of Medi-Cal Funding form (Attachment 2).
- C. All TBS service request forms will be date-stamped upon receipt by MHP.
- D. All consumers receiving TBS services **must** be receiving other SMHS services.
 1. If the applying consumer is NOT receiving SMHS services, then MHP will refer the consumer for a Mental Health Assessment to evaluate the need for SMHS services.
 2. If medical necessity is met, SMHS services will be provided as indicated by the Full Assessment and Plan of Care. The TBS referral will continue per policy and procedure CLN 9:00 Therapeutic Behavioral Services.
- E. The TBS advisor will review the Request for TBS Services form and notify the primary clinician within five (5) working days of receipt of the request whether TBS services were authorized or denied.

1. If TBS services are denied, then MHP will complete a Notice of Action (see MHP 21:00 & 22:00) and mail it to the consumer.
 2. If the TBS services are authorized, the MHP will contact the TBS provider and fax the Request for Therapeutic Behavioral Services and an Interagency Release for Exchange of Information and Records (Attachment 3, 3A & 3B) to the TBS provider. An Interagency Release for Exchange of Information and Records will be signed by the parent/legal guardian, CPS/DSS social worker and a probation officer.
 3. If the parent/legal guardian or caregiver chooses not to participate in the TBS treatment plan, TBS services will not be provided.
 4. Other SMHS services will continue.
- F. MHP will review the provider's TBS assessment and Provider Treatment Plan (Attachment 4) when they are received from the TBS provider and proceed to authorize the number of TBS hours requested.
- G. Packets will be given to both the TBS provider and the mental health clinician, which include documenting charting requirements and all necessary forms.
- H. MHP will convene an initial monthly TBS Team Meeting prior to the end of the initial thirty (30) day authorization period and complete the Initial TBS Treatment Team Meeting form (Attachment 5). The meeting will include the primary therapist, the TBS advisor (MHP) and the TBS provider. Other persons involved with the case may be included (i.e. CPS/DSS social worker, Probation Officer, Group Home representative and/or any other appropriate person). As TBS services are re-authorized by MHP every thirty (30) days following the initial thirty (30) day authorization period, monthly TBS team meetings are required for continuation of services.
1. All team members will sign-in during an MHP/TBS Monthly Team treatment meeting.
 2. The initial Assessment and Provider Treatment Plan will identify the target behaviors. The team members will review the beneficiary's response to the TBS interventions. The team members will identify new treatment target behaviors and develop new interventions, if necessary, or plan for termination of TBS services.
 3. The TBS provider will complete and sign a monthly TBS Assessment and Plan of Care and submit it via fax to the TBS advisor.
- I. If the beneficiary or legal guardian is not satisfied with TBS services, both parties will be notified by the therapist of the complaint and grievance process. A copy of the client's Complaint and Resolution Guide and Grievance form will be made available.
1. The beneficiary and legal guardian will be informed that they may, for any reason and at any time, file a complaint or a grievance.

2. The therapist will document this process in the chart.
- J. The TBS advisor will convene the TBS team monthly to review the outcomes of the beneficiary's response to the TBS service intervention, identify new target behaviors, develop interventions and plan for termination of TBS services.
1. A monthly TBS Treatment Team Meeting form (Attachment 6) is completed.
- V. TBS Provider
- A. TBS services shall be provided by a Licensed Practitioner of the Healing Arts (LPHA) or by trained staff members who are under the direction of an LPHA. Services provided by unlicensed staff without a bachelor's degree in a mental health related field or two years of experience delivering services in the mental health field must have all documentation co-signed by an LPHA.
- B. The TBS provider (coach) will initiate delivery of service with the client and/or parent/legal guardian immediately, or no later than three (3) days, after the TBS team meeting. This is not always possible as the client can AWOL, or move to a different group home and/or location out of Madera or Fresno County.
- C. The TBS coach and supervising LPHS will develop a TBS Provider Treatment Plan based on the TBS Behavior Assessment (Attachment 7) and complete the measurement of behaviors portion of the Provider Treatment Plan. The TBS treatment plan shall include a plan for decreasing and terminating TBS services. This plan shall be completed no later than seven (7) days from the first TBS provider visit.
1. The TBS Treatment Team meeting form will be sent to MHP.
 - a. The TBS Treatment Team meeting form will be date-stamped by MHP.
 2. The TBS advisor will authorize the TBS Provider Treatment Plan or ask for clarifications/revisions and return the form within one (1) working day.
 - a. If clarifications/revisions are needed, the TBS coach(es) and their supervising LPHA will make the necessary revisions and return them to the TBS advisor within one (1) working day.
 3. The approved TBS Provider Treatment Plan will be filed in the client's chart.
- D. The TBS provider shall chart at the end of each shift and utilize the SIROP format (Attachment 8).
1. All progress notes (Attachment 9) shall be legible and in black ink.
 2. All progress notes shall be counter signed by the TBS provider supervising LPHA.
 3. The progress notes will be forwarded monthly to the TBS advisor.
 - a. The TBS advisor will forward the original progress notes to medical records who will immediately file them in the clients chart. A copy of the TBS progress notes will be maintained by MHP.

4. The TBS advisor will review the progress notes for appropriateness of service, which includes the following:
 - a. Specific target behaviors or symptoms being addressed that are jeopardizing the current placement or that are presenting a barrier towards transitioning into a lower level of care.
 - b. Specific interventions are performed to resolve behaviors or symptoms.
 - c. Outcomes of interventions are documented that specify the frequency of target behaviors and the replacement of maladaptive behaviors with adaptive behaviors.
 - d. New target behaviors are identified.
 - e. Transition plan/discontinuation of service is addressed. Each time period the TBS coach spent with the client is documented in a progress note.
 - f. Progress notes include time of service by contact/shift (e.g., 8:00 a.m. to 1:30 p.m.).
- E. If the TBS coach (provider) makes any changes from the proposed time frames approved by MHP, the coach must document changes and their justifications in the progress notes.
 1. Approval of changes must be obtained from the TBS advisor. Approval may be given verbally and shall be documented both by the TBS advisor and the TBS provider.
 2. Approval for additions to time frames shall be obtained prior to service delivery. If it's not possible to obtain prior authorization, then authorization should be obtained at the start of the next working day.
 3. The TBS coach must confer with the consumer's therapist at the start of the next working day. The therapist must agree if the time frame changes are appropriate.
- F. The therapist and TBS coach are expected to maintain timely (no less than 1-2 times per week) communication about the consumer's response to interventions and progress towards treatment goals.
 1. Both the therapist and the TBS coach shall document their communication.
- G. For billing purposes, the TBS contract provider shall submit a monthly report indicating names of beneficiaries and TBS services provided no later than the twentieth (20th) day of the following month to MHP.
- H. The TBS supervisor shall complete a discharge summary that is co-signed by the supervising LPHA. The BHS primary clinician shall complete a Discharge Summary (Attachment 10).

VI. Urgent TBS

- A. TBS services may be needed on an urgent basis when sufficient time is not

available to request services through the regular approval process. Examples of urgent needs are:

1. Immediate need to keep a client out of the hospital, but not in lieu of the need for a 5150.
 2. To prevent immediate out-of-home placement.
 3. To enable the consumer to return from a higher level of care to his/her placement in the community (i.e., home or foster care).
- B. When immediate services are requested by the therapist, the parent/legal guardian, care giver, CPS/DSS social worker or Probation Officer making the request shall proceed as follows:
1. Notify the clinician of the need for immediate TBS services.
 2. The clinician will notify the TBS advisor regarding the immediate need for TBS services. A copy of the Request for TBS Services form, along with all assessments and current treatment plan should be faxed or delivered to MHP within 24 hours.
 3. The MHP TBS advisor will review the request along with all available assessments and reports and authorize or deny services. If services are denied, a Notice of Action will be completed and the referring therapist will be notified (see MHP 22:00 Notice of Action-B).
 4. If services are authorized, the MHP TBS advisor will notify the TBS provider via telephone of the request for immediate TBS and fax the TBS referral form to the TBS provider.
 5. The MHP TBS advisor will convene the TBS team to begin services.
 - a. The TBS provider will initiate TBS contact with the beneficiary and/or parent/legal guardian within two (2) working days after the TBS team meeting for urgent services.

VII. Monitoring Activities

- A. The MHP TBS advisor will monitor the following:
1. Maintain copies of Request for TBS forms for all consumers referred to services.
 2. Monitor provision of approval of services through a review of documentation, SAL's, invoices and site visits.
 3. Submit a monitoring report to the BHS director by the 25th of each month.
 4. Review the mental health chart quarterly
 - a. MHP shall disallow payment if TBS services are not therapeutically justified in the documentation.
- B. The Quality Management Coordinator will review documentation for compliance to

State Department of Mental Health standards and investigate any quality of care concerns.

- C. The Quality Management Coordinator will work with the TBS provider to develop a Plan of Correction for any deficiencies.
- D. Provide Consumer Satisfaction Surveys to clients and their families on an annual basis.

VIII. General TBS Procedures

- A. The approval process for continuation of TBS services is the same as the approval process for the initial request.
- B. The request for continuation of services must be approved and authorized by MHP every thirty (30) days.
- C. MHP support staff will maintain a copy of all TBS referrals and a list of clients approved for TBS services in Public Share.
- D. The MHP program assistant will maintain a tickler file for tracking quarterly TBS team meeting approvals for continuation of services, quarterly TBS authorization checklists (Attachment 11& 12) and any other time sensitive meetings or required documentation.

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

REQUEST FOR THERAPEUTIC BEHAVIORAL SERVICES

Type of Request for Services: Initial Continuation

DATE: _____

CONSUMER:

Date of Birth: _____ SSN: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ ZIP CODE: _____

PARENT: _____

LEGAL GUARDIAN: _____

ADDRESS (if different from consumer's): _____

CITY: _____ TELEPHONE: _____

LANGUAGE SPOKEN BY PARENT/GUARDIAN: PRIMARY: _____ SECONDARY: _____

PROBATION OFFICER: _____ TELEPHONE: _____

CPS SOCIAL WORKER: _____ TELEPHONE: _____

SPECIAL NEEDS: _____

CRITERIA FOR TBS SERVICES:

A.	Eligibility for TBS Services (must meet criteria 1 and 2)	YES	NO
	1. Full-scope Medi-Cal beneficiary under age 21 years.	<input type="checkbox"/>	<input type="checkbox"/>
	2. Meets MHP medical necessity criteria	<input type="checkbox"/>	<input type="checkbox"/>
B.	Member of the Certified Class (must meet criteria 1, 2, 3, or 4)		
	1. In RCL 12 or above	<input type="checkbox"/>	<input type="checkbox"/>
	2. Placement being considered for RCL 12 or above and/or a locked treatment facility for the treatment of mental health needs.	<input type="checkbox"/>	<input type="checkbox"/>
	1. One psychiatric hospitalization in preceding 24 months	<input type="checkbox"/>	<input type="checkbox"/>
	2. Previously received TBS while Class Member	<input type="checkbox"/>	<input type="checkbox"/>

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C. Need for TBS Services (must meet criteria 1 and 2)

- 1. Consumer is receiving other mental health services [] []
 - a. Prevent placement in a Higher Level of Care [] []
 - b. Enable transition to a Lower Level of Care [] []

Progress Towards Previous Objectives (including response to previous interventions): _____

List the behaviors or symptoms that may cause this child/youth to need a higher level of placement or prohibit transition to a lower level of care (Describe frequency, intensity, and duration): _____

What are the antecedent events of this (these) behaviors? (Who is around, what is the activity, when and where do behaviors occur, when do behaviors never occur?): _____

What are the replacement behaviors needed to maintain current residence or allow a lower level of care? (Please be specific): _____

Discuss how the TBS interventions are expected to address these behaviors or symptoms: _____

Number of hours requested per week. Days of the week requested (Note if specific days and times are needed): _____

Please state any specific needs with regard to the TBS coach's language, gender, or other: _____

Where would the TBS Coaching take place: _____

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Parent/Legal Guardian Name:(print) _____

Parent/Legal Guardian Signature: _____ Date: _____

COMPLETED BY: _____

(Name of Clinician and license)

Date

Beneficiary' s Name:(print) _____

Beneficiary' s Signature: _____ Date: _____

MHP ACTION: APPROVED: _____ DENIED: _____

COMMENTS/DISPOSITION:

Review Date: _____

MHP SIGNATURE: _____

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

VERIFICATION OF MEDI-CAL FUNDING

Client Name: _____ Date of Birth: _____

Medi-Cal card number: _____

Current active Medi-Cal status in Madera County Yes No

Primary Aid Code: _____

Medi-Cal Cost Center Number: _____

Name and signature of the person who has opened the case in a Medi-Cal cost center:

Name: _____ Signature: _____

Date opened: _____

Name and signature of the person verifying the Medi-Cal status:

Name: _____ Signature: _____

Date verified: _____

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES
THERAPEUTIC BEHAVIORAL SERVICES
INTERAGENCY RELEASE FOR EXCHANGE OF INFORMATION AND RECORDS

Date: _____

Client Name: _____ Birth Date: _____

I hereby authorize the agencies checked on the following list, to release to any other agency on this list as members of a multi-disciplinary team obtained in the course of my dealings with any agency also checked on the list below. I understand that any agency on the following list, which is not checked, will not be able to share information or obtain information from any other agency.

Please specify specific agency where appropriate

- School _____
- Central Valley Regional Center
- Alcohol and Drug Program _____
- Mental Health Provider _____
- Madera County Child Protective Services
- Madera County Behavioral Health Services
- Madera County Probation Department
- Other _____
- Other _____
- Other _____
- Other _____

I understand that I can revoke this release at any time except to the extent that action has been taken in reliance on this release. If not revoked earlier, this release will terminate on: 3 months from the date of this release OR (list specific date) _____

Client Date

Parent, Guardian, or Authorized Representative Date
(Sign whenever client is a minor or conservatee)

Witness Date

To Recipient Agencies: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 CFR, Part 2) prohibit you from making further disclosure of mental health, alcohol, or drug abuse records without the specific written consent of this person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

CLIENT HAS RECEIVED COPY A COPY OF THIS FORM _____
SIGNATURE OF PERSON PROVIDING COPY TO CLIENT

A REQUEST FOR RELEASE OF WRITTEN MENTAL HEALTH, ALCOHOL, OR DRUG ABUSE TREATMENT RECORDS MUST BE MADE BY SEPARATE WRITTEN REQUEST SIGNED BY THE CLIENT.

IMPORTANT: THIS RELEASE EXPIRES ON: _____

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**MADERA COUNTY BEHAVIORAL HEALTH SERVICES
TBS - THERAPEUTIC BEHAVIORAL SERVICES
PARENTAL/CARE PROVIDER PERMISSION**

I hereby give permission for _____ (child/teen), _____ (date of birth) to go on outings with _____ (TBS Mental Health Worker), and I also authorize any necessary emergency treatment by proper medical authorities for any accident or illness while in the care of the above named Mental Health worker. I also give permission for this form to be photocopied.

Parent/Care Provider's Name (please print) _____ Relationship _____

Address/City _____

Day Phone: _____ Evening Phone: _____

Family Doctor's Name: _____

Address/City: _____ Phone: _____

Medical Insurance _____ Member Number _____ Expires: _____

PERSON(S) TO CONTACT IN CASE OF EMERGENCY, IF PARENT NOT AT HOME

Name: _____	Name: _____
Telephone Number: _____	Telephone Number: _____
Relationship: _____	Relationship: _____
Address/City: _____	Address/City: _____

Signature of Parent or Guardian: _____ Date: _____

Copy to: *Parent(s) *TBS Original to chart

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

CONSENT FOR EVALUATION AND/OR TREATMENT OF A MINOR

Therapeutic Behavior Service

I, the Undersigned, hereby consent to Therapeutic Behavior Services for my child _____ by _____, an agency contracted with Madera County Mental Health. I have been made aware of the scope of services to be provided and agree to be a participating member of the treatment. I understand that this mental health treatment will use a multi-disciplinary approach.

 Signature Relationship to Child Date

Signatory received copy

 Witness Signature Witness Name (Print) Date

VALID THROUGH _____

Please update Consent for Treatment on a yearly basis.

Original to MHP file
 Copy to TBS Provider
 Copy to Mental Health Chart
 Copy to Signatory

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES
Therapeutic Behavioral Services
Provider Treatment Plan

To be completed by TBS provider

Client Name: _____ **Birth Date:** _____

TBS Provider: (agency) _____

(TBS coach) _____

(LPHA) _____

Client Strengths and Resources: _____

1. Target Behavior: (Behavior jeopardizing living situation or transition to lower level of care) _____

Intervention(s): (Be very specific. Describe caregiver involvement) _____

Measurable Outcome\ Replacement Behavior: (Be very specific) _____

Frequency, duration, and intensity of target and replacement behaviors will be measured by _____

2. Target Behavior: (Behavior jeopardizing living situation or transition to lower level of care) _____

Intervention(s): (Be very specific Describe caregiver involvement) _____

MUST BE COMPLETED WITHIN SEVEN (7) DAYS FROM FIRST PROVIDER VISIT

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Dates Form Approved: QIC – Pending / Management – Pending
/Forms and Letters/MHP/TBS/TBS Provider Treatment Plan

Form Revised: 02-19-04
Page 1 of 2

Measurable Outcome\ Replacement Behavior:): (Be very specific) _____

Frequency, duration, and intensity of target and replacement behaviors will be measured by _____

3. Transition Plan: (How to assist parent/caretaker to provide continuity of care, skills, and strategies. Be specific) _____

4. TBS Service Plan

Planned Average Hours of TBS per Week: _____

Estimated Number of Weeks of TBS: _____

TBS Coach Signature Date

LPHA Date

MUST BE COMPLETED WITHIN SEVEN (7) DAYS FROM FIRST PROVIDER VISIT

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**-MADERA COUNTY BEHAVIORAL HEALTH SERVICES
INITIAL TBS TREATMENT TEAM MEETING**

Check which Apply: Is in RCL 12 or above facility Psychiatric hospitalization in past 24 months
 Risk of placement in RCL 12 or above facility Previously received TBS while member of certified class

Check One: Initial Form 3-Month Renewal

1. Target Behavior: (Behavior jeopardizing living situation or transition to lower level of care) _____

Intervention(s): _____

Measurable Outcome\ Replacement Behavior: _____

2. Target Behavior: (Behavior jeopardizing living situation or transition to lower level of care) _____

Intervention(s): _____

Measurable Outcome\ Replacement Behavior: _____

3. Transition Plan: (How to assist parent/caretaker to provide continuity of care, skills, and strategies) _____

Client Name: _____ Client Number: _____

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**MADERA COUNTY BEHAVIORAL HEALTH SERVICES
MONTHLY TBS TREATMENT TEAM MEETING**

1. Target Behavior\Interventions: (Brief description of interventions used in last month and effectiveness) _____

Measurable Outcome\ Replacement Behavior: (Progress toward desired outcomes in the last month) _____

Revisions or changes to target behavior/interventions/desired outcomes : _____

2. Target Behavior\Interventions: (Brief description of interventions used in last month and effectiveness) _____

Measurable Outcome\ Replacement Behavior: (Progress toward desired outcomes in the last month) _____

Revisions or changes to target behavior/interventions/desired outcomes : _____

Measurable Outcome\ Replacement Behavior: _____

3. Transition Plan: (Describe arrangements being made) _____

Original to Mental Health Record / Copy to MHP file / Copy to TBS Provider file

Client Name: _____ **Client Number:** _____

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BEHAVIOR ASSESSMENT

During the past rating period, what behaviors was the client able to do?

	able to do Independently	able to do with help or prompting	able to do with a lot of help	doesn't apply
Self Care				
avoids hurting self	3	2	1	na
eats appropriately	3	2	1	na
takes care of hygiene	3	2	1	na
remains in home or group home	3	2	1	na
Avoids physical conflict				
with peers	3	2	1	na
with authority figures	3	2	1	na
Avoids verbal conflict				
with peers	3	2	1	na
with authority figures	3	2	1	na
Engages in positive social interactions				
with peers	3	2	1	na
with authority figures	3	2	1	na
Initiates positive social interactions				
with peers	3	2	1	na
with authority figures	3	2	1	na
Resolves problems				
with peers	3	2	1	na
with authority figures	3	2	1	na
Controls impulses				
identifies rising agitation	3	2	1	na
self soothes	3	2	1	na
self distracts	3	2	1	na
uses substitutive behavior	3	2	1	na
talks about impulses	3	2	1	na
anticipates problem events/times	3	2	1	na
School				
attends	3	2	1	na
behaves appropriately	3	2	1	na
Treatment (can be ind, gr, or day tx)				
attends	3	2	1	na
behaves appropriately	3	2	1	na
Group Home activities (GH kids only)				
attends	3	2	1	na
behaves appropriately	3	2	1	na
Community activities (non-GH kids only)				
attends	3	2	1	na
behaves appropriately	3	2	1	na

List # of the following:	Week of:	Week of:	Week of:	Week of:	Week of:		Month Totals
SIR's (Group Home Only)							
AWOL's							
Assaults							
Restraints Necessary							
Self-Mutilation (or attempt)							
Suicidal Statements							
Verbal Aggression/Threats							
Property Destruction							
Refusal to Comply							
						Total incidents	
# of TBS Hours						Total TBS Hrs	

Mental Health Clinician _____ Date: _____
Name and designee

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GUIDELINES FOR TBS COACH CHART NOTES

- T A chart note needs to be written daily and countersigned by the therapist or advisor. Remember to leave a little room for the note to be countersigned.
- T **Always use BLACK ink**
- T If you need to cross out something on a chart note: make one single line through the error and initial it. **Do not** use white-out or scribble over an error.

Contents of the note:

The first line of the note should have the date, type of service and where it took place, for example: 4-10-00 TBS Coach Services at the client's home.

The body of the note should be written in **S-I-R-OP** format, as explained below:

- ☐ **[S = symptoms]** describe an aspect of the child's behavior that day that is characteristic of the symptoms or problems you are working on.
example: child misunderstood something her mother said and began to tantrum
- ☐ **[I = intervention]** describe your interventions.
example: Waited for child to calm down on her own; then processed what happened with her and rehearsed how she can, in the future, recognize when she starts to lose control and take a time out; helped child to use positive communication skills with her mother to clarify what the mother meant; helped the child and the mother to communicate and negotiate with one another.
- ☐ **[R = response]** describe the response to the intervention
example: The child and mother successfully negotiated a solution and the child's mood became calm and happy.
- ☐ **[OP = overall progress]** describe the overall progress toward treatment goals and state the plan for continuing to address these goals:
example: The client is making initial progress controlling temper tantrums. Will continue to address target behavior of tantrums by helping child to identify when she is first beginning to lose control and have her take a time out. Will begin to focus more on self calming skills and will continue to coach her on communication skills.

Another example:

- 1-2-2000 TBS coach services in the client's home.
- (S)** The child became frustrated with his brother and began to yell and throw objects.
- (I)** Coached child to take a "cool out"; once he was calm, helped child to verbalize his feelings to the coach; then assisted him in identifying what he was angry about and rehearsed communicating his needs to the brother and the parents; provided support to child as he practiced communicating his needs to family members.
- (R)** The child resolved the conflict with the brother and they completed a game together cooperatively.
- (OP)** The child is making progress limiting physical fights with siblings. Will continue to cue child to use a "cool out". Will begin to focus on teaching him to recognize, on his own, when he needs a "cool out" period: will also continue to teach communication skills to address this milestone.

It helps to keep a copy of the Target Behaviors for TBS Team and the TBS Delivery Plan with you for reference when charting, in order to remember the treatment goals that you are charting to.

MADERA COUNTY BEHAVIORAL HEALTH SERVICES
THERAPEUTIC BEHAVIORAL SERVICES

DISCHARGE SUMMARY

CONFIDENTIAL: This is a privileged communication sent to you as this client's licensed Care giver. It shall not be placed at the disposal of any other person.

CLIENT: _____ Case No: _____

Date of Admission: _____ Date of Discharge _____

IDENTIFICATION: Gender: Female Male Age: _____ DOB _____

Ethnicity _____

Number of prior admissions _____

Initial Identified Behaviors: _____

SERVICE SUMMARY:

Service goals and progress toward those goals: _____

Living arrangements: Home Foster Home Group Home

CONDITION AT DISCHARGE:

- 1. Marked Improvement
- 2. Moderate Improvement
- 3. Minimal Improvement
- 4. No Improvement

Reasons for Discharge: _____

RECOMMENDATIONS: _____

Current Date

Service Provider Signature

LPHA Signature

Original to Mental Health Chart
Copy to MHP file

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

TBS REQUEST CHECK LIST

Please include all pertinent information

/	CHECK BELOW THE ITEMS WHICH ARE INCLUDED IN THE REFERRAL PACKET:
	1. Request for Therapeutic Behavioral Services *
	2. Psychiatric evaluation
	3. Psychological evaluation
	4. Clinical check list form *
	5. Updated reauthorization/Treatment Plan including TBS *
	6. Mental health assessment (comprehensive assessment of child & family strengths and needs) *
	7. Treatment plan from minor=s most recent psychiatric hospitalization
	8. Release of Information *
	9. Client information sheet
	10. Last group home report
	11. Behavior Assessment Form *
	12. Inpatient Hospitalization Record (most current)
	13. Parent/Caregiver consent for treatment signed *
	14. Verification of Medi-Cal
	15. SIR Tally (For Group Homes Only)

* Mandatory

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Dates Form Approved: QIC – Pending / Management – Pending
/Forms and Letters/MHP/TBS/TBS Request Check List

Form Revised: 02-19-04
Page 1 of 1

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

TBS TIME-FRAME CHECKLIST

Date request was received at MHP office: _____ Date of review by MHP: _____ Authorized: ___ Yes ___ No

Date of authorization: _____

Purpose for non-authorization of TBS: _____ Notice of Action (NOA) sent _____
Date

Date initial authorization checklist completed and mailed to the DMH: _____

Name of Agency providing TBS: _____ Contact Person: _____

Date of initial team meeting: _____ Date TBS began: _____

Dates service delivery plan received by MHP from TBS provider: _____

MONTHLY FOLLOW-UP TEAM MEETING

Date: _____ Team Treatment meeting update completed and signed? _____

Date: _____ Team Treatment meeting update completed and signed? _____

Date: _____ Team Treatment meeting update completed and signed? _____

QUARTERLY AUTHORIZATION CHECKLIST

Next due date: _____ Date completed and sent to the DMH: _____

Next due date: _____ Date completed and sent to the DMH: _____

TERMINATION OF TBS

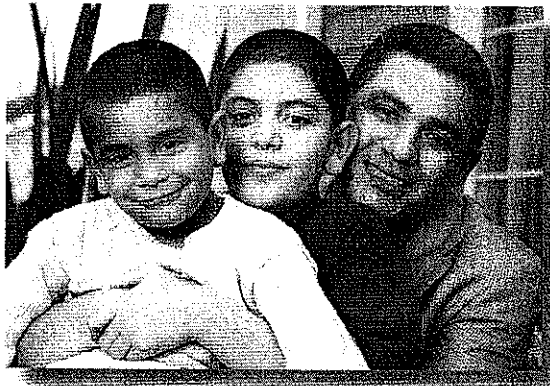
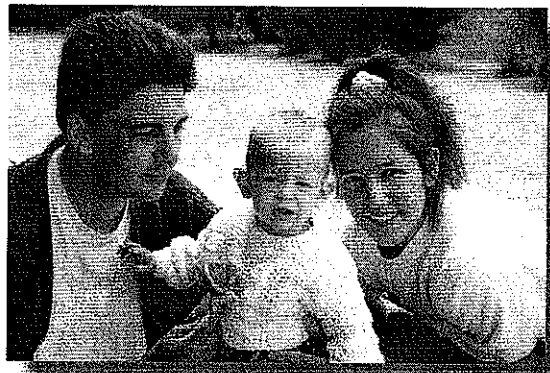
Date of termination: _____ Purpose: _____

Status of Case/Need for NOA: _____

Original to MHP file

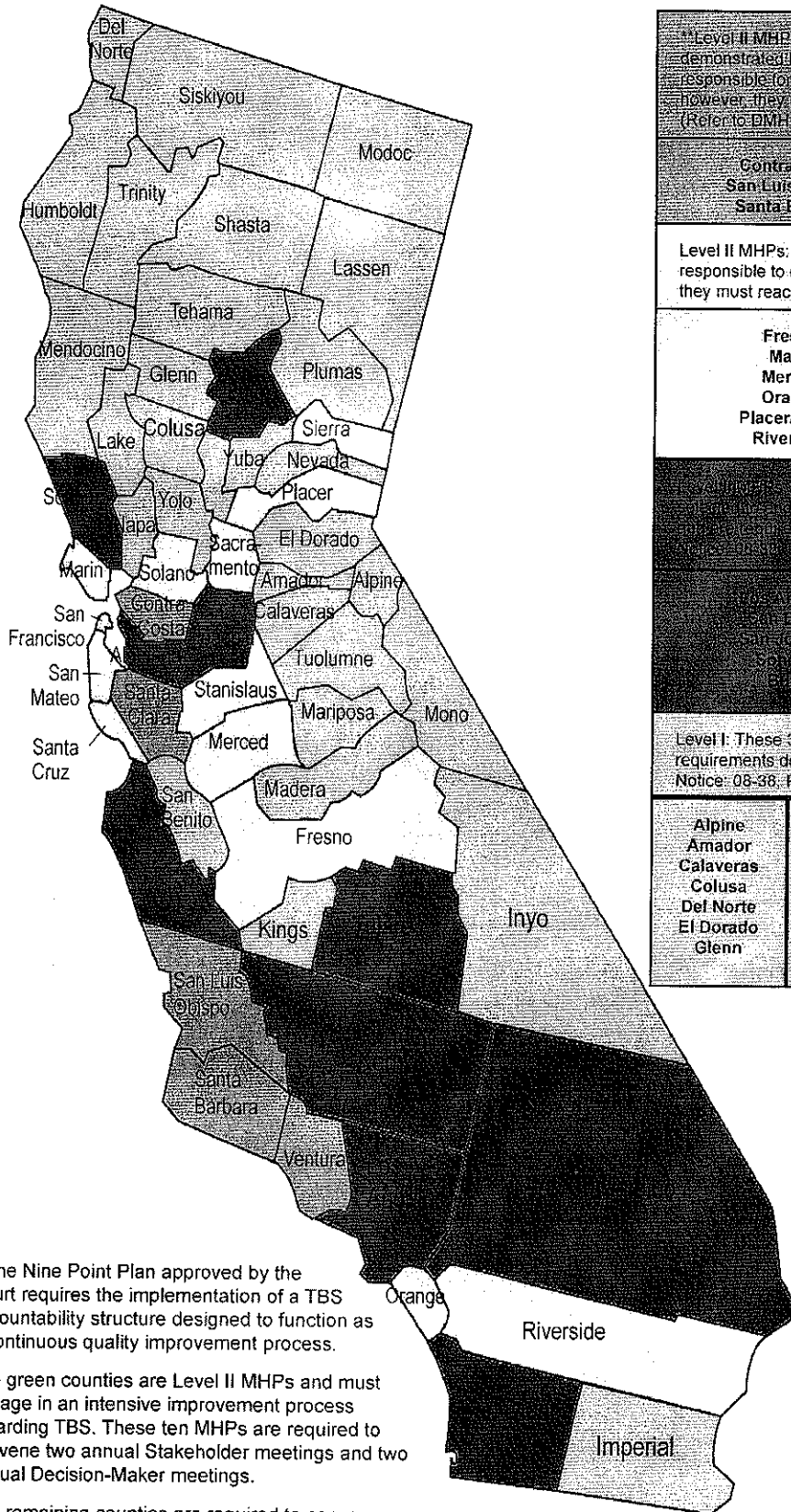
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Therapeutic Behavioral Services (TBS) Coordination of Care Best Practices Manual



California Department of Mental Health

October 2010, Version 2



<p>Level II MHPs: As of January 1, 2009, these 5 MHPs have demonstrated high performance in TBS delivery. They are only responsible for completing Level I requirements at this time; however, they must remain above the 4% benchmark for TBS. (Refer to DMH Info Notice 08-38, Section IX, Pg. 9)</p>			
<p>Contra Costa San Luis Obispo Santa Barbara</p>		<p>Santa Clara Ventura</p>	
<p>Level II MHPs: These 12 medium and large MHPs are only responsible to complete Level I requirements at this time. However, they must reach the 4% benchmark for TBS.</p>			
<p>Fresno Marin Merced Orange Placer/Sierra Riverside</p>		<p>Sacramento San Francisco San Mateo Santa Cruz Solano Stanislaus</p>	
<p>Level I: These 30 small and rural counties must meet the requirements described in Section IX, A of DMH Info Notice 08-38, Pg. 8; Level I, MHPs.</p>			
<p>Alpine Amador Calaveras Colusa Del Norte El Dorado Glenn</p>	<p>Humboldt Imperial Inyo Kings Lake Lassen Madera</p>	<p>Mariposa Mendocino Modoc Mono Napa Nevada Plumas</p>	<p>San Benito Shasta Siskiyou Sutter/Yuba Tehama Trinity Tuolumne Yolo</p>

**The Nine Point Plan approved by the Court requires the implementation of a TBS accountability structure designed to function as a continuous quality improvement process.

The green counties are Level II MHPs and must engage in an intensive improvement process regarding TBS. These ten MHPs are required to convene two annual Stakeholder meetings and two annual Decision-Maker meetings.

The remaining counties are required to convene one annual Stakeholder meeting and one annual Decision-Maker and increase TBS utilization rates.

All Level II counties are required to reach a 4% utilization rate for TBS by December 31, 2010.

Emily Q: Statewide Map of Level I and Level II MHPs Revised: 7/7/10



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EXECUTIVE SUMMARY

Version 2.0 note: In an effort to ensure that this training and education manual is of value to the field, the CDMH will circulate the manual for practitioner and administrator review and comment on an annual basis. This review will coincide with the *TBS Documentation Manual* and the *Medi-Cal Compliance Protocol* annual reviews. Prior to the review period, CDMH will send out notification via e-mail to subscribers of the TBS e-distribution list. If you are interested in subscribing to this list, please e-mail tbs@dmh.ca.gov.

Additionally, if you have any questions or concerns about content in this manual, please submit them electronically to tbs@dmh.ca.gov. If you would like to discuss issues about this manual with a CDMH specialist, please contact Troy Konarski at (916) 654-2643.

The *Therapeutic Behavioral Services Coordination of Care Best Practices Manual* is designed to assist counties in their efforts to increase the use and quality of their Therapeutic Behavioral Services (TBS) programs.

The manual is intended for agency administrators, judges, social workers, probation officers, therapists, teachers, attorneys, family members, youth and other interested parties who may have little to no familiarity with TBS. They may use this information to collaborate locally and take advantage of TBS for children and families in their communities. The collaboration will be more successful with the commitment, willingness and trust of all community care providers (public and private) in furnishing services to children who are Emily Q class members. Emily Q class membership for TBS is described in the "TBS in Brief" section, under the heading "Who can receive TBS?"

Mental health, social services, juvenile justice, education and TBS providers and families must work together in supporting children who are eligible for TBS and giving them the best opportunity to succeed. Administrators of mental health plans (MHPs) will need to continually work with other government agencies to establish and maintain an effective working relationship across service delivery systems. Communication by all agencies and services is vitally important in responding to the multi-faceted service needs of

the children who meet the class definition for TBS.

The manual is designed to improve understanding of TBS by defining and describing the various ways in which services are performed through professional disciplines outside of the traditional mental health services.

A brief explanation of TBS is followed by vignettes that illustrate the ways in which TBS is making a difference for children who receive services from various child-serving agencies. The reader may choose to focus upon the section devoted to a particular area of interest, such as child welfare, probation, schools or mental health, to use this manual as a focused education or reference tool.

Following the illustrative examples, the section titled *Strategies for Supporting Access to TBS* reviews successful approaches that communities have used to increase TBS utilization and quality, including interagency collaboration, training and outreach, easily accessible referral procedures, and proactive utilization guidelines.

The subsequent section, *Improving Outcomes through Coordination of Care: The TBS Decision-Maker Meetings Model*, describes the successful decision-maker meeting component of the Emily Q Nine-Point Settlement Implementation Plan.

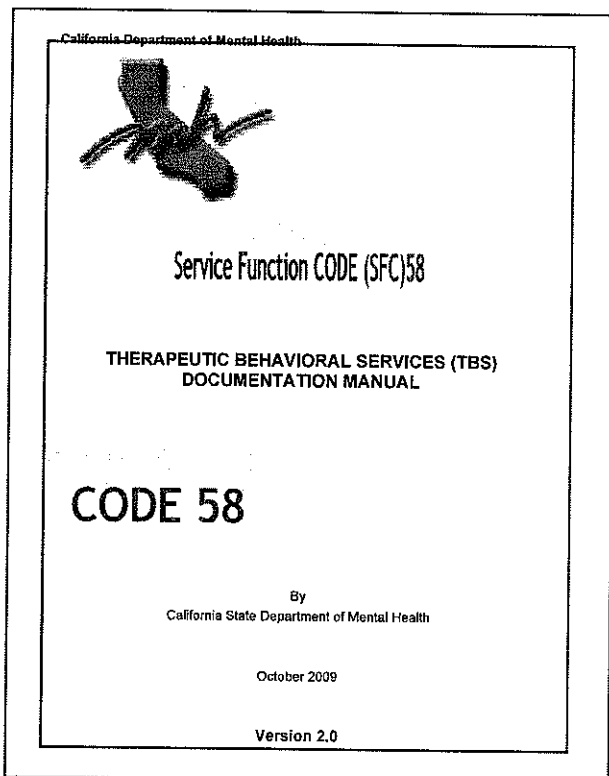
Therapeutic Behavioral Services: Best Practices, contained in the manual's appendix, is a more detailed description of TBS, as presented in the Emily Q Nine-Point Settlement Implementation Plan (Nine-Point Plan), for professionals, care providers, and family members who are interested in a more detailed understanding of how to provide effective TBS. Additional materials from the CDMH website that can support coordination of care efforts are included in the appendices as well.

This *Coordination of Care Best Practices Manual* is one part of a multifaceted effort to support the federal court-approved *Emily Q v Bonta* TBS Nine-Point Plan. The California Department of Mental Health (CDMH) is committed to the performance improvement process as described in the Nine-Point Plan and to provision of support for the 56



MHPs with data, training and technical assistance to help increase access and utilization of TBS.

This manual complements another tool for MHPs and private providers, the California Department of Mental Health's 2009 *TBS Documentation Manual* http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/TBSManualsE-Newsletters.asp. The 2009 *TBS Documentation Manual* was developed to offer clear instruction about effective TBS Specialty Mental Health billing and claims administration practices that support access and utilization of this service.



Both of these manuals, as well as other helpful information and materials regarding Therapeutic Behavioral Services, can be found at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSTDT.asp on the California Department of Mental Health TBS website.

The CDMH TBS website includes court documents; CDMH letters and notices; TBS Data Reports; information from the Emily Q Settlement Team and the TBS Accountability, Communications and Training (TACT) Team; and a variety of other supportive materials. CDMH

is adding new material regularly, and readers are encouraged to subscribe at the website to receive periodic updates. You may subscribe to the TBS website from the link at: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Apps/subscription/default.asp.

The CDMH gratefully acknowledges the work of the members of the multi-disciplinary team who collaborated for several months on this project, and likewise recognizes their sponsoring organizations, including:

- The Emily Q Settlement Team
- The TBS Accountability, Communications and Training (TACT) Team
- California Department of Education
- California Department of Social Services
- California Department of Alcohol and Drug Programs
- California Administrative Office of the Courts and selected judges
- APS Healthcare Inc.
- California Alliance of Child & Family Services
- California Mental Health Directors Association (technical assistance)
- California Institute for Mental Health (CiMH)
- Casa Pacifica (private TBS provider)
- Chief Probation Officers of California
- Child and Family Policy Institute of California
- JDT Consultants Inc. (private TBS provider)
- Napa County Special Education Local Plan Area (SELPA)
- California Court Appointed Special Advocates Association (CASA)

The CDMH welcomes suggestions or questions about these manuals or other TBS issues.

Comments about TBS can be sent to CDMH at TBS@dmh.ca.gov. You also may contact either of the following CDMH staff members: Sean Tracy, Assistant Deputy Director, Community Services, at Sean.Tracy@DMH.ca.gov; Troy Konarski, Staff Mental Health Specialist, Program Support Branch, at Troy.Konarski@DMH.ca.gov

Please visit the CDMH website for additional TBS information at www.dmh.ca.gov and go to TBS Updates on Emily Q v Bonta.

TBS IN BRIEF

What Is TBS?

Therapeutic Behavioral Services (TBS) is a one-to-one behavioral mental health intervention. TBS can help children, youth, parents, caregivers, foster parents, group home staff, and school personnel learn new ways of reducing and managing challenging behaviors, as well as strategies and skills to increase the kinds of behaviors that will enable children and youth to succeed in their current environment.

TBS behavior “coaches” or “specialists”¹ work intensively with a child in his or her home or community. No regulatory limitation is imposed on the intensity or length of TBS services; however, the service is guided by the needs of each child. TBS specialists may design, structure, model and support one-to-one interventions to modify target behaviors of concern or teach appropriate alternative behaviors, so that children or youths and their family members (caregivers) can manage on their own. Transition plans are developed to help each child and his or her family (caregivers) learn to use new skills by which to sustain improvements after TBS concludes.

How Can TBS Help?

TBS is designed to help children, youth, parents and caregivers (when available) manage challenging behaviors utilizing short-term interventions to achieve measurable goals based on the needs of the child or youth and family. TBS is never a stand-alone therapeutic intervention. It is used in conjunction with another mental health service, and can make the difference in averting need for a higher level of care or helping a child make a successful transition to a lower level of care.

TBS can effectively help children receiving child welfare services to attain permanence, or can help youth on probation to avoid subsequent law violations or detentions, or can help children and youth receiving mental health services to maintain their school placements.

Who Can Receive TBS?

TBS is available to children and youth under age 21 who have serious emotional challenges and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal).

In addition, to qualify, a child must be at risk of placement in a Rate Classification Level (RCL) 12 (or higher) group home (whether or not a RCL 12 or higher placement is available) or psychiatric hospital (whether or not a psychiatric hospital is available), or have a history of psychiatric hospitalization within the past 24 months, or be in an RCL 12 (or higher) group home and need TBS to prevent placement failure.

How Is TBS Started?

Children can be referred for TBS in many ways and each county has its own referral process. Parents, caregivers, foster parents, CASAs, social workers, probation officers, and mental health providers can ask for TBS services.

Each county mental health system has developed procedures for requesting a TBS assessment, providing the necessary documentation, and receiving TBS services². The county mental health case worker will have more information on how to start the process for the child.

¹ No standard title has been adopted for the practitioners who directly deliver TBS. The terms “coaches,” “specialists” and “workers” are commonly utilized designations. These titles are used interchangeably in this document.

² For more information on TBS, including contact information for TBS coordinators from each MHP, see California Department of Mental Health (DMH) TBS Web site at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp



TBS WORKING FOR CHILDREN AND YOUTH

How TBS Makes the Difference

Half of all mental health disorders begin in childhood³. Mental health disorders are prevalent among children. Disorders commonly experienced during childhood include disruptive disorders (e.g., conduct and oppositional defiant disorders), attention-deficit/hyperactivity disorder, and depression and anxiety disorders (including those resulting from traumatic experiences).

In California, children who have Medi-Cal insurance have access to mental health treatment through county-operated mental health plans, including an array of services accessible through a combination of county clinics and private community-based organizations.

Numerous mental health treatments are available, including individual therapy, medication treatment and case management. These services often are fully effective in treating mental health disorders and in restoring personal and social functioning.

While productive treatments are available, the severity of disorders and, in turn, treatment success, varies among children and circumstances. In some cases, the severity of emotional and behavioral problems require treatment in a psychiatric hospital or in an out-of-home placement (i.e., foster care or group home). TBS is specifically intended to meet the needs of children and youth at risk of being placed in higher-level care (hospital or group home) or undergoing a transition to lower levels of care.

TBS is proving to be very effective in assisting children and youth with various severe emotional and behavioral difficulties, including children served by child welfare, probation and schools.

As a result of TBS, children and youth are able to achieve permanence, avoid incarceration, and maintain school placements.

Children and youth being served by probation departments, receiving child welfare services and having serious difficulties in school may have mental health disorders that place them at risk of a psychiatric hospitalization or group home placement, or jeopardize their ability to remain in their current environment. TBS may be of assistance in all of these situations. Examples of behaviors that could benefit from TBS intervention include, but are not limited to:

- poor impulse control;
- poor or impaired judgment;
- oppositional behaviors toward caregiver and/or teacher directions;
- extreme tantrums;
- aggression toward peers or adults;
- fighting with peers and teachers;
- extreme and unremitting anxiety or isolation; and
- unsafe or self-injurious behavior.

The four sections that follow highlight, with illustrative examples, how TBS has been used to support the goals of the child welfare system, probation departments, the courts, schools, and public mental health services.

It is important to note that the following vignettes are intended as general examples only; treatment



³Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Co-Morbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun; 62 (6):617-27.

goals, interventions and replacements behaviors can vary and are unique to each situation.

For further clarification of behaviors and documentation procedures, please refer to the TBS Documentation Manual.

Probation: TBS and Juvenile Justice Services

The courts and probation departments could consider using TBS at numerous stages in the delinquency process — for example:

- At the pre-disposition stage, to demonstrate to the court that a child can be managed safely outside of a detention or group home setting;
- After a youth has been assigned a suitable placement order, so that he or she can be placed in a lower level of care or return to his or her family's care;
- When youth are at home on community supervision, to prevent the need for a psychiatric hospitalization or group home placement; and
- A juvenile that is in a detention center and has a placement order signed by a judge is considered Medi-Cal eligible and can obtain TBS.

If you would like additional information on TBS eligibility and institutional status, please refer to the California Code of Regulations (CCR), Title 22, Section 50273.

TBS can assist the youth during the transition phase from a juvenile detention center to a placement or the family home.

The following vignette illustrates how TBS was used successfully with one youth who was on probation.

A youth was experiencing emotional and behavioral difficulties at the group home where he resided. The major presenting problem was verbal and physical aggression and property destruction.

The client was a 17-year-old teenager on probation for grand theft auto and unsafe behaviors (alcohol and drug use, leaving home without permission,



and setting fire to property). He was removed from his mother's home due to parental substance abuse, neglect and physical abuse, as well as sexual abuse by an adult neighbor. The youth was placed in an RCL 10 boys' group home and was at risk of a placement in RCL 12 or above. His probation officer made the TBS referral.

The youth was violating his probation regularly by leaving the group home without permission — absent without leave (AWOL) — and displaying verbal and physical aggression (regularly punching walls, throwing chairs, slamming doors, and threatening to harm peers and staff). The client was diagnosed with post-traumatic stress disorder (PTSD), major depressive disorder and conduct disorder.

The referring probation officer doubted that this youth would be able to maintain his placement and avoid incarceration if his behaviors failed to meet the terms and conditions of his probation within a reasonably short period of time. In consultation with administrators from the youth's group home, the court, and the county mental health department, the probation officer decided to refer this youth for TBS. His mental health assessment was updated, and a TBS treatment plan was added to the youth's mental health care plan.

An interagency team, utilizing the youth's strengths as a foundation, developed the TBS plan. A specific TBS coach was assigned to work with the youth, and to collaborate with group home staff that played important roles in nurturing and supporting the youth.



TBS treatment goals included the following two important steps: 1) develop coping skills to increase frustration tolerance and to discourage the youth from leaving the group home without permission and using drugs; 2) increase anger management skills to decrease physical aggression.

TBS included three interventions to reduce the youth's target behaviors of unauthorized departure from the group home, aggression and drug abuse.

- *Relaxation.* — The TBS coach taught the youth relaxation techniques to reduce feelings of tension and anxiety that sometimes triggered his impulse to leave the group home without permission. The TBS coach modeled the repetition of slow, deep breathing “tense and release” exercises for the youth, and they practiced until the youth was able, without prompting from the worker, to engage in this process independently.
- *Reinforcement for participation in a drug/alcohol treatment program.* — The TBS coach developed a chart to keep track of the youth's attendance at the group home's drug/alcohol program meetings (three times per week). For each week in which the youth maintained attendance at all

meetings he was given a token, which he could exchange for the privilege of choosing television programming at various times during the week. (The TBS coach consulted with the youth to determine how tokens would be rewarded.)

- *Replacement behaviors.* — The TBS coach helped the youth develop a list of behaviors to replace impulsive flight from the group home, drinking and drug use. With the TBS coach's assistance, the youth was able to recognize triggers and resolve them promptly, and practiced consulting the list (which he chose to post inside his desk); he also learned to choose an alternative behavior when he felt triggered to leave the group home without permission, drink or use drugs.

This youth received TBS for approximately four months, during which time he was able to meet his treatment goals and maintain his group home placement. The team of people working with the youth then determined that TBS was no longer needed, and the TBS coach receded and concluded his services. The probation officer reported this success to the court.

Social Services: TBS and Child Welfare Services

The courts and county social services departments could consider using TBS at numerous stages in the child welfare system, including:

- As a family maintenance intervention to safely maintain a child with his or her family (or a relative caregiver);
- As an intervention to support foster care parents, in order to prevent placement disruption to a higher level of care; and
- As a reunification intervention strategy, so that a child can be safely and successfully returned to his or her family's care.

The following vignette illustrates how TBS was used successfully with one youth who was served by Child Welfare Services (CWS).



A youth was experiencing emotional and behavioral difficulties in her foster home. She was very oppositional, failing to follow rules that her foster parents set, lying and throwing tantrums.

The client was a 13-year-old Caucasian female, who had been living in her foster home for 1 year and 10 months at the time of the referral to TBS. She had been removed from her mother's care two years earlier, following her father's suicide, because her mother had become unable to care alone for her and her siblings. She was living with her 9-year-

old biological sister, 8-year-old half-sister, her foster mother's biological daughter, and her foster mother. The foster mother was a single parent.

The foster mother reported that the youth would not follow house rules and expectations, which included doing chores, bringing her grades home from school, doing her homework, and refraining from taking things without permission. The client was starting to lie about her violations of these rules, and when confronted became verbally aggressive (yelling at the foster mother, calling her biological mother offensive names and using profanity). The client was diagnosed with oppositional defiant disorder, adjustment disorder and bipolar disorder (provisional).

The referring CWS worker foresaw that this youth would lose her placement with her biological siblings if her behaviors did not improve, and the foster mother did not feel better equipped to handle the client's behavioral problems. In consultation with the client's individual therapist, the family's therapist, the client's psychiatrist, the county case manager, and the foster mother, the county mental health department decided to refer this youth for TBS. Her mental health assessment was updated, and a TBS treatment plan was added to the youth's mental health care plan.

An interagency team, utilizing the youth's strengths as a foundation, developed the TBS plan with family and youth involvement. A specific TBS coach was assigned to work with the youth, and to collaborate with the foster mother to support her in responding more effectively to the youth's behaviors.

TBS treatment goals included two important steps: 1) help the girl develop problem-solving skills to increase her compliance with adult directives and to enable her to meet household expectations while decreasing oppositional behavior; 2) support the youth's acquisition of anger management skills to decrease verbal aggression (yelling, cussing, name calling).

TBS included three interventions to reduce the youth's target behaviors of non-compliance, lying, and verbal aggression.



- *Impulse control.* — The TBS coach taught the youth problem-solving techniques (such as *stop-think-choose*) to help her make more positive choices. The TBS coach helped the client identify short- and long-term goals for herself, and plans to reach these goals. The intervention focused upon encouraging the client to experience being in charge of her own life, rather than feeling controlled and “ordered around” by her foster mother. The TBS coach frequently created an “outcome tree” with the client to help her think ahead about the different outcomes that would result from various choices she might make.
- *Clear system of rewards and consequences for the foster home.* — Working with the foster mother and the youth, the TBS coach developed a chart to keep track of the youth’s daily and weekly tasks in the home, thereby reducing the need for the foster mother to remind the client daily about her responsibilities. In addition to making expectations clear, the system established the rewards the youth would earn for successfully meeting them. The foster mother opposed using tangible rewards (for example, money or music CDs); instead, the foster mother, youth and TBS coach identified privileges such as rewarding extra computer and TV time in the evenings, allowing the youth to choose foods for Friday night dinners, and permitting her to visit her friends more frequently. The client was responsible for taking her chart to her foster mother to get it “checked off” as she completed her assignments.
- *Conflict resolution skills.* — The TBS coach helped the youth develop a list of behaviors to replace the urge to lie about completing her chores. With the TBS coach’s assistance, the youth was able to recognize triggers that influenced her to avoid her chores (e.g., feeling controlled by others) and developed the ability to use positive self-talk to remind herself of her goals and recognize the areas of her life in which she did have control. The girl and the TBS coach also practiced using assertive communication with the foster mother when the youth believed the chores were unfair. The TBS coach was able to introduce the conflict cycle, as well as collaborative problem-solving techniques, to help the two “hear” each other’s concerns and find solutions.

This youth received TBS for approximately four months and met her treatment goals. The social worker reported the success to the courts, and the girl remained in her foster home. The team of people working with the youth determined that TBS was no longer needed, and the TBS coach gradually reduced her time until services ended.

Schools: TBS and Education

TBS also can be conducted in the context of a school program as part of a mental health treatment plan. It is important to note that, although TBS can work in conjunction with educational programs, TBS is separate from the requirements of an Individualized Education Program (IEP) and Behavioral Intervention Plan (BIP). The following vignette illustrates how TBS was used successfully to help a child maintain his school and foster care placement.



A child was experiencing serious emotional and behavioral difficulties both in school and at his foster home. The major presenting problem was aggressive and assaultive behavior.

The child was a 7-year-old boy enrolled in a special education class at a public school. His social worker made the referral for TBS in consultation with his foster parent and CASA volunteer. The referral was prompted by concerns, reported by his teacher at an interagency meeting, about aggressive behavior directed toward other children in the class and toward the teaching staff.

The foster mother already was well aware of the child's difficulties, which also were evident in the foster home and documented in his IEP. However, she did not know how to obtain additional support for his particular emotional and behavioral needs. She was feeling hopeless and desperate, and feared that she would need to ask to have him placed in another foster home.

The child's teacher reported that his school placement also was at risk and was a frequent topic of discussion at IEP team meetings. The child's behavioral difficulties had become very severe. More specifically, both the child's teacher and his foster mother reported that his physical aggression, assaultive behaviors, angry outbursts, and oppositional defiance were overwhelming.

The foster mother, teacher and representatives from the child welfare and county mental health departments collectively decided to start TBS in addition to supports the child was receiving through his IEP. The child's mental health assessment was updated, and a TBS treatment plan was added to the child's mental health care plan. The TBS plan was developed for the child by an interagency team that included the child's foster mother, mental health and school staff, his child welfare social worker, and the TBS specialist, utilizing the child's strengths as a foundation. TBS took place in the foster home and school, in collaboration with the teacher, foster mother, and others who played important roles in nurturing and supporting the child.

TBS encompassed four interventions to reduce the child's target behaviors of physical aggression, threats, angry outbursts, and instances of oppositional defiance. They focused not only on the child and his behavior, but also on assisting the child's teacher and foster mother, whose ongoing learning about TBS techniques and support would be vital to the success of the TBS interventions. The four interventions were:

- *Relaxation.* — The TBS specialist instructed the child in relaxation techniques to reduce angry and emotional outbursts and physical aggression. He modeled the repetition of slow, deep breathing "tense and release" exercises, and the child practiced until he was able, without prompting from the TBS specialist, to engage in this process independently. This occurred in both the foster home and at school.
- *Prompting.* — The child was motivated by "prompting" to comply with his





teacher, foster parent and other adults who issued directives. The TBS specialist offered the child nonverbal (hand-up visual signals) as well as verbal prompts. This signaling occurred primarily in school, but also in the foster home, as needed. The child's foster mother and teacher also were instructed and encouraged to use this type of prompting.

- *Stop and think.* — The TBS specialist helped the child learn ways to “stop and think” before acting out or reacting inappropriately. The child's teacher and foster parent also were informed about

the “stop and think” strategy, so that this technique of behavioral modification could be maintained in the absence of the TBS specialist.

- *Token economy.* — The TBS specialist implemented a token economy system to reduce oppositional defiance and provide positive reinforcement. As part of the token economy system, the TBS specialist recognized the child's compliance with teacher and adult directives by offering the child tokens to be exchanged for small rewards and privileges. The TBS specialist assisted and collaborated with the teacher and foster mother in using the token economy plan, with the goal of continuing this strategy after TBS concluded.

The child received TBS for approximately five months, during which time he was able to meet his treatment goals and maintain both his school and foster home placements. At the end of that five-month period, the interagency team decided that TBS services no longer were needed, and the TBS specialist withdrew from the school and home settings.

Mental Health: TBS and Mental Health Services

Children receiving mental health services often have serious emotional and behavioral disorders that place them at risk of a psychiatric hospitalization or group home placement. The following vignette illustrates how TBS was used successfully with one such child.



A child was experiencing serious emotional and behavioral difficulties both in school and at home. The major presenting problem was aggressive and self-injurious behavior.

The child was a 10-year-old girl enrolled in a county mental health program. The child's therapist, concerned that she would harm herself or a member of her family, contacted her parents to discuss using TBS.

Her parents shared similar fears about their daughter harming herself or another member of the family, and about their ability to maintain her in the home. When bored, tired or hungry, she frequently engaged in self-injurious behaviors, such as hitting her head against the wall, biting herself and deprecating herself. She was also aggressive with her younger brother and other family members. She engaged in fights with her older sister, who had been removed from the home but visited frequently. In addition to the physical aggression, she threatened and swore at her family members.

After consultation with the child, the child's parents and colleagues at the mental health

program, the therapist decided to seek TBS services for this child. A TBS treatment plan, which the therapist developed in collaboration with the child, her parents and the TBS coach, was added to the child's mental health care plan. The plan matched TBS interventions to target behaviors, building upon the child's strengths (e.g., artistic skills, athleticism and desire to please others). TBS was provided to the child in her home and in collaboration with her family members.

TBS included the following three interventions to reduce self-injurious and assaultive behaviors. The strategies focused not only on the child and her behavior, but also on the family as a whole.

- *Trigger identification.* — The TBS coach and the child practiced identifying her thoughts and feelings when she engaged in self-injurious and assaultive behaviors. The TBS coach gave her art materials so that she could draw representations of her thoughts and feelings when she was frustrated, bored, and unhappy.
- *Developing coping skills.* — The TBS coach helped the child, through role-playing activities, to respond to triggering events in constructive ways that would help her achieve her goals. She learned how to use assertive language and "I feel" statements to communicate with her family members. In addition, the TBS coach modeled self-soothing techniques, such as deep breathing and muscle relaxation.
- *Parent education and support.* — The TBS coach helped her parents practice appropriate responses to her challenging behaviors, to set limits, to praise, and to use calming techniques. They also collaborated in establishment of household structure and rules.

The child received TBS for approximately four months, during which time she was able to meet her treatment goals and remain at home with her parents. After that four-month period, her parents, the TBS provider and her therapist agreed that TBS services no longer were needed, and the TBS coach gradually withdrew from the home.



STRATEGIES FOR SUPPORTING ACCESS TO TBS

Approximately 5,000 children throughout California are receiving TBS annually. They include recipients of child welfare services; youth on probation; and children with serious emotional and behavioral problems that jeopardize their ability to participate in school and remain at home. However, many more children who can benefit from TBS are not being referred and are not receiving these services.

Discussions with county mental health, probation and child welfare departments, schools, and TBS providers indicate that the use of TBS is greatly facilitated by the following key systems-level characteristics:

- strong interagency coordination
- streamlined referral procedures
- prompt eligibility determinations
- proactive TBS providers
- families and caregivers that are responsive and supportive of TBS.

Strong Interagency Coordination

Strong interagency coordination typically involves activities at multiple levels within and across the collaborating agencies that improve access to services, reduce fragmentation, and enhance outcomes for children and families. Components of successful strategies include:

1. Policy-level coordinating bodies, consisting of agency directors and administrators who routinely meet (e.g., monthly) for the purpose of establishing and sustaining policies conducive to coordination of children services across agencies;
2. Program-level coordinating bodies, consisting of agency managers and supervisors who meet frequently (e.g., weekly or monthly) to support interagency projects for the purpose of insuring the routine and successful implementation of one or more collaborative programs, such as interagency placement review committees;

3. Interagency programs, consisting of staff from two or more agencies, that collaborate daily in delivery of services and supports for individual managed care efforts — for example, mental health therapists collocated in child welfare or probation units to facilitate easy access to mental health assessment and treatment services;
4. Practical information consisting of presentations, trainings, program descriptions and easy-to-use referral instructions — specifically prepared for social workers, probation officers, teachers, therapists, judges and families — intended to support timely and appropriate access to needed services, including TBS;
5. Court leadership and education about TBS as an alternative to institutional placement is effective. (Judges have a unique ability to call together local administrators and leaders to support problem solving. They may encourage personnel from multiple agencies to collaborate in devising innovative solutions to complex and difficult problems.);
6. Routine communication and coordination between the county mental health department, TBS providers, families, and referring parties;
7. Collaboration between TBS providers, probation officers, and child welfare social workers such that the appropriateness of TBS for specific children can be discussed, and when indicated, recommendations can be prepared for consideration in disposition and suitable placement hearings;
8. School-based treatment planning meetings with participation by mental health clinicians, school staff, children, and parents;
9. Placement of mental health therapists in school, child welfare and probation settings to discuss the needs of individual children;

10. Local judges convening meetings with multiple child-serving agencies to support problem resolution and service delivery;
 11. Outreach and involvement of judges and attorneys with responsibility for children receiving child welfare or probation services;
 12. Routine consideration of the use of TBS in the context of wraparound child and family meetings or team-based decision-making meetings; and
 13. Periodic review, by probation officers and child welfare social workers, of the children on their caseloads who are showing volatile or at-risk behaviors.
2. Routine consideration of TBS for children who are at risk of, or returning from, psychiatric hospitalization; and
 3. Routine consideration, by the courts, of the appropriateness of TBS for children at risk of group home-level placement.

Proactive TBS Providers

Proactive TBS providers demonstrate:

1. The capacity and readiness to complete assessments and start TBS services, without delay, upon receipt of a referral and eligibility determination; and
2. Development of school-based TBS roles, responsibilities and classroom protocols.

Streamlined Referral Procedures

Streamlined referral procedures, timely eligibility determinations and proactive TBS services are built upon a foundation of strong communication and collaboration between county mental health plans, their TBS providers, and the larger community of child- and family-serving agencies. Efficient TBS programs are characterized by:

1. Clear instructions and easy-to-use forms for making referrals;
2. Creation of simple, easy-to-complete TBS referral forms, tailored for probation officers, child welfare social workers, mental health therapists and school staff; and
3. Establishment of multiple gateways for referrals, from parents, therapists, schools, probation officers, child welfare agencies, and courts.

Prompt Eligibility Determinations

Streamlined eligibility determinations are extremely helpful for all stakeholders in providing timely and appropriate mental health services. They include:

1. Straightforward procedures for making eligibility determinations promptly using the streamlined TBS administrative requirements⁴;

⁴See DMH Information Notice No. 08-38 at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/DMH_Documents.asp

Families and Caregivers that are Responsive and Supportive of TBS

County agencies and providers have reported success with outreach to families and numerous strategies for supporting access to TBS. These effective strategies include:

1. Preparation of briefing materials concerning TBS for courts, probation officers, child welfare social workers, teachers, therapists, families, and youth; and
2. Regular and recurrent trainings and outreach meetings to support the use of TBS involving the courts, probation departments, county social services, schools and mental health providers, and families and youth.



IMPROVING OUTCOMES THROUGH COORDINATION OF CARE: THE TBS DECISION-MAKER MEETINGS MODEL

Successful interagency collaboration efforts are exemplified by TBS decision-maker meetings. In November 2008, the federal court-approved the Emily Q Nine-Point Settlement Implementation Plan (the Nine-Point Plan)⁵. This plan creates a comprehensive set of requirements for settling the Emily Q lawsuit, and increasing the utilization and quality of TBS. Recognizing that the children and youth who will benefit from TBS often are served by a variety of agencies, including probation departments, child welfare agencies, schools and the courts, the Nine-Point Plan specifically supports and calls for activities that will increase the coordination of care across child, youth and family-serving agencies. The TBS decision-maker meeting is a key component of this approach.

The Nine-Point Plan recognizes that optimal use of TBS will require participation at multiple levels and across the community; however, the decision-maker meeting capitalizes upon the understanding that the support and attention of agency leadership is essential for success. The Nine-Point Plan defines the membership of the decision-maker meeting as:

- Director of Mental Health
- Director of Child Welfare Services
- Chief Probation Officer
- Presiding Judge of the Juvenile Court
local SELPA Director or Special Education Representative
- parent representatives
- TBS provider representatives
- other agencies that provide services to the Emily Q class members.

The first set of decision-maker meetings focused on four questions:

1. Are the children and youth in the county who are Emily Q class members, and who would benefit from TBS, receiving TBS?

2. Are the children and youth who receive TBS experiencing the intended benefits?
3. What alternatives to TBS are being provided in the county?
4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

Decision-maker meetings that follow will highlight different sets of questions or other priorities.

Participants in decision-maker meetings review the information provided by the CDMH, including TBS Data Reports. That review process creates opportunities for stakeholders to identify shared areas of interest, such as reducing group home placements and institutionalization of children and youth, as well as returning children and youth to their families and communities, and helping them remain in their homes.



These meetings also are helpful in identifying barriers that inhibit access to TBS. Through this process, participants in decision-maker meetings develop strategies to surmount barriers and create opportunities to increase use and improve the efficacy of TBS.

County mental health departments have completed reports documenting their decision-

⁵See the CDMH TBS website at: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/EPSTDT_docs/Nine_Point_Plan_Total.pdf

maker meetings and highlighting their successful strategies. The CDMH TBS website has examples of these reports, and offers a variety of other practical resources to support local decision-maker meetings, including TBS brochures (available in 11 languages), helpful local meeting documents and forms, and sample county meeting announcements (http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSTDT.asp).

In March 2010, the CDMH presented to the federal court The 2009 TBS MHP Progress Report that helped to evaluate the strengths and best practices of MHP decision-maker meetings and stakeholder meetings. This progress report will be updated throughout 2010, and the reader may want to review local activities and programs relative to TBS and the Nine-Point Plan implementation: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/Exit_Plan_4-09-09.pdf

As a result of the 2009 experience with implementation of the Nine-Point Plan, CDMH, the Super TACT and the Emily Q Settlement Team (EQST) determined that there was a need for increased attention to family, consumers and youth participation and leadership involving TBS stakeholders and decision-maker meetings. The CDMH initiated a TBS Family and Youth Strategy that is being developed as this manual is published. We invite you to review this plan and offer opinions about ways to advance a consumer- and youth-centered focus in this local service delivery and coordination of care model, after it is posted to the CDMH website at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/TBS_FamilyandYouthStrategy/FamilyYouth_Strategy_Update.pdf.

CONCLUSION

TBS is a one-to-one behavioral mental health service that is making a difference for children and families by helping to keep children in their homes and communities, and by preventing the need for high-level group home care and psychiatric hospitalization.

TBS is highly effective for children with a variety of severe emotional and behavioral difficulties, including children served by child welfare agencies, probation departments and schools. As a consequence, children and youth are able to achieve permanence, avoid incarceration and maintain school placements.

Despite this success, even more children can benefit from TBS, but they first need to be identified and referred for these services. Strategies for improving access to TBS are characterized by strong interagency coordination, streamlined referral procedures, quick eligibility determinations, and proactive TBS providers. Moreover, numerous specific strategies are being

identified by counties, in TBS decision-maker meetings and other settings, and are being used with success throughout the state.

This *Coordination of Care Best Practices Manual* is one part of a multifaceted effort to support the federal court-approved *Emily Q v Bonta* TBS Nine-Point Plan, and to help increase access and utilization of TBS. CDMH is very committed to the performance improvement process as described in the Nine-Point Plan and to provision of corresponding supports, training, and technical assistance. To this end, helpful information regarding TBS is available at the California Department of Mental Health TBS website at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSTDT.asp.

Moreover, stakeholders are encouraged to share their suggestions or questions about TBS by contacting CDMH at TBS@dmh.ca.gov.



APPENDICES

Appendix 1

Therapeutic Behavioral Services: Best Practices

The following is reproduced, in its entirety, from Appendix D of the Emily Q Nine Point Settlement Plan, developed in response to Point 4 of the plan: Define TBS Best Practice to Promote Service Integrity.

Therapeutic Behavioral Services (TBS) is a one-to-one behavioral mental health service available to children and youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention. It is always used in conjunction with a primary mental health service. TBS is available for children and youth who meet the requirements of being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children and their parents or caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs.

TBS can help children and youth, families, foster parents, group home staff and school staff learn new ways of reducing or managing challenging behavior as well as strategies and skills to increase the kinds of behavior that will enable success in their current environment. A TBS treatment plan will be developed by the treatment team to outline what the child, the family or caregiver and the TBS specialist will do during TBS, and when and where TBS will occur. The TBS plan will identify and describe the challenging behaviors that need to change and the replacement behaviors the TBS specialist will teach the child and family or caregivers. The plan will say when the TBS specialist will work with the youth and family or caregivers. The hours may be during the day, early morning, evening or night. The days may be on weekends, as well as weekdays. The TBS specialist can work with children in most places where they are likely to need help with challenging behaviors. This includes family homes, foster homes, group homes, schools, day treatment programs and many other areas in the community. The TBS specialist, the child and the family or caregiver will work together very intensely for a limited period of time, until a child has displayed improvement with behavioral goals and no longer needs TBS.

Service Philosophy

TBS is based on the research and philosophies of Behavior Modification. Evidence shows that the success of an intervention hinges on: 1) understanding why children behave in a certain way; and 2) replacing inappropriate behavior with a more suitable behavior that serves the same function (or results in the same outcome) as the challenging behavior. Intervention with challenging behavior begins with assessing and identifying the underlying needs being met by the maladaptive behavior. TBS is provided to children and their families or caregivers in the community through a well-trained interdisciplinary team of licensed and unlicensed staff. Services are provided working cooperatively and collaboratively with the youth, family or caregiver, community agencies and the TBS professional staff. The TBS mental health plan development and service delivery is based on the following tenets and values:

- The belief that when provided with useful therapeutic tools, a child can learn to manage their symptoms, yielding success in the home, school and community.
- The belief in the importance of cultural competence and sensitivity and multi-lingual mental health service delivery in meeting the diverse cultural needs of consumers.

- The belief that the parents and guardians of the child are an integral and valued member of the child's treatment team.
- The belief that youth that have experienced or are experiencing serious emotional distress during times of crisis, loss and transition will stabilize successfully when provided with competent and comprehensive short-term one-to-one support.
- The belief in providing children with specific, measurable and accomplishable short and long-term treatment goals specially focused on their areas of need.
- The belief in the importance of self-determination and the formulation of individualized Treatment Plans involving the child and family or caregiver in this process, highly valuing their input from the onset of service delivery.
- The belief in the importance of children being placed in the least restrictive environment with full inclusion in age and developmentally appropriate activities, peer groups and education.
- The belief in the commitment to youth wellness, creating well-being, obtaining balance in one's life and helping children to realize and reach their potential.

Family Engagement

The process of engaging the family or caregiver is a crucial component of providing TBS. It is the role of the TBS clinician and assigned staff to welcome and engage the family or caregiver. The caregiver engagement process builds trust and sets the stage for the work to come. It can ultimately make or break the partnership and affect the success of the child and family's outcomes. Engagement with the child and family or caregiver is an ongoing process and continues to need nurturing past the initial "getting to know you" phase.

Cultural Competence

TBS is committed to the recognition and appreciation of cultural diversity among service delivery staff, clients and community partners. Every effort will be made to provide the service to children in their primary or preferred language. It is also important that any forms, documents, and brochures be provided in multiple languages to reflect the cultural needs of the community. It is critical for TBS programs to employ from diverse cultural and language backgrounds similar to that of the counties that are served. As consumers are referred, their language and cultural needs should be matched with the appropriate Specialist(s).

It is equally important that TBS is committed to an atmosphere of inclusion, engagement, and supportive collaboration. Whenever possible, care givers should be encouraged to participate in the treatment plan implementation to promote understanding of the service and allow them to take ownership of the outcomes and an improvement in their child's functioning. Families who participate in TBS should feel non-judged, welcomed, and included in the process of helping their child. TBS should make every effort to meet the family or caregivers "where they are" and make any time, day, or environmental (location) adjustments that will help with the service be successful and limit the intrusiveness of the interventions.

Service Delivery

After receiving the TBS referral, the TBS clinician or TBS specialist will initiate contact to help coordinate a TBS Initial meeting with the referring clinician, social worker, or probation officer, the family or guardian, the client and other significant parties in the child's life to discuss treatment planning and service delivery. The TBS service delivery model should be based on a comprehensive assessment focusing on the children's strengths and needs. A licensed clinician (LPHA) should oversee the Initial Treatment Planning meeting to develop the TBS Treatment Plan and provide ongoing therapeutic supervision of services.



Initial Meeting of the Treatment Team

- The meeting is attended by a TBS clinician in conjunction with TBS staff, parent or caregiver, child, and the referring party (ie. mental health worker, probation officer, social worker). This group comprises the treatment team. Other participants in the treatment team may include family members, CASAs, teachers, therapists, partner agencies, support staff, etc.
- At this meeting, TBS is introduced and explained before any discussion of the youth's behavior occurs.
- It is very important that the parent or caregiver take as active a role in plan development and plan implementation as possible. It is advised that a caregiver be at home during home visits so the TBS staff can check in and out with an adult. The parent or caregiver is not required to sit down with the specialist at all visits, but may be asked to participate in a parent meeting, family meeting or youth meeting from time to time. By the end of services the parent or caregiver should be equipped in utilizing effective TBS interventions with their child. It is important to note here that TBS can still be an effective intervention for youths who may not have parental or caregiver involvement in their lives at the time of the service delivery. This is especially true for Transitional Age Youth (age 18 to 21).
- Team communication is very important. TBS specialists will be discussing the case with the clinician, teacher, parents, and caregivers to ensure that the entire treatment team knows what is working and areas that need more attention. It is recommended that a team should meet at least every 30 days to review the progress and adjust the plan as the goals are being met.
- TBS is not a crisis response service. In the event of a crisis the family or caregiver is encouraged to utilize a crisis stabilization service or follow a safety plan established in conjunction with their primary therapist or worker.
- The TBS team then has a discussion of challenging behaviors, narrowing the behavioral concerns and developing a TBS Treatment Plan in conjunction with the overall goals of the Mental Health Treatment Plan.

The TBS Treatment Plan

During the initial meeting process, specific and measurable data related to the frequency and duration of the child's challenging behaviors is obtained to enable comparison as services progress. To promote collaboration for client benefit, a signed release of information is requested at the time of the initial assessment so that communication can occur with the child's therapist or other members of the TBS team.

The individualized TBS Plan will identify specific target behaviors or symptoms that are jeopardizing the current placement or are presenting a significant barrier to transitions. A careful review of the presenting symptoms and subsequent behaviors to be targeted is prioritized, with the plan focusing on the behavior(s) that are most likely to disrupt the child's current living arrangement, inhibit the ability to transition to a lower level of care, or that will lead to placement in a higher level of care.

It is of utmost importance that goals in the individualized TBS Plan are clearly stated in specific and measurable terms. The goals reflect the child's baseline performance in targeted areas so that progress can be accurately recognized. Pre-test data is intended to offer accurate information related to the consumer's baseline performance and involves reports by both the child and their family or caregiver. Each target behavior is stated in descriptive and measurable means. Interventions to target each behavior are determined and specific measurable outcomes are identified.

An important factor is to determine antecedents and consequences to the youth's challenging behavior. Antecedents and consequences are not always apparent at the time of the Initial Meeting, and therefore determining antecedents and consequences to challenging behaviors is often incorporated into the child's TBS Treatment Plan as an early primary intervention.



TBS Initial Plan Implementation and Assessment Period

During the first 30 days of treatment, TBS is in an implementation and assessment phase. It is crucial to engage the family or caregivers and build trust during this phase. The TBS specialist should begin introducing the treatment plan and gather first-hand data in regard to the youth's challenging behaviors. This period at the beginning stage of TBS includes giving immediate assistance to the child and parent or caregiver to relieve stress and avoid crisis, while also gathering valuable information on the function and intensity of the behavior in the environment where it occurs. The TBS Specialist in conjunction with the TBS clinician should complete a Functional Analysis of Behavior, including: 1) identification of target behaviors, 2) frequency, intensity and duration of target behaviors, 3) antecedents and consequences of the behaviors (function), and 4) potential replacement or alternative behaviors, during this timeframe.

A child's progress toward goals and objectives offers valuable insight into the youth's ability to manage their symptoms, make appropriate choices in the future without TBS assistance, and their ability to incorporate skills and coping strategies learned into daily living.

A key component to behavior monitoring and overall success involves obtaining accurate baseline data related to the symptoms or behaviors to be targeted in the Treatment Plan. During the initial assessment process, the child's Treatment Team, i.e. licensed therapist, TBS Specialist, TBS supervising clinician, the child's CASA, family or caregivers and the child should carefully adhere to the following guidelines to ensure a meaningful and accurate baseline evaluation of behaviors:

- Careful documentation of the initial frequency and duration of the challenging behaviors to be targeted.
- In obtaining this baseline behavioral data, the clinician and TBS Specialist will gather this data from a variety of sources which may include observations by the TBS Specialist, parent or caregiver; the child's self-report; and the teacher or primary therapist.
- A careful review of environments (school, home, community) where the target behaviors are demonstrated will be completed. Specific information related to each domain will offer an ability to effectively monitor progress in each setting.
- During the assessment and beyond, identification of antecedents and consequences to target behaviors will be a focus of the behavior monitoring process, continuing to gather valuable information that assists in understanding the origins and precipitating events to challenging behaviors and symptoms.
- The ongoing assessment of the youth's behavioral changes will employ daily observations, reports and information obtained from family or care providers and the evaluation of the frequency of targeted behaviors.

Progress will be stated in measurable and specific terms throughout TBS involvement. Treatment plan modifications result from a review process between the Specialist, Clinician and Treatment Team.

TBS Interventions

TBS interventions are based upon the tenants of behavior modification, cognitive-behavioral therapy and supported by evidence-based practices. TBS interventions will be provided on-site between the child and TBS Specialist through therapeutic contact. TBS interventions are designed to help the youth develop improved emotional and behavioral skills and increase the child's ability to manage symptoms and behaviors once treatment goals have been met and services have been discontinued.

Interventions should be developed with the goal of parent or caregiver learning adaptive skills in order to successfully manage their child's behaviors once TBS has ended. It is critical that parents or



caregivers be able to watch, practice, role play, and implement interventions with the youth while TBS staff is present in the environment (home, classroom, etc.) to increase confidence, consistency, and sustainability.

Interventions will be stated clearly and concisely reflecting the methods that will be employed to meet the desired goals or outcomes. Interventions are designed to build skills and provide the child with tools to address their areas of difficulty; i.e. anger, threats, impulsivity.

Interventions are planned and implemented to increase the youth's ability to cope with situations that lead to behaviors and choices that jeopardize success in their home, school or community.

The TBS Specialist should be trained in providing behavioral interventions to emotionally or behaviorally challenged children and youth. TBS Treatment Plan goals are accomplished through planned interventions, which commonly include: role modeling, intermittent and planned reinforcements, teaching children and their parents or caregivers coping skills and strategies for symptom and behavior management and empowerment. TBS Specialists will focus on the strengths, talents and interests of the youth and their families or caregiver in developing intervention strategies. Through planned and systematic interventions, the child or youth will learn to exhibit self-control, act responsibly and feel empowered and successful. The development of a trusting one-to-one relationship with their TBS Specialist will help in acquiring and developing interpersonal skills.

Meaningful incentives and consequences to the child will be determined, and a plan for either intermittent or planned reinforcements will be included in the treatment plan to reinforce desired behavior. Parents and caregivers should take an active role in developing incentives and consequences and the interventions should fall within the general scope and ability of the parent or caregiver to fulfill after TBS is terminated.

The following are guidelines for respectful and successful TBS interventions:

- The purpose of TBS interventions is to teach, not control. Children need to learn how to make informed choices, weighing the potential consequences and rewards for their choices (behaviors).
- All children have a need and desire to be successful, liked and appreciated by adults and their peers. However, the manner in which they attempt to get their needs met is often not appropriate. Through one-to-one support and education, they can learn to meet their needs in a more successful manner.
- All behaviors are intentional and have a purpose to the youth. Through determining the outcome desired by the youth, successful interventions can be developed to achieve this outcome.
- The children and their families or caregivers are valued members of the Treatment Team and should be included in all aspects of service delivery.
- There is always hope for a positive outcome, regardless of the child's history or symptoms. The ability of the Treatment Team to maintain hope and faith in children and their positive outcome is imperative to success.
- Lastly, all youths and their families or caregivers deserve the best efforts of professionals to provide services in a competent, ethical and consistent manner.

TBS Supervision

TBS Supervision is recommended as a valuable means of monitoring the success of interventions to effectively meet the TBS Treatment Plan goals and objectives. It is important that all staff providing

direct service attend regular Supervision. For example, one TBS Case Model consists of weekly meetings held for two hours in duration and includes a team (max. 8 members) consisting of the TBS supervising clinician and the TBS Specialist(s) providing services to children. The focus of supervision is to discuss pertinent issues related to the child and services, which may include:

- Group discussion and updates on ongoing issues regarding safety and safety plans for youth, family, caregivers, and TBS specialists.
- Follow up discussion and processing of crisis events by the group.
- Discussion of youth's progress toward TBS goals. Emerging issues are also discussed.
- Discussion of behavioral intervention strategies as well as to work as a team to provide encouragement, ideas and feedback regarding interventions to individual specialists.
- Discussion of challenges in the provision of TBS services (i.e. rapport lapses, youth participation, level of parent or caregiver involvement, environmental factors, etc.)
- Discussion of and provision of group support for TBS Specialists' frustrations and personal challenges in the field.
- To inform the group of any changes to TBS scheduling, procedure or protocol.
- To provide training to the group regarding clinical issues such as boundaries and confidentiality.
- Discussion of upcoming TBS reviews, contact with primary clinician, frequency of services and fade out plan.
- To acknowledge the successes of the youth and family or caregivers.

Monthly TBS Review Meetings

Monthly TBS Review Meetings should be scheduled and all Treatment Team members be included. In addition to the TBS clinician, TBS Specialist, children, their parents or caregivers, members may include the child's primary therapist, care coordinator(s), the Case Manager and placement worker, CASA and any person who is significant to the youth and who has information that may be helpful to the TBS Treatment Plan. The focus of the TBS Review Meeting is to determine the effectiveness of the plan and the interventions and to adapt the plan as needed in order to facilitate progress toward the TBS goals. Treatment Team members should be encouraged to offer suggestions, observations and insight into TBS service delivery, progress and interventions employed. Parents or caregivers should be encouraged and supported in bringing up any concerns or issues with regards to TBS and how it is being implemented in their environment. The youth should be invited to this meeting to share their thoughts and experiences resulting from TBS involvement. Recommendations for changes in the level of services, interventions or modifications in the targeted behaviors should be discussed at this meeting.

TBS Termination

In response to the time limited nature of TBS, transition and termination procedures are thoroughly discussed with the child, family or caregivers and primary therapist during the Initial meeting and throughout the service. Criteria for decreases or increases in the intensity of TBS services and eventual elimination of these services are based on the youth's progress toward behavioral goals delineated in his or her Treatment Plan. Based on the child's progress, the frequency and duration of services are adjusted, transitioned or titrated. These transitions are discussed with the child, family or caregiver, and treatment team at regular (monthly) TBS Review Meetings. From the inception of services, the treatment team will be advised of the following to offer them a framework for transitioning TBS services:



- TBS services are not meant to “fix” a child or lead to a “perfect” child or perhaps an absolute elimination of all target behaviors. Rather, the goal of TBS services is to provide meaningful interventions to the child and family or caregivers that lead to a significant reduction in the targeted behaviors.
- Through TBS service delivery, the youth and parent or caregiver will develop skills and strategies for coping with target behaviors.
- TBS involves a team, and the parent or caregiver and child are significant members of the team. In a family based or home environment, child and parent or caregiver involvement in TBS service delivery and TBS Review Meetings are critical to the success of services. It is highly probable that TBS services will not be successful, in this environment, without youth and family or caregiver involvement.
- TBS can be effective in working with Transition Age Youth (age 18-21) or children who do not have immediate adult support. But it is crucial that from the onset of TBS, informal supports (friends, coaches, clergy, co-workers, etc.) for the child be encouraged to take part on the Treatment Team (at the request of the child) to ensure that termination of services does not feel like abandonment.
- Decreases in TBS services are very exciting and represent an important accomplishment on the part of the youth, family or caregivers and significant support people in the child’s life.

As transitions occur in the intensity of TBS services to the child, an addendum to their Treatment Plan will be made. Addendums will also be made if it is determined that additional behaviors are in need of TBS interventions. When the majority or all of the targeted behaviors have been decreased to a level where the child and parent or caregiver can maintain existence successfully in their current environment or the targeted behaviors have decreased to a level that can increase the possibility of a successful transition to a lower level of care, then TBS can be terminated.

Decreases and the successful elimination of services will be communicated to the child and family or caregivers as a very positive experience, as they have been successful for this to occur. Incentives, rewarding the success of the child’s progress toward targeted behaviors will occur as services are decreased. When the successful completion of TBS services occurs, a celebration or graduation should be held for the family or caregiver to recognize the youth’s accomplishments.

Toward the end of TBS service delivery, the TBS Specialist, child and family or caregivers should discuss a Setback Prevention and Response Plan. Factors to be discussed with the child and family or caregivers to prevent and respond to setbacks include the following:

- Attention to patterns, circumstances and antecedents to the youth exhibiting the targeted behaviors in setback prevention.
- Support systems available to the child and family or caregiver.
- Community resources and agencies that can provide support.
- Interventions learned that were successful for the child and family or caregiver to manage symptoms and behaviors.
- The importance of maintaining open communication between the youth and their primary mental health clinician.
- “Speaking up” right way when setbacks begin to occur, not allowing the behaviors to become extreme and frequent prior to getting help.

When TBS services are intensive and last for an adequate amount of time without observable improvement toward treatment goals, the appropriateness of the service to provide stabilization of the



child's living situation will be assessed. To prevent inappropriate changes in placement and to address a lack of the child's progress, strategies may include the following:

- The lack of the child's progress in response to the Treatment Plan should be discussed throughout the TBS Review Meeting process, both internally (TBS specialist and supervising clinician) and with the Treatment Team.
- When a youth is unresponsive to TBS services being delivered, continual weekly efforts should occur to locate interventions and strategies to elicit a positive behavioral response. Members of the Treatment Team should be consulted to obtain their feedback.
- Barriers to TBS service effectiveness should be explored and methods to counteract barriers are determined and implemented.
- If after extended TBS, a child's maladaptive behavior increases or progress toward target behavioral goals have plateaued, the Treatment Team should discuss possibilities that the child may need alternative mental health services or determine if further TBS may be counterproductive, placing the child at risk of an increased level of care.

Transition and termination of TBS is discussed with the youth and the family or caregivers throughout the service delivery. Given the intensity of the one-to-one relationship between the youth and Specialists, this can represent a significant loss to the youth. Specialists should receive training regarding the TBS termination process and termination principles when discontinuing services to the child. The focus of termination as a positive and necessary process in life should be related to the child by the Specialists. Teaching challenged children to terminate in a positive way is very important and prepares them for these experiences throughout their life. The termination training for Specialists should address principles that include the following:

- Based on the intense, yet time-limited nature of this service, ongoing discussion should occur between the youth and Specialist about termination. Specialists should be advised not to promise contact with the youth and that it is important that the youth experiences termination (good-byes) in a positive way, as it is a process that occurs throughout their life.
- Specialists should begin terminating with the child 30 days prior to the proposed elimination of services. The TBS program should provide training to educate Specialists how to role model and help children express their feelings about termination (goodbye) and not seeing their Specialist anymore.
- Specialists should plan a celebration or graduation from TBS with the child, making this transition a happy and meaningful one. Children should determine how they will say goodbye, who will be there and the activities that they will do to celebrate their success.
- Reaching behavioral goals should be addressed as a very positive accomplishment, and as decreases in services occur, the children should be complemented on their accomplishment and success.
- Specialists should receive training on positive methods of creating transitional objects to be given at termination that offer children a tangible possession that they can refer to and feel good about as a reminder of all their hard work.
- Specialists will also terminate with the family or caregivers and exchange comments with the parent or caregiver related to how the termination of TBS services is impacting their child.

Treatment Team communication during the last 30 days will be to discuss the termination, receive feedback as to how the child is responding, plans on responding to the child's reactions, and



development of the Setback Prevention Plan. The children may want some or all of the Treatment Team to attend their graduation celebration. The team will be encouraged to support the children, process the termination (goodbye) with their Specialist and to present this as an exciting accomplishment.

Following termination and graduation the TBS Specialist should complete a TBS Discharge Summary. The TBS Discharge Summary details the child's progress or lack of progress toward the target goals that were demonstrated at each TBS Review Meeting as well as the overall outcome of children maintaining their home or residential placement or successful transition to a lower level of care.

Appendix 2

DEPARTMENT OF SOCIAL SERVICES TBS LETTER



JOHN A. WAGNER
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



ARNOLD SCHWARZENEGGER
GOVERNOR

REASON FOR THIS TRANSMITTAL

April 29, 2010

ALL COUNTY INFORMATION NOTICE NO. I-39-10

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY CWS PROGRAM MANAGERS
ALL CHIEF PROBATION OFFICERS
KARUK TRIBE

SUBJECT: THERAPEUTIC BEHAVIORAL SERVICES

REFERENCE: DEPARTMENT OF MENTAL HEALTH INFORMATION NOTICES
08-38 AND 09-10

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

This All County Information Notice provides important information regarding the availability of Therapeutic Behavioral Services (TBS), and strongly encourages counties to actively work with their local mental health partners to facilitate access to these services for children and youth in foster care who need them.

Background

In 1998 a class action lawsuit (*Emily Q. v Bontá*) brought against the State of California sought to have TBS included under Medi-Cal as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental service. In 2001 the court ruled in favor of the plaintiffs and issued a permanent injunction against the State in which TBS was recognized as a Medi-Cal reimbursable EPSDT supplemental specialty mental health service. The court further ordered the California Department of Mental Health (DMH) to take specific steps to increase access and utilization of TBS.

These steps were formalized in a Nine Point Plan that was approved by the court in November 2008. The Nine Point Plan describes what DMH will do to improve TBS in California.



For example, the Plan significantly reduces administrative requirements related to the provision of TBS, clarifies definitions of eligible and "at risk" populations, and includes strategies to increase access and improve the quality of TBS, which is the Plan's primary goal. The nine points of the Plan are listed below.

Summary of the Nine Point Plan

1. Eliminates many administrative requirements that have burdened counties in the past and have reduced the use of TBS;
2. Presents simple and direct language to clarify TBS eligibility requirements;
3. Establishes an accountability process and structure that DMH will use to monitor and improve TBS utilization in every county;
4. Describes a TBS best practice approach from assessment through service delivery and termination;
5. Proposes a multiagency coordination strategy to engage Social Services and Juvenile Justice agencies at the state and county levels in order to increase and improve TBS service access and delivery;
6. Establishes a statewide TBS training program;
7. Outlines technical assistance manuals covering both TBS practice and chart documentation;
8. Outlines an outreach strategy to increase awareness of TBS and expand its utilization statewide; and
9. Defines a process that will result in Court exit from the Emily Q matter.

TBS Definition

TBS is defined as a one-to-one behavioral mental health service available to children and youth with serious emotional challenges who are under age 21 and who are eligible for full scope Medi-Cal benefits without restrictions or limitations. TBS is never a stand-alone therapeutic intervention, but rather is used in conjunction with another specialty mental health service.

Emily Q Class Members

Class members are all current and future beneficiaries of the Medicaid program below age 21 in California who:

- Are placed in a facility with a Rate Classification Level 12 or above and/or a locked treatment facility for acute psychiatric inpatient hospital services for the treatment of mental health needs; or
- Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability in the past 24 months; or
- Are being considered for placement in these facilities as a result of behaviors that may benefit from TBS interventions, whether or not such a facility is available.

TBS Eligibility

For children and youth identified as meeting the requirements for class membership, the need for TBS is determined based on the following criteria:

1. The child/youth is receiving other specialty mental health services; and
2. The clinical judgment of the mental health provider indicates that the short-term support of TBS is needed to:
 - a) prevent the child or youth from being in placed out of home care, or into a higher level of residential care; or
 - b) address a change in behavior or symptoms that is expected as a child or youth transitions to a home, foster home, or lower level of residential placement.

Information Resources

DMH Information Notices 08-38 and 09-10 provide additional detail and clarification regarding a variety of issues, such as eligibility criteria, Medi-Cal reimbursement, administrative requirements, and training opportunities. The California Department of Social Services (CDSS) has links to these letters available on its website at [CDSS Wraparound](#). In addition, there is a variety of information available on DMH's website at [DMH TBS Information](#). In addition, a Coordination of Care for TBS Best Practices Manual is forthcoming and expected to be available soon. County welfare departments may also be interested in reviewing DMH's data regarding utilization rates for TBS. Data is available statewide and by individual county, however, it is not specific to children in the child welfare system. TBS data is found at [DMH TBS Data](#).

DMH is highly committed to implementing the Nine Point Plan successfully, and providing counties with guidance and support that may lead to increased utilization of TBS. DMH is especially committed to improve TBS service delivery to the foster care population. In addition to receiving services through local county mental health departments, significant numbers of the Emily Q class members are served by Child Welfare, Probation, and the Juvenile Court. As a result, CDSS strongly encourages counties to work with local mental health departments to further align the interagency coordination of services. It is crucial that such coordination take place so that eligible children receive appropriate and timely services.

If you have any questions about this letter, please contact Cheryl Treadwell, Chief, Resources Development and Training Support Bureau at 916-651-6600.

Sincerely,

Original Document Signed By:

LINNÉ STOUT, Chief
Child Protection and Family Support Branch



Appendix 3

LOS ANGELES COUNTY MENTAL HEALTH PLAN SPECIALIZED FOSTER CARE AND TBS LETTER

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director



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MICHAEL D. ANTONOVICH

DEPARTMENT OF MENTAL HEALTH

650 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: (213) 738-2147
FAC (213) 639-1804

<http://dmh.lacounty.gov>

January 14, 2010

Dear Specialized Foster Care Provider:

Your agency is one of over 80 agencies in Los Angeles County that has contracted with the Department of Mental Health (DMH) to provide services related to the Katie A. Settlement Agreement. These programs include Wraparound, Multidisciplinary Assessment Teams (MAT), Intensive In Home Mental Health Services, Intensive Treatment Foster Care, and Basic Mental Health Services. These services are funded primarily through Early Periodic Screening, Diagnosis and Treatment (EPSDT) and are dedicated to children in the care of the Department of Children and Family Services (DCFS). Although the County has made a significant investment to serving foster care children, Specialized Foster Care (SFC) funding has been underutilized due to various challenges. It is critical that these resources are utilized in the most efficient and effective manner to serve as many DCFS involved children as possible.

In an effort to increase the utilization of resources and the services delivered, we will be adding the Basic Enhanced SFC Plan in the Integrated System (IS) to all SFC providers. This will allow our SFC providers flexibility to redirect remaining SFC EPSDT funding for any other mental health services provided to DCFS involved children and families. While we are in support of the flexibility this may provide, there are four important caveats to bear in mind:

1. Your agency must be able to direct SFC funds to the original contracted program as necessary to support the full implementation of the program;
2. Redirected SFC EPSDT funds must be used to serve DCFS involved children and their families;
3. Redirection of SFC funds is limited to EPSDT and does not include any allocations received from DCFS, such as MAT – DCFS, the case rate for Wraparound, or the case rate for Intensive Treatment Foster Care; and
4. You must work with your Lead District Chief to negotiate the funds that you plan to shift between services for the remainder of FY 2009-10 and for FY 2010-11.

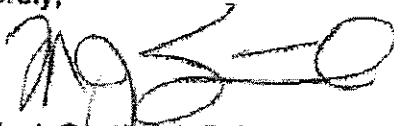
Specialized Foster Care Provider
January 14, 2010
Page 2

We will also be adding the service function code for Therapeutic Behavioral Services (TBS) to all SFC providers for the Wraparound DCFS Plan, the Full Service Partnership Plan and the Basic Enhanced SFC Plan to support expansion of TBS as needed. If you are currently not a certified TBS provider, trainings for TBS certification will be offered in February and March 2010 with details to follow. If you have any questions about TBS, please contact Elizabeth (Betsy) Fitzgerald at (213) 739-2394.

Please contact your Lead District Chief to discuss a plan for redirection that will ensure full implementation of new and expanded programs without any disruption to services.

Thank you for your ongoing commitment to the children of Los Angeles County and support of the multiple Katie A. related initiatives now underway. Should you have any questions, please contact Olivia Celis at (213) 738-2147.

Sincerely,



Marvin J. Southard, D.S.W.
Director of Mental Health

MJS:OC:cb

c: DMH Executive Management Team
DMH District Chiefs

Appendix 4

TBS MARKETING POINTS

Therapeutic Behavioral Services (TBS)

What is TBS? TBS is a unique, short-term intensive intervention that may be included as one component of a comprehensive mental health treatment plan. TBS provides one-to-one support in helping children/youth replace inappropriate behavior with more suitable behavior.

What is the Emily Q settlement? In response to the Emily Q. v. Bonta class action lawsuit settlement, the California Department of Mental Health and local county Mental Health Plan agencies are working to increase utilization of TBS and ensure accessible, effective, and sustained TBS for children and their families in the Emily Q class in California.

Who is eligible for TBS under the Emily Q settlement?

Children and youth under age 21 receiving EPSDT mental health services who:

- are placed in or are being considered for RCL 12 or higher, or
- have received psychiatric hospitalization in the past 24 months, or
- are being considered for psychiatric hospitalization.

TBS can reduce the need for costly high-level group home placement, hospitalization, or incarceration.

Where can TBS be provided?

Family homes, foster homes, group homes, schools, day treatment programs, and many other places.

Who are the key partners in local TBS delivery?

Mental health agencies, child welfare services, juvenile probation, juvenile courts, schools, Court Appointed Special Advocates, service providers, parents, families, foster families—anyone who works with children or youth at risk of high-level placement because of their mental health behavioral needs.

Help increase TBS in your county.

County mental health departments are convening local TBS discussion and planning sessions with an array of agencies and people to discuss four main questions:

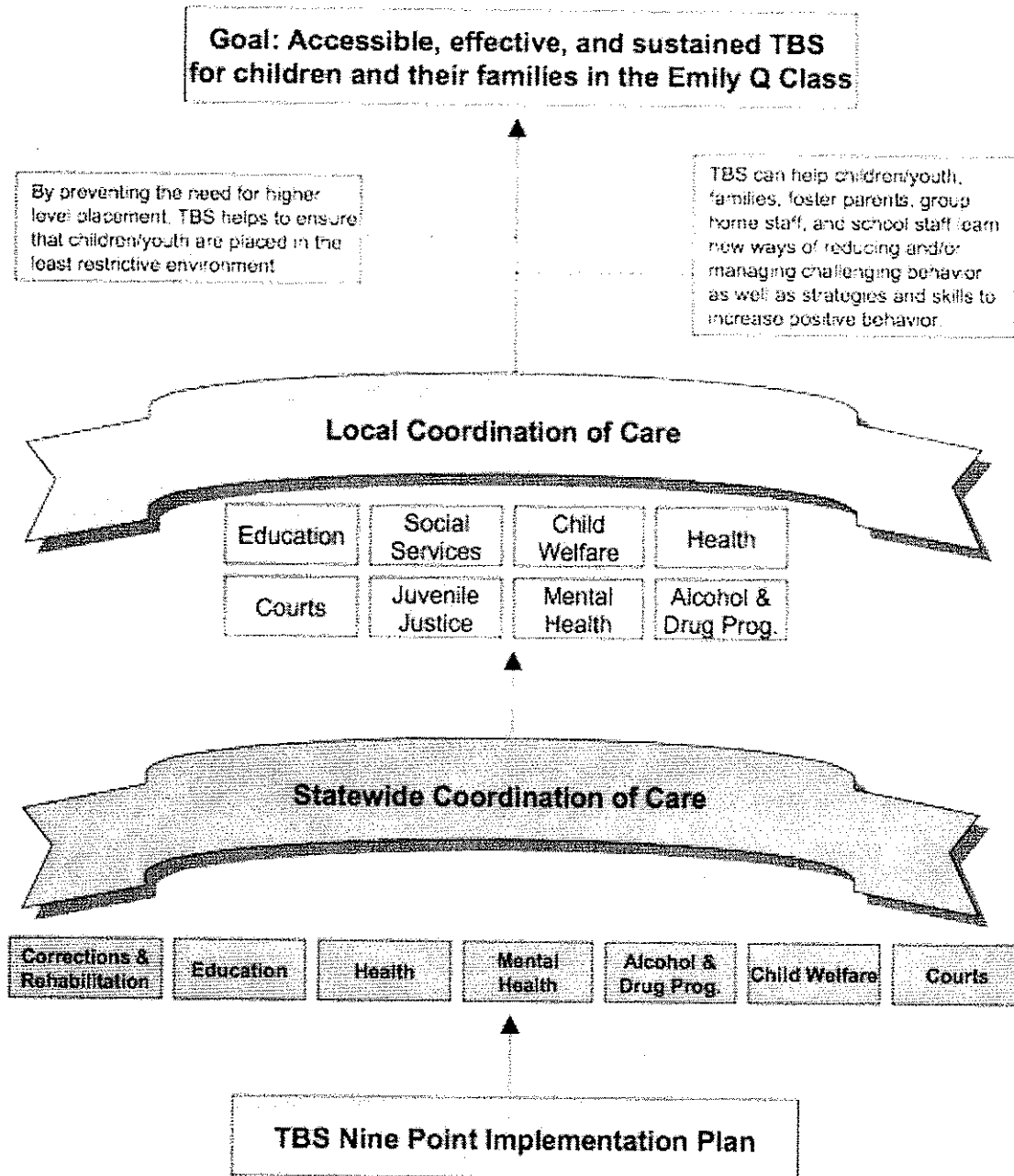
1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?
2. Are the children and youth who get TBS experiencing the intended benefits?
3. What alternatives to TBS are being provided in the county?
4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

CONTACT YOUR COUNTY MENTAL HEALTH DEPARTMENT for more information about TBS and the TBS planning sessions in your county.

For Additional Information: Visit the California Department of Mental Health TBS website at: [http://www.dmh.ca.gov/Services and Programs/Children and Youth/EPSDT.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp)

Prepared by California Department of Mental Health, March 2009

Strategy to Increase Therapeutic Behavioral Services (TBS) utilization in California



Prepared by California Department of Mental Health, March 2009



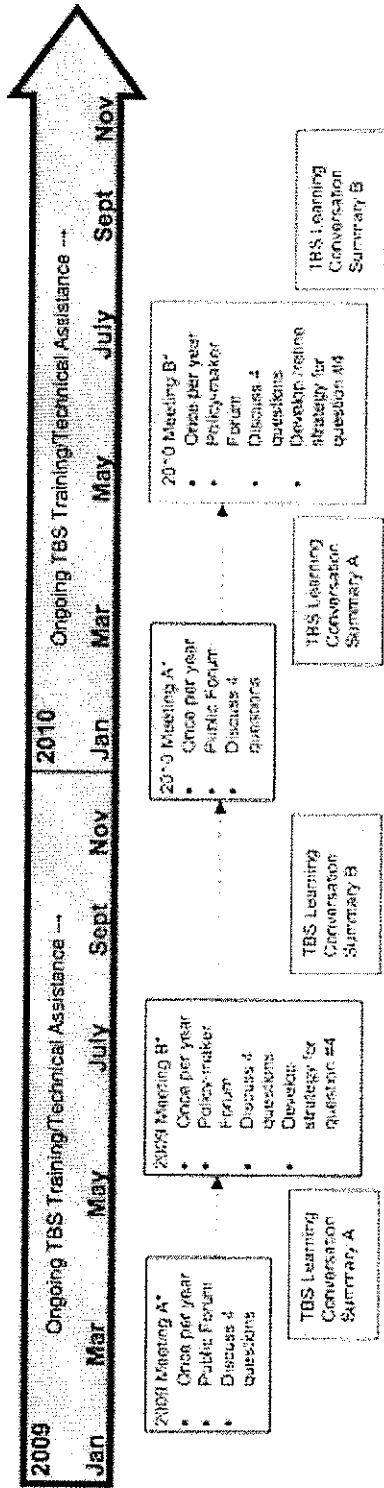
How to prepare for successful Learning Conversations: Statewide Practice and Performance Improvement Structure:

Therapeutic Behavioral Services (TBS) Nine Point Implementation Plan Accountability, Training, and Coordination of Care Process—A County View

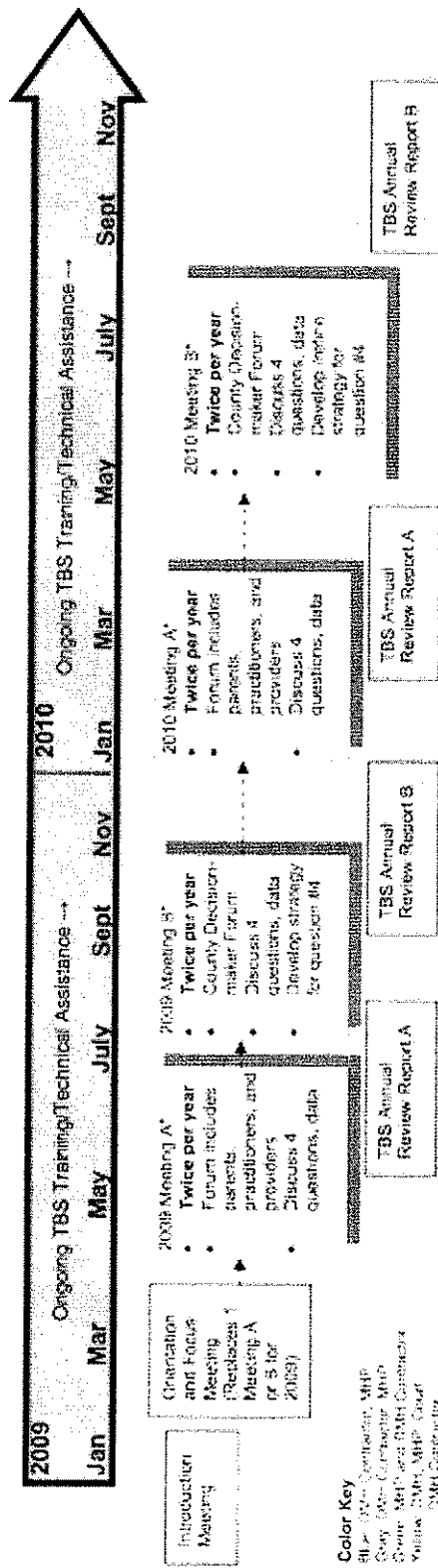
Please refer to Appendix C of the Nine Point Plan for further details.
Appendix C and other TBS-related documents can be found on the DMH TBS website:
http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/PSD/Lastp
DMH will be documenting progress in October 2009 and 2010 reports to the Court and will share with interested parties.



Level I Counties



Level II Counties



Color Key
#1 - 122 - Contra Costa, MHP
#2 - 122 - Contra Costa, MHP
#3 - 122 - Contra Costa, MHP
#4 - 122 - Contra Costa, MHP
#5 - 122 - Contra Costa, MHP
#6 - 122 - Contra Costa, MHP
#7 - 122 - Contra Costa, MHP
#8 - 122 - Contra Costa, MHP
#9 - 122 - Contra Costa, MHP
#10 - 122 - Contra Costa, MHP

*See Background and Meeting Preparation Guidelines on reverse.

Draft, March 2010

- Please review the Nine Point Implementation plan and other important TBS documents posted on the DMH TBS website: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPST.asp.
- Schedule meetings well in advance so that the appropriate policy makers and stakeholders are able to attend.
- Continue and/or expand your current coordination of care efforts with other local partners in TBS delivery who work with youth at risk of high-level placement due to behavioral health needs.
- Think about what actions your county can take to increase access and utilization of TBS by class members.
- As a part of the Statewide Practice and Performance Improvement Structure, Level I and Level II Learning Conversations are designed to bring together public and policy-making stakeholders to consider the following questions:
 1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?
 2. Are the children and youth who get TBS experiencing the intended benefits?
 3. What alternatives to TBS are being provided in the county?
 4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?
- These discussions will inform the TBS Annual Review Report (Level II MHPs) or the TBS Learning Conversation Summary (Level I MHPs) to be generated by the MHP. Report Templates will be posted to the DMH TBS website.
- This process:
 1. ensures TBS are accessible, effective, and sustained as ordered by the court;
 2. includes elements of data review, learning conversations, interagency coordination, and county-state cooperation;
 3. focuses on practice and service coordination rather than compliance and disallowances;
 4. uses a continuous quality improvement process; and
 5. includes outcome and utilization measures.

March 2009



Appendix 6

TBS EQUIVALENT GUIDELINES

Therapeutic Behavioral Services (TBS)

Equivalent/Alternative Certification Guidelines

Purpose: This is designed to assist county Mental Health Plans (MHP) in identifying their proposed services to be considered for certification as a “TBS-equivalent/alternative service” as outlined in the *Emily Q v. Bonta* Exit Plan (April 23, 2009). The Special Master is charged with the review, evaluation, and certification of these services and shall have sole discretion in determining whether these additional programs and services meet the TBS-like criteria. This process is an effort to reasonably account for all mental health services provided by the county MHP that are considered “TBS-like” services. These services will be used as a supplemental utilization rate that will assist counties in attaining the targeted 4% benchmark by June 30, 2012.

Class Eligibility: The TBS-like services must serve the *Emily Q* class. Class eligibility is defined as all current and future beneficiaries of full-scope Medi-Cal below the age of 21 in California who are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs; are being considered for placement in these facilities; or have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

Elements that must exist to be considered a TBS-Equivalent Service:

- Has a time limited focused on specific target goal attainment;
- Has individual treatment planning created with client, family, and treatment team (behavioral health staff, mental health representative, relatives, school personnel, parent partner, therapeutic aid, etc.);
- Establishes clearly defined measurable behaviors that are used to substantiate progress;
- Provides functional analysis of behaviors to understand needs the client is attempting to address in order to teach healthy replacement behaviors and decrease negative behaviors;
- Focuses on one to two behaviors at a time; and
- Has an intensive intervention schedule, with an emphasis on addressing parent/caregiver education and involvement whenever possible.

If counties have mental health services that are believed to be TBS-equivalent, that would assist your MHP in reaching the 4% benchmark, please contact the *Emily Q v. Bonta* Special Master Rick Saletta at rsalpham@sbcglobal.net.

For technical assistance or information regarding TBS or the *Emily Q v. Bonta* Court Orders, please visit http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPST.asp.

EXIT PLAN for the EMILY Q. V BONTA case
Criteria for Performance and Termination of Jurisdiction

“Exit to Success”

Revised April 7, 2009

For the Court to terminate jurisdiction over the Emily Q. case, the California Department of Health Care Services (DHCS) and the California Department of Mental Health (CDMH) must demonstrate that the Nine-Point Plan approved and adopted by the Court on November 14, 2008, has been implemented and that Therapeutic Behavioral Services (TBS) utilization will be both increased and sustained. This requires performance by CDMH, the Mental Health Plan (MHP) counties that contract with CDMH to deliver TBS at the local level, and the Emily Q. Special Master.

Although the parties are in the early stages of implementing the Nine-Point Plan¹ and the effects of this new plan are as yet unknown, the effort needs an exit plan with specific measures that will guide CDMH and the MHPs through December 31, 2010, the proposed date for termination of jurisdiction. It is likely, as information is gathered and experience is gained, that the Emily Q. Settlement Team and the Special Master may submit to the Court for approval, improvements, modifications, and clarifications to this exit plan that will increase the prospects for successful implementation of the Nine-Point Plan.

During the period of this exit plan, oversight will be provided by the Emily Q.

¹ A summary of the Nine Point Plan and the specifics of Points 1 through 8 are set forth as an attachment to the Second Quarterly Report in Response to Court’s Order Appointing Special Master, filed on September 25, 2008 (Docket No. 544).



Settlement Team members, including the Special Master, and by an array of key stakeholders that are being mobilized for this effort including the Accountability Structure Implementation Strategy (ASIS) and Technical Assistance, Communication and Training (TACT) task groups formed by CDMH. To date, the first eight points of the Nine Point Plan have been developed through consensus among the various parties to the settlement. However, some elements of the exit plan that are essential to Point Nine were not developed through consensus, and the Special Master – building on elements where consensus was reached – has stepped forward to propose an exit plan. As the process moves forward, the Special Master encourages all parties to continue to strive for consensus in their understanding of the process and to remain engaged in this collaborative and cooperative effort to ensure that all children in the Emily Q. class who could benefit from TBS are able to receive the appropriate level of services.

The steps outlined in this exit plan meet the Emily Q. Settlement Team criteria that the plan must: be do-able; not let the perfect be the enemy of the good; be within the law and Court Order; increase utilization; decrease disproportionality between MHPs; show evidence of improvement, both quantitative and qualitative; be aligned with the parties' interests; demonstrate simplicity; be sustainable; and result in faster service access.

This exit plan breaks out areas of responsibility for CDMH, the MHPs and the Special Master according to three time periods: January 2009 through December 2010; January 2011 through December 2011; and January 2012 and forward. In brief, this exit plan describes the following:

Activities for the Period January 2009 through December 2010

- Performance Requirements for CDMH
- Performance Requirements for the MHPs
- Performance Requirements for the Special Master
- Small County Strategy
- Corrective Measures and Remedies
- Termination of Jurisdiction by December 2010

Activities for the Period January 2011 through December 2011

- Performance Requirements for CDMH
- Performance Requirements for the MHPs

Activities for the Period January 2012 and Forward

- Corrective Measures and Remedies
- Emerging Trends and Best Practices

For the Period January 2009 through December 2010

This section of the exit plan describes activities that will take place during the period January 2009 through December 2010, and addresses performance requirements for CDMH, the MHPs and the Special Master, along with corrective measures and remedies available to CDMH, and requirements for termination of jurisdiction to occur by December 2010.

Performance Requirements for CDMH – January 2009 through December 2010

CDMH shall be required to complete the following activities prior to termination of jurisdiction in December 2010.



Implement Points One through Eight of the Emily Q. Nine-Point Settlement Plan

CDMH must fully implement Points One through Eight of the TBS Nine-Point Plan, as follows:

1. Reduce administrative barriers to TBS and not replace them with additional barriers;
2. Clarify eligibility for TBS and not confuse eligibility at a later time;
3. Establish an accountability system capable of determining and documenting TBS services by the MHPs;
4. Establish a fidelity performance model for TBS;
5. Develop coordinated linkages with other state agencies that serve TBS class members, especially the California Department of Social Services, Juvenile Justice agencies, and the Administrative Office of the Courts;
6. Develop and implement a comprehensive training program for TBS providers and administrators at the local level;
7. Develop, publish and maintain training manuals consistent with the comprehensive TBS training program; and
8. Develop and implement a TBS outreach effort to children, families, providers and other stakeholders.

Implement Information Notices Regarding TBS

To inform the MHPs and other stakeholders about the Nine-Point Plan and their responsibilities, CDMH shall maintain communication through a series of information notices.

Implement the State TBS “Data Dashboard”

One key element of the Nine-Point Plan is development of a Web-based “data dashboard” that displays the on-going current progress of all 56 MHPs. CDMH

must establish and maintain this on-line data dashboard system.

Document the MHPs' Ability to Answer the Four Key Accountability Questions Identified in Point Three of the Nine Point Plan

Level I and II MHPs are required to convene meetings to discuss the four key questions regarding TBS service delivery in their respective MHPs. Level I MHPs and the Level II MHPs that are not among the ten Level II counties selected for the more intensive process shall convene two meetings per year. The ten Level II MHPs selected for the more intensive process shall convene four meetings per year. (Specific details regarding the types of meetings and required attendees are set forth in Point Three of the Nine Point Plan. For purposes of this exit plan, these meetings will be referred to as the "Local Meetings.") CDMH must ensure that all MHPs conduct these Local Meetings and that MHP answers to the four questions are publicly posted on the Web.

Sustain the ASIS and TACT Groups

CDMH must sustain the ASIS and TACT Groups, including convening monthly meetings of each group and posting meeting minutes on the Web.

Produce an Annual Assessment of MHP TBS Performance in October 2009 and October 2010

CDMH shall provide the Special Master and the public with two annual assessments describing overall implementation of the Nine-Point Plan, including assessment of MHP progress in meeting the performance requirements established in this proposed exit plan. These annual assessments will provide core information to the Special Master for his reports to the Court regarding overall plan progress as well as progress toward termination of jurisdiction.



Performance Requirements for the MHPs – January 2009 through December 2010

The 27 large- and medium-sized MHPs are required to engage in significant effort to fulfill the Court-ordered Nine-Point Plan. This effort will include striving to increase TBS utilization, implementing quality TBS, engaging policy leaders and other key local stakeholder agencies in the TBS effort, engaging with professional staff and contract providers for TBS training, and engaging with local family members and youth who must be involved in the local TBS effort in meaningful and influential ways.

Factors that the Special Master may consider to evaluate and certify MHP performance are outlined below. As new information and findings emerge over the next year through the Emily Q. Settlement Team, ASIS, TACT, and the support contractors hired by CDMH to work directly with the Level II MHPs, the Special Master may consider additional factors to evaluate and certify MHP performance. It is the Special Master's intention, through a consensus approach, to incorporate into the exit process any additional measures that offer direct or proxy indicators of MHP efforts to achieve and sustain the benchmark requirements. When the Special Master is satisfied with an MHP's performance based on the requirements of the Nine Point Plan and this exit plan as well as consideration of any additional factors, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine Point Plan applicable to that MHP. The Special Master shall send a letter to the Director of CDMH and the Director of the MHP informing them that the certification has occurred, and shall also notify the Court. The Special Master shall have discretion to certify an MHP prior to December 2010.

For the five MHPs that have been exempted from Level II because of current high TBS utilization (4% or above), the Special Master shall review their Level I reports and other documentation to ensure their continuing positive performance with TBS. When the Special Master is satisfied with an exempted MHP's performance, he shall notify the Court and send a letter to the Director of CDMH and the Director of the MHP that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

Each MHP that is certified will count toward the percentage of certified MHPs required by this plan for the Court to terminate jurisdiction.

Four Percent Benchmark for TBS Utilization

With this exit plan, the Court establishes a TBS utilization benchmark for the Level II and exempted MHPs of 4% as calculated by the number of children in an MHP receiving TBS divided by the number of children in that MHP who are receiving EPSDT Mental Health services in a given year. This TBS utilization benchmark will apply to the 27 large- and medium-sized MHPs, which represent all 22 Level II MHPs plus the 5 exempted MHPs; together, these 27 MHPs serve approximately 92% of the children who receive EPSDT Mental Health services in the State of California.

Strive to Increase TBS Utilization to the 4% Benchmark

All large- and medium-sized MHPs² are strongly encouraged to achieve the 4%

² The 27 MHPs that are classified as "large- and medium sized" for purposes of the Nine Point Plan are: Los Angeles, San Diego, San Joaquin, Sonoma, Butte, Alameda, San Bernardino, Kern, Monterey, Tulare, Fresno, Marin, Merced, Orange, Placer/Sierra, Riverside, Sacramento,



benchmark. For the Court to terminate jurisdiction by December 31, 2010, two-thirds (18) of the 27 large- and medium-sized MHPs must have reached the 4% TBS delivery threshold. If the Special Master determines that all other requirements are met, the Special Master shall certify an MHP that has achieved the 4% benchmark. If an MHP has met all other requirements, but has not achieved the 4% benchmark, the Special Master shall certify the MHP if the MHP demonstrates to the Special Master that it offers services equivalent to therapeutic behavioral services to Emily Q. class members, and/or demonstrates that the MHP is on a trajectory to achieve the 4% benchmark no later than June 30, 2012. The Special Master shall have discretion to determine whether one or both of these additional criteria will be required in order to certify the MHP, and shall have discretion to look at TBS utilization rates prior to the start of the Nine Point Plan in determining the trajectory. Although being on a trajectory to achieve the 4% benchmark is one avenue for certification, it should be understood that an MHP would have to demonstrate through data and service integrity that certification is appropriate.

The Special Master anticipates that the successful implementation of the Nine-Point Plan will result in, at a minimum, 18 of the 27 certified MHPs achieving the 4% benchmark, and that these MHPs will represent a substantial percentage of all children in California who receive EPSDT Mental Health services. At this time the Special Master will not recommend a fixed percentage of children that must be represented throughout the state. The Special Master will instead wait 12 months and observe the overall impact of the Nine-Point Plan on the utilization benchmark.

San Francisco, San Mateo, Santa Cruz, Solano, Stanislaus, Contra Costa, San Luis Obispo, Santa Barbara, Santa Clara, and Ventura.

At that time it may not be necessary to recommend to the Court a minimum statewide percent of all children in California who receive EPSDT Mental Health services. Special Master Saletta places confidence in the commitment of CDMH, the California Mental Health Directors Association (CMHDA), and the MHPs to fulfill these expectations through the Nine-Point Plan process.

Implement Quality TBS to the Satisfaction of the Special Master

Quality of TBS will be determined by several factors including:

- Fidelity to Point Four of the Nine-Point Plan as a practice standard in the MHP;
- Participation of staff and providers in the TBS training and use of the TBS Manuals described in Points Six and Seven;
- Family and youth participation in the Local Meetings;
- Analysis and documented review of the TBS data dashboard as a required tool in the Local Meetings.

MHPs demonstrate their ability to accurately employ procedure codes, cost reports and CSI data reporting for TBS services.

The Nine-Point Plan includes a streamlined administrative process, which will involve some changes in administrative procedures associated with TBS. MHPs will demonstrate their ability to implement continuing and new procedures to the satisfaction of CDMH.

Engage Other Key Local Stakeholders

The MHP will demonstrate participation of key local stakeholders in the TBS effort, including county Child Welfare Services, Juvenile Probation, the Juvenile Court (dependency and delinquency), and the County Office of Education,



through:

- Stakeholder and policy leaders' attendance at the Local Meetings;
- Increased referrals from these stakeholders of Emily Q. class members for TBS;
- Increased TBS utilization by children referred from other county agencies.

Demonstrate commitment to outreach to, provide TBS training to, and engage with professional staff and contract providers in the MHP.

Outreach to, training of and engagement with professional staff and contract providers will be demonstrated by the following:

- Participation of MHP and contract provider staffs in local TBS trainings;
- Medi-Cal Quality Assurance activities that indicate inclusion of local TBS providers;
- Ad hoc meetings between the MHP and local TBS providers to promote the Nine-Point Plan and improve local TBS efforts.

Demonstrate commitment to outreach to, provide TBS training to, and engage with family members and youth in the MHP.

Outreach to, training of and engagement with family members and youth will be demonstrated by the following:

- Participation of family members and youth in local TBS trainings;
- Medi-Cal Quality Assurance activities that indicate inclusion of family members and youth;
- Ad hoc meetings between the MHP and local family members and youth to promote the Nine-Point Plan and improve local TBS efforts.

Performance Requirements for the Special Master – January 2009 through December 2010

The Special Master assumes oversight obligations in partnership with the various parties, and shall perform the following activities that lead to termination of jurisdiction in December, 2010. As noted above, there are three bases for MHP certification: meeting or exceeding the 4% benchmark, providing TBS and TBS-equivalent services to meet the 4% benchmark, and being on a trajectory to reach the 4% benchmark. The criteria for certification for each of these categories are as follows:

MHPs That Meet or Exceed the 4% Benchmark

The Special Master shall review progress by the 27 large- and medium-sized MHPs toward completing their requirements as described above and as detailed in the Nine Point Plan. Specifically, the Special Master shall determine whether or not an MHP has achieved the 4% utilization benchmark, implemented quality TBS, engaged other key local stakeholders and policy leaders, engaged with professional staff and contract providers, and engaged with local family members and youth as outlined above. When the Special Master is satisfied that an MHP has fulfilled these expectations, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

MHPs That Provide TBS-Equivalent Services to Meet or Exceed the 4% Utilization Benchmark

Some of the 27 large- and medium-sized MHPs may request that the Special Master consider certification based on a combination of TBS and TBS-equivalent services, such as one-to-one behavioral intervention programs that may be part of a



non-Medi-Cal full service partnership funded through the Mental Health Services Act (MHSA) or SB-163 Wraparound, etc., to Emily Q. class members. The Special Master shall determine whether or not a proposed TBS-equivalent service is consistent with the best practice of TBS and, at his discretion, may count class members who receive a TBS equivalent service toward the total number of class members served. If the Special Master is satisfied that an MHP has met the 4 % utilization requirement through some combination of TBS and TBS-equivalent services, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

MHPs That Are on a Trajectory to Reach the 4% Benchmark by June 30, 2012

The Special Master shall work with MHPs to determine whether or not an MHP is on a trajectory to reach the 4% benchmark by June 30, 2012. The Special Master shall review progress by the MHPs toward completing their requirements as described above. Specifically, the Special Master shall determine whether or not an MHP has implemented quality TBS, engaged other key local stakeholders and policy leaders, engaged with professional staff and contract providers, and engaged with local family members and youth as outlined above. In addition to these requirements, the Special Master may take into consideration any or all of the following elements in determining if an MHP is on track to meet the 4% benchmark by June 30, 2012:

- The MHP has demonstrated a significant increase in TBS and/or TBS-equivalent services to Emily Q. class members, and can document that these percentage and numeric increases, if sustained, will reach the 4% benchmark by June 30, 2012. Specifically, and in measurable terms, the MHP must show that the rate of growth achieved during 2009 and 2010 will be sustained and will result in the MHP achieving the 4% benchmark by June 30, 2012.

- The MHP has demonstrated a significant increase in TBS and/or TBS-equivalent services to Emily Q. class members, but the existing percentage and numeric increases in TBS and/or TBS equivalent services will not reach the 4% benchmark by June 30, 2012. In that event, the Special Master may consider whether commitment of additional resources on the part of the MHP will result in increased services, so that the MHP will reach the 4% benchmark by June 30, 2012. The Special Master may consider certification in such a situation, provided the MHP: provides official documentation that adequate and appropriate resources have been committed for this purpose; the MHP demonstrates that the percentage and numeric increases, if sustained, together with the additional resources committed, will allow the MHP to reach the 4% benchmark by June 30, 2012; and the Special Master believes that with the commitment of these additional resources, the MHP will achieve the 4% benchmark by June 30, 2012.
- The MHP has documented budget and contract commitments that will lead to increased TBS or TBS-equivalent services.
- The MHP can demonstrate and document that it is giving class members priority access to TBS or TBS-equivalent services.
- The MHP documents working agreements that have led, will continue to lead, or will lead to an increase in TBS or TBS-equivalent services among county child welfare and probation agencies.

In order to ensure maximum flexibility for the Special Master to certify an MHP based on its trajectory, the Special Master reserves the right to consider additional measures and approaches.

When the Special Master is satisfied that an MHP has met these requirements, and



the other requirements of the Nine Point Plan and this exit plan, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP. Once an MHP is certified, it shall be counted toward the percentage of MHPs required for termination of jurisdiction.

For the five MHPs that have been exempted from Level II because of current high performance, the Special Master shall review their Level I reports, the data dashboards and other documentation to ensure their continuing positive performance with TBS. When the Special Master is satisfied that an MHP has fulfilled these expectations, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

The Special Master shall utilize the CDMH October 2009 Report, experiences and perspective of the Emily Q. Settlement Team, and other factors, to make any necessary recommendations to the Court in January 2010.

Small County Strategy

By February 2010, CDMH, in consultation with CMHDA and the Special Master, shall convene a joint meeting with the 29 Level I small and small/rural county MHPs³ to explore their experience to date with the Emily Q. Settlement Plan and to identify their needs for additional supports and services from CDMH. The goal of this meeting will be to develop, through a consensus approach, a small/rural

³ The 29 small and rural MHPs are: Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Siskiyou, Sutter/Yuba, Tehama, Trinity, Tuolumne, and Yolo.

county-centered strategy to ensure the most appropriate utilization and quality of TBS in those regions. The Special Master shall have discretion to include participation of other appropriate individuals or organizations in this meeting.

Corrective Measures and Remedies

During the period January 1, 2009 through December 31, 2010, corrective measures and remedies will only be exercised for MHPs that are not participating in their respective requirements as outlined in the Nine-Point Plan. These measures and remedies are outlined in the next section of this exit plan.

Termination of Jurisdiction by December 2010

The Special Master shall recommend that the Court terminate jurisdiction when he finds that:

- CDMH has fully implemented Points One through Eight of the Nine-Point Plan; and
- Two-thirds of the large-and medium-sized MHPs (18 MHPs) have been certified by the Special Master as having fulfilled the benchmark requirements, and have established the necessary conditions in the MHP to ensure sustained commitment to utilization, quality, performance, training, and engagement.

For the Period January 2011 through December 2011

Performance Requirements for CDMH – January 2011 through December 2011

Upon termination of jurisdiction (December 31, 2010), CDMH shall assume responsibility for certifying MHPs as having completed their respective requirements as described in the Emily Q. Settlement Plan. CDMH shall maintain



the TBS or TBS-equivalent effort following termination of jurisdiction.

CDMH Support to MHPs that are Making Progress Toward Certification and Certified MHPs on a Trajectory to Reach the 4% Benchmark by June 30, 2012

During 2011, the first year following termination of jurisdiction, CDMH shall provide support to MHPs that are making progress toward certification. CDMH shall also provide support to MHPs that were certified by the Special Master because they were on a trajectory to reach 4% by June 30, 2012, if support is needed to help those MHPs to achieve the 4% benchmark by June 30, 2012. Support provided by CDMH through December 31, 2011, shall include assistance to the MHPs from CDMH's accountability contractor.

CDMH Review of Previously Certified MHPs

In October 2011, CDMH shall review the performance of MHPs that were previously certified by the Special Master. If an MHP that was previously certified because it reached the 4% benchmark or was providing TBS-equivalent services experiences a decline in services that causes it to fall below the 4% benchmark CDMH shall work with the MHP to increase either TBS or TBS-equivalent services to re-achieve the 4% benchmark. If an MHP that was previously certified because it was on a trajectory to reach the 4% benchmark is not making adequate progress to achieve the 4% benchmark by June 30, 2012, CDMH shall work with the MHP and provide support with the goal of bringing the MHP back in line with the expected trajectory. Through December 31, 2011, support to the MHPs described in this paragraph shall include assistance from CDMH's accountability contractor if such assistance is needed to help MHPs re-achieve the 4% benchmark, or to resume progress toward the trajectory to reach the 4% benchmark by June 30, 2012.

Corrective Measures and Remedies

MHPs that were not certified as of December 31, 2010, and are not making progress toward certification as described above during the January 1, 2011 through December 31, 2011 time period shall be subject to corrective measures and/or sanctions. CDMH shall impose an array of appropriate corrective measures including technical assistance and the remedies in the state mental health managed care regulations [Cal. Code of Regs., Tit. 9, § 1810.325, 1810.380 1810.385.], including site visits, Performance Improvement Plans, monitoring, imposition of corrective action plans, withholding Federal Financial Participation revenues, termination of the MHP's managed care contract and civil penalties against the MHP of up to \$5,000.

Review and Revision of the TBS Plan

Following termination of jurisdiction, CDMH, with input from key TBS stakeholders, will review and revise the Nine-Point Plan to sustain and improve TBS utilization, quality, training and engagement as the TBS effort matures in California.

Performance Requirements for the MHPs -- January 2011 through December 2011

For the period January 2011 through December 2011, MHPs that were not certified as of December 31, 2010, and are not making progress toward certification (as described above) during the January 1, 2011 through December 31, 2011 time period shall be subject to corrective measures and remedies as outlined above.



For the Period of January 2012 and Forward

Corrective Measures and Remedies

Beginning January 2012, supports through a CDMH contractor to non-certified MHPs and to those previously certified but who fell below the 4% benchmark or failed to maintain a trajectory to reach the 4% benchmark by June 30, 2012 , (as described above) will end. The only intervention CDMH will offer to non-certified MHPs will be the corrective measures and remedies outlined above.

In the event that an MHP previously certified because it achieved the 4% benchmark or provided TBS-equivalent services reduces its TBS effort (or reduces TBS-equivalent services) such that it falls below the 4% benchmark, reduces the quality of its TBS services, disengages from its local agency partners, or disengages from its family members and youth, CDMH shall impose corrective measures and/or remedies outlined above that CDMH deems appropriate, with the goal of restoring the MHP to its former level of success in TBS.

With respect to MHPs previously certified because they were on a trajectory to reach the 4% benchmark by June 30, 2012, from January 1, 2012 through June 30, 2012, CDMH will continue to provide support and assistance to these MHPs as necessary to assist them in achieving the 4% benchmark by June 30, 2012. In the event that an MHP previously certified because it was on a trajectory to reach the 4% benchmark by June 30, 2012, fails to meet the 4% benchmark by June 30, 2012, reduces the quality of its TBS services, disengages from its local agency partners, or disengages from its family members and youth, CDMH shall impose corrective measures and/or remedies outlined above that CDMH deems appropriate, with the goal of restoring the MHP to its former level of success in

TBS. CDMH shall have discretion to determine which corrective measure(s) and/or remedy(ies) will be imposed.

Emerging Trends and Best Practices

CDMH shall continue to promote and develop TBS to members of the Emily Q. class with the intent of sustaining TBS utilization, quality, partner engagement, and family member and youth participation. It is expected that TBS will be developed and refined as more is learned about successful therapeutic behavioral supports and interventions. With regard to improvements in TBS, CDMH is encouraged to adopt promising trends and new best practices as these emerge, with the intent of continuously improving TBS and TBS-equivalent services to members of the Emily Q. class. It is the intention of this exit plan that CDMH will maintain a competent and effective statewide TBS program from January 2012 into the future that is sufficient to meet the ongoing needs of Emily Q. class children and prevent any recurrence of litigation for failure to serve members of the class.

If a new Medi-Cal behavioral intervention service is approved in the future, and it is determined by CDMH to be an equivalent to TBS that affords children, youth and families the same level of engagement, quality and effectiveness as TBS, CDMH should not be constrained by the post-jurisdiction requirements described above from providing the best possible behavioral services and supports.



Appendix 8

FAMILY AND YOUTH STRATEGY FOR TBS

Therapeutic Behavioral Services (TBS)

Development of the Family and Youth Strategy

CDMH Contact – Kathleen Carter Nishimura
(916) 651-6613

Background: In November 2008, United States Central District Court Judge A. Howard Matz approved a “TBS Nine-Point Plan” that establishes methods and measures to increase access and utilization of Therapeutic Behavioral Services (TBS) in California.

Important themes of the Nine-Point Plan are family and youth involvement and consistent application and awareness of cultural competency practices and services. The TBS Family and Youth Strategy supports implementation of:

- Point 3 – informing about TBS;
- Point 6 – encouraging and empowering family and youth to engage at the local level;
- Point 8 – training and building parent and youth capacity.

The plan was developed through an interest-based decision-making process facilitated by the Court’s Special Master, Richard Saletta, to help resolve the issues of a decade-long lawsuit, *Emily Q v. Bonta*. The California Department of Mental Health (CDMH) continues to support the plan along with its contractors, the California Department of Health Care Services (CDHCS), the *Emily Q* Settlement Team, and a stakeholder-consultant group known as the TBS Accountability, Communications and Training (Super TACT) Team.

In 2009, CDMH recognized a need to promote strategies, identify models, and encourage counties to increase family and youth involvement and cultural competency through the stakeholder and decision-maker reports submitted as a result of the TBS Nine-Point Plan. Consequently, CDMH and the Super TACT Team began discussing various ways to address these needs and support counties and consumers in a productive dialogue and action plan for TBS.

2009–2010 Activities:

- In March 2010, CDMH presented to the Federal Court and public a *TBS County Mental Health Plan 2009 Progress Report*. Two of the applicable program report criteria for the counties in 2009 and 2010 include: 1) convening TBS Stakeholder meetings and 2) convening TBS Decision-Maker meetings. The meetings were evaluated on the content of the reports submitted to CDMH, including family and youth participation.
- Continued CDMH monitoring and offer for technical assistance to support the MHP TBS reports for family and youth Stakeholder and Decision-Maker participation in 2010;
- Development of a family / youth-focused marketing letter to support TBS and the Nine-Point Plan which was distributed to a statewide family partner network and TACT contact list;
- Addition of a “Family & Youth” icon on the CDMH TBS website to ensure materials are available in a user-friendly manner;

- Outreach and education for family and youth members will be a standard component of the CDMH e-newsletters;
- Release and marketing of a TBS Coordination of Care Best Practices Manual with the guidance of consumers, family and youth advocates/organizations;
- Presented at the May 2010 UACF Family Partner breakfast (California Mental Health Advocates for Children and Youth (CHMACY) Annual Conference) about team outreach/recruiting;
- Initiate conversations about creating family/youth action and network groups; and
- Submitted update to the Family and Youth Strategy Workgroup, Super TACT and Emily Q Settlement Team in April 2010 for feedback.

Strategy Development:

The CDMH and Emily Q Settlement Team are developing the "California TBS Family and Youth Strategy" in an effort to increase the meaningful involvement, outreach, and engagement with family and youth members in a culturally competent manner.

In January 2010, CDMH recommended that the Super TACT form a workgroup to develop a family and youth strategy. The goal of the Workgroup discussions was through a consensus approach, to engage family and youth in a culturally competent way to promote the Nine-Point Plan and to improve local TBS efforts.

The TBS Family and Youth Strategy Workgroup convened in February, March, and April 2010 and have developed a framework to design the strategy. CDMH is appreciative for the participation of those who were able to provide input at the April brainstorming meeting. Representatives of the major stakeholder groups have been invited to participate in this Workgroup to plan, develop and execute the release of a strategy.¹

However, the Workgroup identified that in order for the strategy design to be successful and meet the needs of the TBS community, the input and participation from the following mental health consumer and county groups would strengthen the strategies and activities: United Advocates for Children and Families (UACF); National Alliance on Mental Illness (NAMI); the Client Network; County MHPs; California Mental Health Directors' Association (CMHDA); California Welfare Directors' Association (CWDA); and other key stakeholders may include the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, and other specific TBS private providers.

The CDMH is grateful for the support it has received from private providers who have experience working with families and youth and who have invested their expertise and time to help develop this strategy. Cindy Robbins-Roth, Amber Burkan of the California Youth Empowerment Network (CAYEN) and APS Healthcare were very helpful in pulling together their resources to work on the strategy and identifying valuable contacts during our initial spring 2010 meetings.

¹The following stakeholders were represented: Rick Saletta, Special Master; Melinda Bird, Disability Rights California; Amber Burkan, California Youth Empowerment Network (CAYEN); Kathleen Carter Nishimura, CDMH Community Services; David Gray, Facilitator; Troy Konarski, CDMH Community Services; Steve Korosec, Facilitator; Rita McCabe, CDMH Community Services; Mike Reiter, APS; Cindy Robbins-Roth, Parent/Family Partner; Gail Schifsky, CDMH Community Services; Nicette Short, Policy Advocate; Sean Tracy, CDMH Community Services; Melinda Vaughn, DOJ and Barbara Zweig, CDMH Legal Services.



Proposed Workgroup Strategies:

In an effort to address the above mentioned challenges and assist the counties, CDMH is offering this framework for the Family and Youth Strategy which is designed to inform about TBS, encourage and engage at the local levels as partners in TBS, and training and building parent and youth capacity in all aspects of TBS. The proposed strategies include:

- Information and Communication
- Engaging with Parents and Parent Organizations
- Partnering with Other Service Agencies
- Family, Youth and MHP Training
- Evaluation

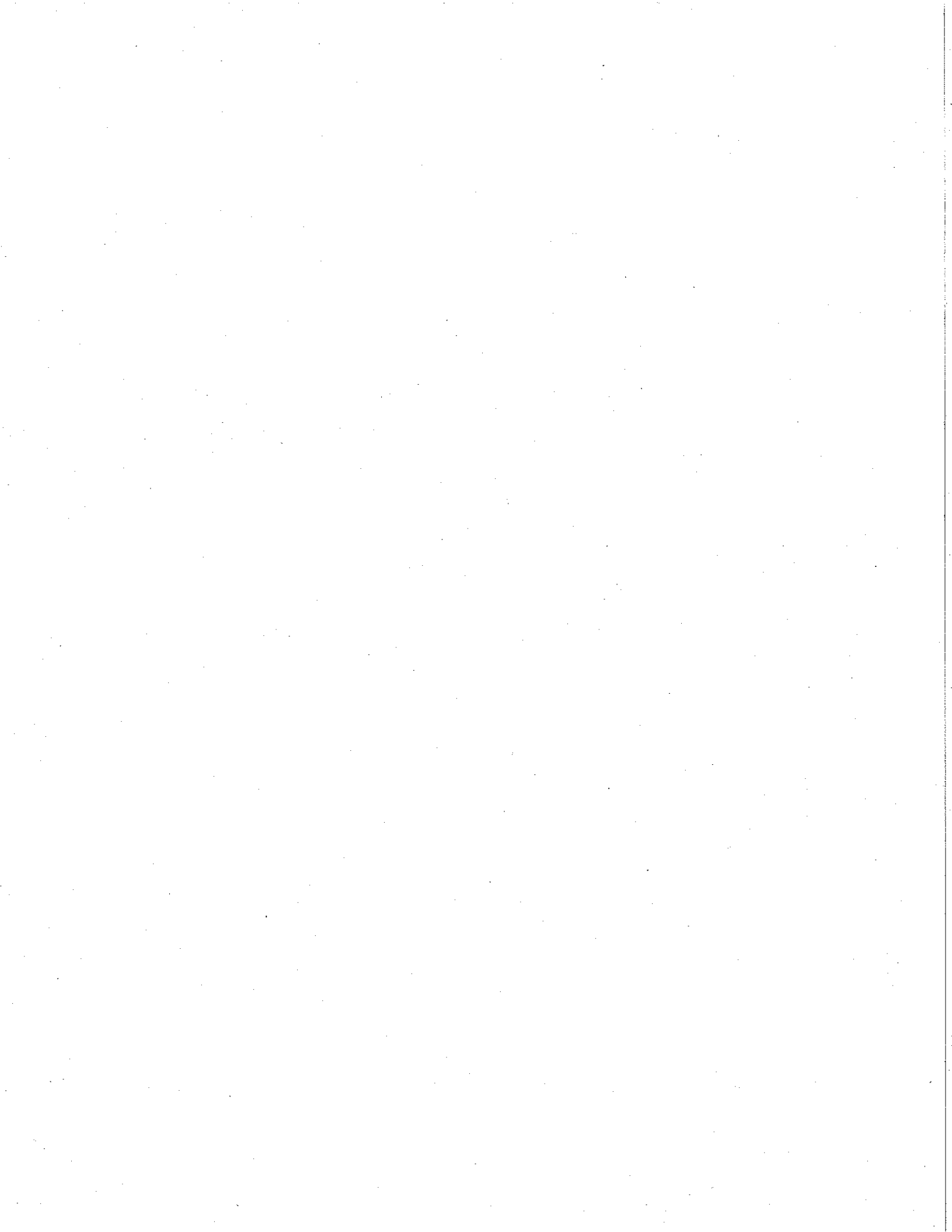
Next Steps:

In order for CDMH to finalize and implement the strategy, the next steps could include:

- Holding additional Workgroup meetings in Summer 2010 to develop the strategy and further engage key family and youth stakeholders to participate provide input to the strategies;
- Proposing the final draft strategy at the August 2010 Super TACT and Emily Q Settlement Team meetings;
- Releasing the strategy to the public and implement, as appropriate; and
- Providing a report to the Federal Court about Points 3, 6 and 8 of the Nine-Point Plan by or in December 2010.

Contact Information:

If you are interested in participating or learning more about this strategy, please contact Kathleen Carter Nishimura at Kathleen.Carter@dmh.ca.gov or (916) 651-6613.



California Department of Mental Health



Service Function CODE (SFC)58

THERAPEUTIC BEHAVIORAL SERVICES (TBS) DOCUMENTATION MANUAL

CODE 58

By
California State Department of Mental Health

October 2009

Version 2.0

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What is Service Function Code (SFC) 58?

All direct and indirect TBS services should be recorded as Mode 15, Service Function Code (SFC) 58. For more information about Code 58 and which TBS activities should be recorded as Code 58, please refer to page 19 of the documentation manual.



Found throughout the documentation manual, this symbol is intended to draw attention to important information regarding TBS assessment and documentation.

Service Function CODE (SFC) 58

CHAPTER 1

Forward

To bring the *Emily Q. v Bonta* case to a successful conclusion, the Federal Court in Los Angeles appointed a Special Master to ensure that the members of the certified *Emily Q* Class have increased access to and utilization of Therapeutic Behavioral Services (TBS).

The Special Master and the *Emily Q* Settlement Team worked collaboratively in the development of the court approved plan. This Settlement Team consists of the Department of Mental Health (DMH) and California Department of Health Care Services (DHCS) staff, defendant's and plaintiffs' counsels, a local mental health plan director, a mental health director's association executive, a private sector TBS provider, and a family/youth representative. Together, this Settlement Team developed a "Nine-Point Plan" to increase access and utilization to TBS. The Court issued an order approving the Nine-Point Plan on November 14, 2008.

To support the implementation of the Nine-Point Plan, the DMH issued Information Notices 08-38, 09-10, a TBS specific webpage and the creation of the TBS Accountability Communications and Training (TACT) committee.

Point 9 of the Nine-Point Plan (Exit Strategy) explicitly states that each MHP has the responsibility to "demonstrate their ability to accurately employ procedure codes, cost reports and CSI data reporting for TBS services." This TBS documentation manual will be instrumental in helping MHPs and TBS providers meet the Court's expectations of success in providing and documenting TBS.

Implementation of the Nine-Point Plan began in January 2009 with the issuance of Information Notice 08-38. This comprehensive plan requires that DMH produce two technical assistance manuals: one on TBS best practices and one on chart documentation. Settlement Team members determined that the TBS documentation manual was a critical element in increasing access to and utilization of TBS for class members. DMH contracted with the California Institute for Mental Health (CiMH) to assist in the development of the training and technical assistance components of the Plan. This document is a result of the collaborative work among the parties involved in *California Department of Mental Health (DMH)*

the *Emily Q* Settlement process.

Introduction

This TBS Documentation manual is supplemental to the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Chart Documentation Manual and replaces the TBS section of that manual. This documentation manual is intended to instruct counties/provider-agencies on how to document and claim Medi-Cal appropriately when providing TBS. It will also serve as a training tool for DMH Program Compliance staff and their audit contractors to assist local agencies and their contract providers.

In all cases, the reader should defer to California Code of Regulations (CCR), Title 9; Federal requirements; Mental Health Plan (MHP) contractual requirements, and applicable MHP policies and procedures. The MHP has the authority to administer and authorize services according to program and organizational needs that may require additional standards and other requirements that are not covered in this manual. (Welfare & Institution Code §14680 - §14684).

***NOTE:** Point 1 of the Nine Point Plan significantly reduces and streamlines administrative requirements that may have been barriers to TBS access and utilization. For a complete list of these changes please refer to DMH Information Notice 08-38 at: http://www.dmh.ca.gov/DMHDocs/2008_Notices.asp.

Included with this documentation manual are Appendices 1-5 that provide information on the provision of TBS that may assist MHPs in meeting their responsibilities under the Court's approved Exit Strategy.

This Documentation Manual will be maintained by DMH and reviewed and updated as needed. The most recent version of this document can be found on the DMH webpage at [http://www.dmh.ca.gov/Services and Programs/Children and Youth/EPSDT.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp)

Acknowledgements

DMH would like to acknowledge the following groups and organizations for their dedication and efforts resulting in this documentation manual:

California Department of Mental Health (DMH)

The Emily Q Settlement Team

The TBS Accountability, Communications, and Training (TACT) Team

California Institute of Mental Health

CHAPTER 2 - THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Therapeutic Behavioral Services (TBS)

Definition

Therapeutic Behavioral Services (TBS) are *supplemental* specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Title 9, California Code of Regulations (CCR), Section 1810.215 states, "EPSDT supplemental specialty mental health services" means those services defined in Title 22, [CCR] Section 51184, that are "provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter."

TBS is an intensive, individualized, one-to-one behavioral mental health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs.

A "Specialty Mental Health Service" must be one of the following as defined by California Code of Regulations:

- (a) Rehabilitative Mental Health Services, including:
 - (1) Mental health services;
 - (2) Medication support services;
 - (3) Day treatment intensive;

California Department of Mental Health (DMH)

- (4) Day rehabilitation;
- (5) Crisis intervention;
- (6) Crisis stabilization;
- (7) Adult residential treatment services;
- (8) Crisis residential treatment services;
- (9) Psychiatric health facility services;
- (b) Psychiatric Inpatient Hospital Services;
- (c) Targeted Case Management*;
- (d) Psychiatrist Services;
- (e) Psychologist Services;
- (f) EPSDT Supplemental Specialty Mental Health Services; and
- (g) Psychiatric Nursing Facility Services.

***NOTE:** Targeted Case Management is recognized as a Specialty Mental Health Service. Targeted Case Management is defined as services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

TBS in conjunction with a Specialty Mental Health Service can help children/youth and parents/caregivers, foster parents, group home staff, and school staff or others to learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kinds of behavior that will allow children/youth to be successful in their current environment.

TBS can be provided anywhere in the community: at home, school, other places such as after-school programs and organized recreation program, except during lock-outs (see appendix 7).

***NOTE:** TBS is not appropriate for "suicide watch" consisting solely of supervision.

ELIGIBILITY

Eligibility for TBS Services is based on Medical Necessity and Class Certification. Each of the required criteria must be supported and substantiated by documentation.

*Appendix 1 includes a “TBS Assessment/Eligibility Flowchart.” The TBS Assessment/Eligibility Flowchart will aid the clinician/organization in determining the clinical appropriateness and need for TBS services.

Establishing Medical Necessity

Medical necessity criteria must be met for reimbursement of specialty mental health services through the Medi-Cal Program. For medical necessity to be met there must first be a diagnosis identified in the California Code of Regulations (CCR), Title 9, Chapter 11, 1830.205 (see Appendix 2). A detailed description of these diagnoses may be found in the Diagnostic and Statistical Manual of Mental Disorders, (DSM), published by the American Psychiatric Association. In addition for medical necessity to be met there must be impairment as a result of the mental disorder, an intervention that addresses the impairment, and there must be an expectation that the intervention would significantly diminish the impairment or prevent deterioration, or allow for individually appropriate developmental progress (see Appendix 2).

Specific criteria for medical necessity for MHP specialty mental health services reimbursement for eligible beneficiaries under 21 years of age are identified in CCR, Title 9, Chapter 11, 1830.210 (see Appendix 2).

All components of the medical necessity criteria stated above must be met and clearly documented in the record for reimbursement through the Medi-Cal Program.

TBS Class Criteria

In addition to meeting medical necessity criteria, TBS recipients must also meet “class criteria.” The class criteria defines a certified class of children and youth who are eligible for TBS services. The following is a description of the certified class.

- Child/Youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; or
- Child/Youth is being considered by the county for placement in a facility described above; or
- Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; or
- Child/Youth has previously received TBS while a member of the certified class; or
- Child/Youth is at risk of psychiatric hospitalization.

A child/youth meets the requirements of “**at risk of**” hospitalization in an acute care psychiatric facility when hospitalization is *one option* (not necessarily the only option) being considered as part of a set of possible solutions to address the child’s needs. Additionally, a child meets the requirements when his or her behavior *could result in hospitalization* in such a facility if the facility were actually available, regardless of whether an inpatient psychiatric facility is available.


A child/youth meets the requirements of “**being considered for**” placement in an RCL 12 or above when an RCL 12 or above placement is one option (not necessarily the only option) that is being considered as part of a set of possible solutions to address the child’s needs. In addition, a child meets the requirements when his or her behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available.

CHAPTER 3 - DOCUMENTATION STANDARDS

TBS Assessments

Documentation standards for client care are identified in the contract between DMH and the MHP. These are the minimum standards to support Medi-Cal claims for the delivery of services. All of the standards must be addressed in the client record; however, there is no requirement that the records have a specific document or section addressing these topics. For children/youth or certain other clients unable to give a history, this information may be obtained from parents/caregivers. The TBS Assessment should establish Medical Necessity for TBS by evaluating the child/youth's current behavior (presenting problem/impairment) and documenting the following:

- (1) How the behavior causes a significant impairment in an important area of life functioning,
- (2) A reasonable probability of significant deterioration in an important area of life functioning without TBS services, or
- (3) A reasonable probability that the child/youth would not progress developmentally as individually appropriate without TBS services.

 The following elements are required documentation components in order to substantiate medical necessity for mental health services. TBS assessments can be separate, or part of a more comprehensive assessment.

- Presenting problem: Documentation of the client's chief behavioral impairment, history of the presenting problem(s), including current level of functioning, and current family information including relevant family history.
- Psychological Factors: Documentation of relevant conditions and psychosocial factors affecting the client's physical health and mental health, including living situation, educational/vocational situation, daily

activities, social support, cultural and linguistic factors, and history of trauma.

- **Mental Health History**: Documentation of mental health history and previous mental health treatment: providers, therapeutic modality, (e.g., medications, psychosocial treatments) and response. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
- **Medical History**: Documentation of the complete, relevant medical history and physical health conditions reported by the child/youth or parent/caregiver. Include the name, address and current phone number of current source of medical treatment.
 - **Note**: All appropriate Releases of Information forms should be completed prior to communication with other treatment providers.
- **Prenatal**: Documentation of the prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
- **Medication**: Documentation about medications the client has received or is receiving to treat medical conditions, including duration of medical treatment. Documentation of allergies or adverse reactions to medications, etc.
- **Substance exposure/Substance use**: Documentation of past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over-the-counter, and illicit drugs.
- **Strengths**: Documentation of client strengths that may be utilized in strategies for achieving client treatment plan goals.
- **Risks**: Documentation of special status situations that present a risk to client or others, including past or current trauma.

- Mental status examination
- Diagnosis: A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-9 code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.
- Any additional relevant clarifying formulation information.

TBS Assessment Documentation

 **In addition to the minimum components listed above, the TBS assessment must identify the following:**

- Medical Necessity: Documentation must be comprehensive enough to identify that the child or youth meets the medical necessity criteria specifically for the provision of TBS services.
- Medi-Cal Eligibility: Documentation must state that the child/youth is a full-scope Medi-Cal beneficiary under 21 years of age.
- Member Eligibility: Documentation must note that the child/youth is a member of the certified class; that the child/youth is receiving other specialty mental health services; and that the child or youth has specific behaviors that require TBS.
- Targeted Behavior(s): Documentation must identify the specific behaviors that jeopardize continuation of the current residential placement or put the child at risk for psychiatric hospitalization or the specific behaviors that are expected to interfere with a plan to transition to a lower level of residential placement.

- Clinical Judgment: Documentation must include sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement, or to successfully transition to a lower level of residential placement; and that TBS can be expected to provide a level of intervention necessary to stabilize the child/youth in the existing placement.
- Behavior Modification: Documentation should identify observable and measureable changes and indicate when TBS services have been successful and could be reduced or terminated.
- Adaptive Behaviors: Documentation should note identified skills and positive adaptive behaviors that the child/youth uses to manage the problem behavior and/or uses in other circumstances that could replace the specified problem behaviors.

Initial and on-going TBS assessments may be included as part of an overall assessment of a child or youth's mental health needs or may be a separate document specifically establishing whether initial/ongoing TBS is needed.

TBS Plans of Care/Client Plans

TBS client plans can be either separate plans or part of a more comprehensive plan. The TBS client plan provides clinical direction for short-term intervention(s) to address specific behaviors of the child/youth that were identified in the TBS assessment. Interventions that directly address the behaviors identified during the assessment process are the key component necessary to developing an effective TBS client plan. Interventions may be modified over time based on the degree of effectiveness of the intervention strategy and the child/youth's changing behaviors and needs.

TBS client plans provide a detailed description of the treatment including behavior modification strategies for the child/youth.

TBS client plans should document the following:

- Targeted Behaviors: Clearly identified specific behaviors that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.
- Plan Goals: Specific, observable quantifiable goals tied to the targeted behaviors.
- Benchmarks: The objectives that are met as the child/youth progresses towards achieving client plan goals.
- Interventions: Proposed intervention(s) that will significantly diminish the targeted behaviors.
 - A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
 - A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
 - A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving expected results.
- Transition Plan: A transition plan that describes the method the treatment team will use to decide how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks have been reached or when reasonable progress towards goals/benchmarks is not occurring and, in the clinical judgment of the treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills and strategies to provide continuity of care when TBS is discontinued.

- Transitional Age Youth (TAY): As necessary, includes a plan for transition to adult services when the beneficiary is no longer eligible for TBS and will need continued services. This plan addresses assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

If the beneficiary is between 18 and 21 years of age, include notes regarding any special considerations that should be taken into account.

- Signature: A signature (or electronic equivalent) of, at least, one of the following:
 - A clinician who developed the care plan or is providing the service(s)*
 - A clinician representing the MHP providing the service

*If the above person providing the service is not licensed or waived, a co-signature from a physician, licensed/waivered psychologist, licensed/registered social worker, or a licensed or registered marriage and family therapist is required.

- Evidence of the child/youth's degree of participation and agreement with the client plan as evidenced by the child/youth's or legal guardian's signature. If child/youth or legal guardian is unavailable or refuses to sign the client plan, a written explanation in the progress notes why the signature could not be obtained.
- Evidence that a copy of the Client Plan was provided to the child/youth or parent/caregiver upon request.

***NOTE:** TBS Client Plan updates should document the following: any significant changes in the child or youth's environment since the initial TBS Client Plan; and if TBS interventions tried to-date have not been effective and the child/youth is not making progress as expected towards identified goals. In this situation, there must be documentation indicating that the provider has considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective. A TBS Client Plan update is an addendum to the initial TBS Client Plan and is not a progress note.

TBS Assessments and Plans With Other Intensive Services

TBS assessments and services can be provided in conjunction with an intensive program, such as Day Treatment or Residential Treatment; however, medical necessity for TBS must be documented and should reflect that TBS is not being provided solely for the convenience of the Day Treatment or Residential Treatment program staff, that TBS does not supplant existing program staff requirements, and that the staff providing TBS are not staff counted in the other program's staffing ratios.

***NOTE:** Although TBS can be provided in a Day Treatment setting, TBS services can only be claimed for the actual amount of time that the TBS coach spends actively implementing the TBS Plan. Additionally, the child/youth must be present in the day treatment program for at least 50 percent of the time for the provider to claim the day treatment day or half-day. If the child's behavior requires the TBS coach to intervene to the extent that the child is unable to participate in the Day Treatment Program for a minimum of 50 percent of the day, Day Treatment hours cannot be claimed.

TBS to support transition to Lower Level of Care

TBS may be appropriate for transitioning a child/youth to a lower level of care (step-down) from an inpatient or residential treatment setting when specific target behavior(s) or symptom(s) prevent, or can be expected to jeopardize, that step-down. Planned interventions must focus on the specific target behaviors identified in the assessment.

30-Day Unplanned TBS Contact Documentation

The MHP may conditionally authorize/approve the provision of TBS for a maximum of 30 calendar days when class membership cannot be established for a child/youth. This may be done:

- Up to 30 days or until class membership is established, whichever comes first; and
- When the child/youth presents with urgent or emergency conditions that jeopardize his/her current living arrangement.

Documentation must include evidence that TBS was medically necessary and the most appropriate level of service available to address the child/youth's mental health condition.

Inpatient TBS Assessments

TBS Assessment and Planning While the Child/Youth is in a Psychiatric Inpatient Unit, an Inpatient Unit at a Psychiatric Health Facility (PHF), an Institute for Mental Disease (IMD), or Juvenile Detention Facility for Transition to a Lower Level of Care Utilizing TBS

Although a child/youth currently placed in an IMD, juvenile detention facility (unless evidence that the court has ordered placement in a group home or other non-institutional setting), or an acute inpatient facility is not eligible to receive TBS while in these settings, TBS eligibility can be established and TBS can be planned. However, such planning activities are not Medi-Cal reimbursable, except upon the day of admission. In such cases, the MHP is responsible for determining and assuring there is documentation of: 1) the child/youth's Medi-Cal eligibility upon discharge; and 2) the child/youth's eligibility for County Mental Health Plan (MHP) services upon discharge. If the MHP determines that the child/youth is eligible for Medi-Cal services upon discharge and that TBS are appropriate, the MHP must ensure that the services are available upon discharge. See appendix 7 for more details.

***NOTE:** TBS (code 58) is only reimbursable on days of admission to Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services reimbursed by Medi-Cal.

TBS Progress Note Documentation

TBS Progress notes should clearly document the occurrence of the specific behaviors that threaten the stability of the current placement or interfere with the transition to a lower level of residential placement, and which are the result of the covered mental health diagnosis, and the interventions provided to ameliorate those behaviors/symptoms.

Progress Note Guidelines

For the substantiation of all mental health services it is critical to maintain documentation that is **clear, concise and succinct**.



All TBS Progress notes should include the following:

- **DATE:** The date of service must be documented for all services rendered.
- **LEGIBILITY:** Charting must be legible, including the legibility of provider's signature and professional credentialing.
- **INTERVENTION:** Each progress note must document key clinical decisions and interventions that are directed to the TBS goals of the child/youth.
 - Documentation must reflect interventions that are consistent with the TBS client plan.
 - Documentation must identify clinical interventions provided that are


designed to change or eliminate maladaptive behaviors and increase adaptive behaviors (not provided solely for the convenience of the family or other caregivers, physician, teacher, or staff).

- Documentation must focus on identified target behaviors.
 - Documentation must identify child/youth's receptivity/response to interventions.
 - TBS documentation should not address conditions that are not part of the identified child/youth's mental health condition.
-
- **SIGNATURE:** A signature (or electronic equivalent) of the staff providing the service, including their clinical license, professional degree, or job title (if staff member is licensed, clinical license, such as LCSW, MD, MFT, etc., must be included).

 - **TIMELINESS/FREQUENCY:** Records should include a corresponding note for every TBS service contact including, but not limited to:
 - Direct one-to-one TBS service
 - TBS Assessment and/or Reassessment
 - TBS Collateral contact (see CCR Title 9 Section 1810.206)
 - TBS Plan of Care/Client Plan or its documented review/updates

***NOTE:** Progress notes must include a comprehensive summary covering the time TBS services were provided, but need not document every minute of service time.

TBS Service Function Codes (SFC 58)

 All direct and indirect TBS services should be recorded as **Mode 15, Service Function Code (SFC) 58**. The following descriptors further clarify what TBS activities should be recorded and documented under SFC 58. (Note: In some counties Code H 2019 is the crosswalk code that links to SFC 58.)

The following are billable TBS (SFC 58) services:

TBS INTERVENTION: A TBS intervention is defined as an individualized *one-to-one* behavioral assistance intervention to accomplish outcomes specifically outlined in the written TBS treatment plan.

A TBS intervention can be provided either through face-to-face interaction or by telephone; however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time. (See Appendix 8 – Reasons for Recoupment)

TBS COLLATERAL: A TBS collateral service activity is an activity provided to significant support persons in the child/youth's life, rather than to the child/youth. The documentation of collateral service activities must indicate clearly that the overall goal of collateral service activities is to help improve, maintain, and restore the child/youth's mental health status through interaction with the significant support person.

***NOTE:** Not all contacts with a significant support person will qualify as a TBS Collateral contact; it is important to distinguish TBS Collateral contacts from Case Management service contacts.

TBS ASSESSMENT: A TBS assessment service activity is an activity conducted by a provider to assess a child/youth's current problem presentation, maladaptive at risk behaviors that require TBS, member class inclusion criteria, and clinical need for TBS services. Periodic re-assessments for continued medical necessity and clinical need for TBS should also be recorded under this service function.

TBS PLANS: TBS Plans of Care/Client Plan service activities include the preparation and development of a TBS care plan. Activities that would qualify under this service function code include, but are not limited to:

- Preparing Client Plans
- Reviewing Client Plan (Reimbursable only if review results in documented modifications to the Client Plan)
- Updating Client Plan

- Discussion with others to coordinate development of a child/youth's Client Plan (excludes supervision). (Reimbursable only if discussion results in documented modifications to the Client Plan.)

CHAPTER 4 - SERVICES NOT ALLOWABLE

TBS is not allowable when:

1. Services are solely:
 - For the convenience of the family or other caregivers, physician, or teacher;
 - To provide supervision or to assure compliance with terms and conditions of probation;
 - To ensure the child/youth's physical safety or the safety of others, e.g., suicide watch;
 - To address behaviors that are not a result of the child/youth's mental health condition; or
 - For supervision or to assure compliance with terms and conditions of probation.
2. The children/youth can sustain non-impulsive self directed behavior, handle themselves appropriately in social situations with peers, and appropriately handle transitions during the day.
3. The child/youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.
4. The children/youth is currently admitted on an inpatient psychiatric hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program.
5. On-Call Time for the staff person providing TBS (note, this is different from "non-treatment" time with staff who are physically "present and available" to provide intervention – only the time spent actually providing the intervention is a billable expense).

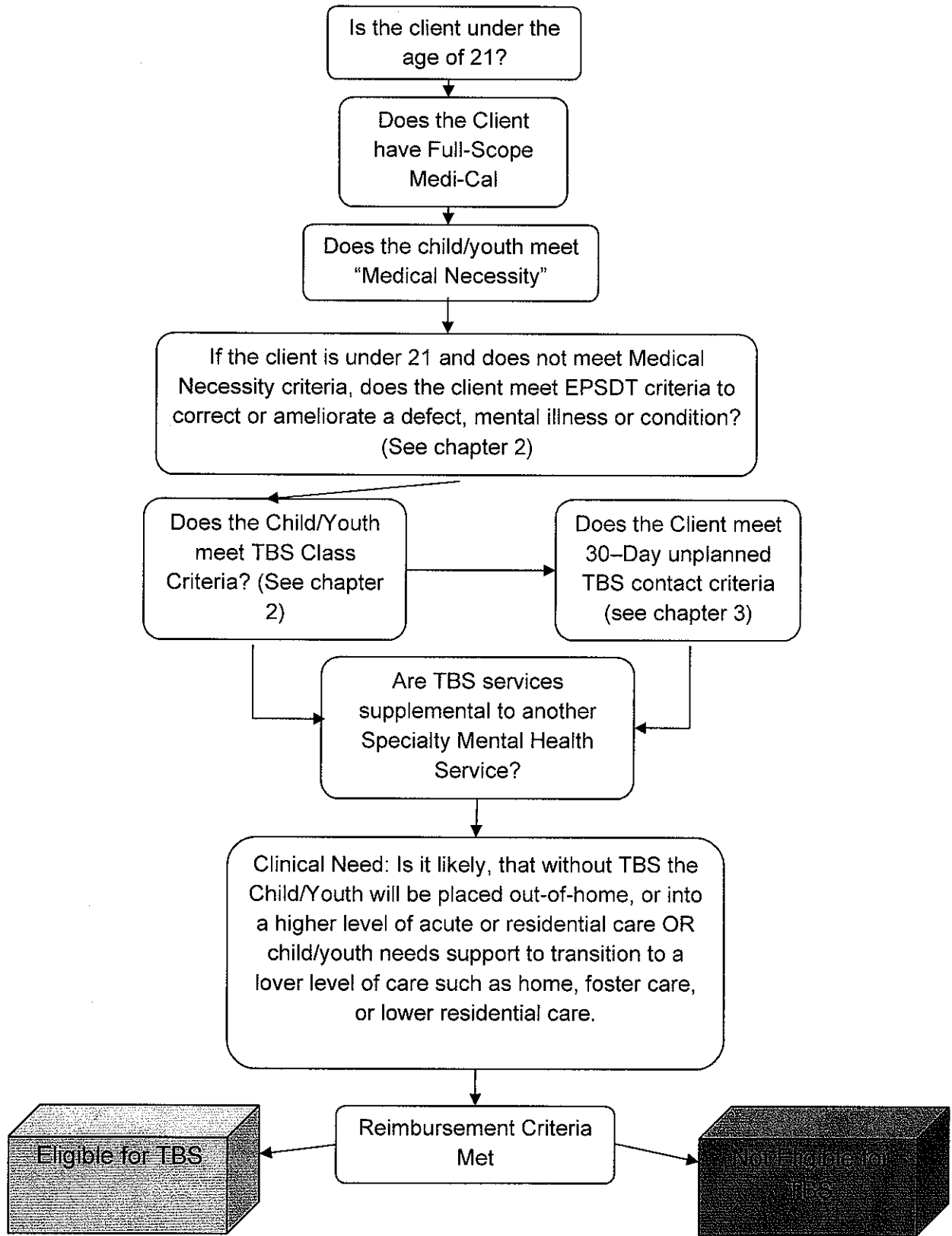
6. The TBS staff provides services to a different child/youth during the time period authorized for TBS.
7. Transporting a child or youth. (Accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances).
8. TBS supplants the child or youth's other mental health services provided by other mental health staff.

Service Function CODE 58

APPENDIX 1 – TBS FLOWCHART

TBS Assessment/Eligibility Flowchart

To provide a “quick” start for TBS service eligibility, the following TBS Required Criteria Flowchart will aid the clinician/organization in determining the clinical appropriateness and need for TBS services. A “yes” response allows you to move down the flowchart.



APPENDIX 2 – MEDICAL NECESSITY

MEDICAL NECESSITY CRITERIA

CCR §1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services

- (a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under the Subchapter, except as specifically provided.

- (b) The beneficiary must meet criteria outlined in Subsections(1),(2),(3) below to be eligible for services:
 - (1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:
 - (A) Pervasive Developmental Disorders, except Autistic Disorders
 - (B) Disruptive Behavior and Attention Deficit Disorders
 - (C) Feeding and Eating Disorders of Infancy and Early Childhood
 - (D) Elimination Disorders
 - (E) Other Disorders of Infancy, Childhood, or Adolescence
 - (F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
 - (G) Mood Disorders, except Mood Disorders due to a General Medical Condition

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- (H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- (I) Somatoform Disorders
- (J) Factitious Disorders
- (K) Dissociative Disorders
- (L) Paraphilias
- (M) Gender Identity Disorder
- (N) Eating Disorder
- (O) Impulse Control Disorders Not Elsewhere Classified
- (P) Adjustment Disorders
- (Q) Personality Disorders, Excluding Antisocial Personality Disorder
- (R) Medication-Induced Movement Disorders related to other included diagnoses

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

- (A) A significant impairment in an important area of life functions.
- (B) A reasonable probability of significant deterioration in an important area of life functioning.

- (C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

- (A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.
 - (B) The expectation is that proposed intervention will:
 - 1. Significantly diminish the impairment, or
 - 2. Prevent significant deterioration in an important area of life functioning, or
 - 3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
 - 4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).
 - (C) The condition would not be responsive to physical health care based treatment.
- (c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

CCR 1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

- (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
- (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
- (3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in *T.L. v. Belshé*.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

APPENDIX 3 – TBS CHECKLIST

Item	Criteria	Additional Criteria	YES	NO
1	Under the Age of 21?			
2	Full Scope Medi-Cal?			
3	Principal Diagnosis is an included DSM IV-TR/ICD-9 diagnosis (see List)	This included Principal Diagnosis is the focus of treatment		
4	As a result of the included diagnosis, the child/youth must have, at least, one of the following criteria:	Significant impairment in an important area of life functioning.		
		A probability of significant deterioration in an important area of life functioning		
		A probability that the child will not progress developmentally as individually appropriate		
5	Additionally, the child/youth must meet the following intervention criteria:	Focus of proposed intervention is to address the condition identified		
6	The proposed mental health intervention will do, at least, one of the following:	Significantly diminish the impairment		
		Prevent significant deterioration in an important area of life functioning.		
		Allow the child to progress developmentally as individually appropriate.		

<p>7</p>	<p>If the client is under 21 years of age and does not meet the above Medical Necessity criteria, the client is eligible under EPSDT when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition.</p>			
<p>8 a. OR</p>	<p>Meets Class Inclusion Criteria currently or must have previously received TBS while a member of the certified class....OR</p>	<p>Either currently placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs (not necessarily the only option)</p>		
		<p>Are being considered for placement in these facilities; (child/youth behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available) or</p>		
		<p>Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; (child/youth behavior could result in psychiatric hospitalization in such a facility if the facility were actually available, regardless of whether hospitalization is available)</p>		

Item	Criteria	Additional Criteria	YES	NO
8 b.	<p>Class Inclusion Criteria cannot be established for a child/youth</p>	<p>Maximum 30 Day Unplanned Contact</p>		
		<p>Child/youth presents with urgent or emergency conditions to address his/her behaviors, and</p>		
		<p>Those behaviors jeopardize his/her current living arrangement, and</p>		
		<p>The MHP determines that TBS would be an appropriate intervention, and</p>		
<p>Documentation includes evidence that TBS was medically necessary and the most appropriate level of service available to address the child/youth’s mental health condition.</p>				
9	<p>TBS is supplemental to other specialty mental health services</p>	<p>Child/youth is receiving other specialty mental health services</p>		
10	<p>Clinical Need Criteria: If the clinical judgment of the mental health provider indicates that it is highly likely that without the additional short-term support of TBS that:</p>	<p>The child/youth will need to be placed out-of-home, or into a higher level of residential care, including acute care, because of the child/youth’s behaviors or symptoms which jeopardize continued placement in the current facility; “acute care” includes acute psychiatric hospital inpatient services, psychiatric health facility services, and crisis residential treatment services or;</p>		
		<p>The child/youth needs this additional support to transition to a home or foster home or lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS are needed to stabilize the child/youth in the new environment. The MHP or its provider must document the basis for the expectation that the behavior or symptoms will change.</p>		

11	Reimbursement Criteria: TBS Is <u>NOT</u> provided for any of the following:	-for the convenience of the family or other caregivers, physician, or teacher.		
		-for supervision or to assure compliance with terms and conditions of probation.		
		-to ensure the child/youth’s physical safety or the safety of others (e.g. suicide watch).		
		-to address conditions that are not a part of the child’s mental health condition.		
		-for children/youth who can sustain non-impulsive, self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day.		
		-for children/youth who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision; or when the beneficiary is an inpatient of a hospital, psychiatric health facility, nursing facility, Institutions for Mental Diseases (IMD), or crisis residential program.		

APPENDIX 4 – REIMBURSEMENT REQUIREMENTS

Reimbursement Requirements for TBS

Contact and Site Requirements

The person providing TBS is typically available on-site to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written treatment plan.

TBS must be provided by: Licensed Practitioner of the Healing Arts (LPHA), a registered/waiver LPHA or trained staff members who are under the direction of a LPHA. The type and breadth of training will be determined by the MHP.

The person providing TBS services should be trained in functional behavioral analysis with an emphasis on positive behavioral interventions.

Claiming Unit

The Claiming unit is the time of the person delivering the service in minutes of time. TBS designated time periods may vary in length and may be up to 24 hours a day, depending upon the needs of the child/youth.

Reporting and Recording (TBS)

MHPs should use mode 15 and service function code 58 for all TBS related service time to allow DMH to track utilization.

APPENDIX 5 – NON REIMBURSABLE ACTIVITIES

Non-Reimbursable Services/Activities: Trends recorded by DMH

The following table illustrates the most frequently reported TBS services that were determined to be non-reimbursable services/activities:

Type of Non-reimbursable service/activity	Fiscal Year 04/05	Fiscal Year 05/06	Fiscal Year 06/07	Fiscal Year 07/08	Fiscal Year 08/09
<p>Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in Section 1830.205(b)(1)(A-R), the child/youth has, at least, one of the following impairments:</p> <ul style="list-style-type: none"> ➤ A significant impairment in an important area of life functioning ➤ A probability of significant deterioration in an important area of life functioning ➤ A probability the child will not progress developmentally as individually appropriate <p>For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate</p>	X	X	X	X	X
<p>Initial plan was not completed within time period specified in MHP's documentation guidelines, or, lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.</p>			X	X	X
<p>No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with DMH.</p>	X	X			X
<p>No progress note was found for service claimed.</p>	X	X	X	X	X
<p>The time claimed was greater than the time documented.</p>			X	X	
<p>The progress note indicates the service provided was solely clerical.</p>	X	X		X	

APPENDIX 6 – FACTORS TO CONSIDER

Factors to consider: Common Causes for Disallowance and Possible Solutions

The six most common reasons for disallowance can be addressed by the MHP and providers.

The number one reason for recoupment is the absence of progress notes. Although it is predicted this issue may be resolved with technical innovations, such as the migration to an electronic health record, in the meantime providers should consider the development of in-house checks and utilization management reviews to assure that all claims are supported by a documented record filed in the correct chart.

The second most frequently encountered reason for recoupment is the lack of documented medical necessity. Staff training should emphasize the requirement of a thorough assessment that documents how the child/youth's targeted behaviors are tied to an included diagnosis and functional impairment. This clinical formulation would inform the TBS Plan of Care/Client Plan with specific interventions addressing the targeted behaviors and reflected in the service delivery progress notes that substantiate need and intervention activities.

Issues surrounding "time claimed was greater than the time documented" fall into two different areas of concern. The first is a technical error: the time entered in the chart was on the wrong date or the time recorded on the physical progress note was entered incorrectly into the claiming system. This type of error will also be reduced or corrected with the introduction of an electronic health record and diligent utilization management review and cross-checking claims against the physical record. The second area of concern, is that the time claimed is not justified by the documentation provided can be addressed by staff training that should include training on documentation standards that support and substantiate the TBS service provided and claimed. Additional staff supervision and internal reviews can also decrease this reason for recoupment.

The lack of documentation for the absence of caregiver or client's participation in the Plan of Care/Client plan and not completing a plan of care within the time allotted can

either be technically or clinically driven. Staff should be reminded to document how the client participated in the development and implementation and due diligence should be taken in obtaining evidence of the client's agreement or participation in their own client plans of care. Solutions may include a "tickler" or "flagged" file at the front of the chart for those documents requiring additional attention (such as signatures, attestations or acknowledgements); staff can be trained to refer to the tickler file each time they open the chart for items requiring follow-up or immediate attention.

The remaining reason for recoupment, i.e., the claiming of a service that was solely clerical/administrative activities can also be addressed with staff training and reminders that clerical activities are not reimbursable. Examples of non-reimbursable activities include, but are not limited to: copying or faxing charts, collating or filing, mailing out appointment reminders, leaving voicemail messages, writing discharge summaries, etc.

The checklist in appendix 3 may be useful in assuring the criteria for reimbursement are met.

APPENDIX 7 – LOCK OUTS

Lock-outs (TBS)

TBS Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission to the facility.

TBS Service (and any other service) are not reimbursable on days when the child/youth resided in a setting where the client was ineligible for FFP, e.g., Institute for Mental Disease (IMD), juvenile hall (unless there is evidence that the court has ordered placement in a group home or other non-institutional setting), jail or other similar settings).

Because Crisis Stabilization is an all inclusive service, TBS Services are not reimbursable when provided during the same time period that Crisis Stabilization – Emergency Room or Crisis Stabilization – Urgent Care services that are reimbursed by Medi-Cal.

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APPENDIX 8 – REASONS FOR RECOUPMENT

The Department of Mental Health produces an annual document titled “*Reasons for Recoupment*” illustrating the specific parameters for possible recoupment penalties, as well as the associated references to California Code of Regulations. You can find the 2008-2009 list of ‘reasons for recoupment’ at the following location.

http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-22_Enclosure2.pdf

APPENDIX 9 – ADDITIONAL INFORMATION

Websites:

The following public websites are available for easy access to additional relevant information and resources.

California Department of Mental Health (DMH) – EPSDT and TBS

[http://www.dmh.ca.gov/Services and Programs/Children and Youth/EPSTDT.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSTDT.asp)

DMH County Administrators and Providers

[http://www.dmh.ca.gov/Services and Programs/Medi Cal/docs/Contacts/1-StatewideTBSPProviderRoster.pdf](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/docs/Contacts/1-StatewideTBSPProviderRoster.pdf)

<http://www.dmh.ca.gov/docs/CMHDA.pdf>

APPENDIX 10 – CODE REFERENCES

Code References

The following Regulations, Laws and Citations are arranged alphabetically according to the Regulation Area/Topic.

California Code of Regulations

Title 9 (Quick Reference Index) Regulation or Law	Title	Code Section (§)	Regulation Area/Topic
California Code of Regulations	9	§1810.204	Assessment
California Code of Regulations	9	§1810.205	Beneficiary
California Code of Regulations	9	§1810.206	Collateral
California Code of Regulations	9	§1810.209	Crisis Intervention
California Code of Regulations	9	§1810.210	Crisis Stabilization
California Code of Regulations	9	§1810.211	Cultural Competence
California Code of Regulations	9	§1810.212	Day Rehabilitation
California Code of Regulations	9	§1810.213	Day Treatment Intensive
California Code of Regulations	9	§1810.215	EPSDT Supplemental Specialty Mental Health Services (i.e., Therapeutic Behavioral Services-TBS)
California Code of Regulations	9	§625	(Licensed Clinical) Social Worker [LCSW]

Title 9 (Quick Reference Index) Regulation or Law	Title	Code Section (§)	Regulation Area/Topic
Code of Federal Regulations	42	§440.130	(Licensed Practitioner of the Healing Arts) [LPHA] Diagnostic, screening, preventative, and rehabilitative services
California Code of Regulations	9	§ 626	Marriage and Family Therapist (formally Marriage, Family and Child Counselor) [MFT]
California Code of Regulations	9	§1830.205	Medical Necessity Criteria for MHP Reimbursement Of Specialty Mental Health Services
California Code of Regulations	9	§1830.210	Medical Necessity Criteria for MHP Reimbursement for Specialty MHS for Eligible Beneficiaries Under 21 Years of Age
California Health & Safety Code	N/A	§123105(b)	Medical Record
California Code of Regulations	9	§1810.225	Medication Support Services
California Code of Regulations	9	§1810.226	Mental Health Plan
California Code of Regulations	9	§1810.227	Mental Health Services
California Code of Regulations	9	§630	Mental Health Rehabilitation Specialist

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Regulation/Law	Title	Code Section (§)	Regulation Area/Topic
California Code of Regulations	9	§1840.312	Non-Reimbursable Services
California Code of Regulations	9	§1810.231	Organizational Provider
California Code of Regulations	9	§1810.232	Plan Development
California Code of Regulations	9	§623	Psychiatrist
California Code of Regulations	9	§624	Psychologist
California Code of Regulations	9	§1810.243	Rehabilitation
California Code of Regulations	9	§782.44	Registered Nurse
California Code of Regulations	9	§1810.247	Specialty Mental Health Services
California Code of Regulations	9	§1810.246.1	Significant Support Person
California Code of Regulations	9	§1810.380 & §1810.385	State Oversight & Civil Penalties
California Code of Regulations	9	§1810.249	Targeted Case Management
California Code of Regulations	9	§1810.250	Therapy
California Code of Regulations	9	§1810.254	Waivered/Registered Professional (LPHA)

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APPENDIX 11 – SAMPLE PROGRESS NOTES

***NOTE:** Sample Progress notes are not intended to be a template for TBS Progress note documentation and should not be used as a ‘one size fits all’ method of TBS documentation. These notes simply outline the necessary features required in a TBS progress note. The *Suggested Enhancements* are simply other recommended ways to make the progress notes more comprehensive and descriptive for optimum documentation standards.

Individual Service : xxxxxxxx		Medical Record	xxxxxxx			
EXAMPLE 1: Represents an adequate note with suggested enhancements.		Service Date	xx/xx/xxxx			
Provider:		Location	Field			
Procedure:	Therapeutic Behavioral Services	Number of client(s)	1			
Client						
Name of Clinician		Staff Time	2	HR	55	Min(s)

GOAL/REASON FOR SERVICE:

TBS initial treatment meeting to present and explain TBS services to family, establish target behavioral goals, establish client’s crisis plan, gather background information relevant to the development and implementation of client’s behavioral plan, and discuss frequency of visits and fade-out plan. Face-to-face time, travel time, and documentation time included. Present at meeting: TBS Clinical Supervisor, TBS Specialist Care Coordinator, and client’s foster mother. Target Behavior Goal #1: Increase anger management skills to decrease aggression, so that verbal aggression (screaming, tantrums, crying, threatening) occur no more than 5x’s per day, and physical aggression (kicking, hitting, throwing objects,

slamming doors) occurs no more than 5x's per week over the next 30 days.
Target Behavior Goal #2: To increase communication skills to decrease non-compliance so that non-compliance occurs no more than 10x's per day over the next 30 days.

INTERVENTION/CLINICAL DECISION

Specialist focused on gathering information regarding client's interests in order to formulate interventions that will engage client in services. Specialist then explained possible future TBS interventions designed to assist client in goal attainment including: coping skills, development of system of rewards and consequences, coaching, and parent meetings. Specialist also reviewed mandated reporting laws and identified client's crisis plan before ending visit. Specialist thanked mother for her participation in TBS services, and scheduled first observation and assessment visit at school on 5-27-09. The team agreed that the TBS specialist will meet with client at school and at home as target behaviors were present in both environments.

Suggested Enhancements: To make this a stronger note, the TBS specialist should describe the information gathered regarding the client's interests. The TBS specialist should also indicate how the information gathered will be utilized in the formulation of the treatment interventions. The information gathered may be included in the Client Plan. It would be helpful if additional detail were available within the note to determine whether the information was utilized appropriately—or whether the time billed is commensurate with the amount of information obtained.

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Individual Service : xxxxxxxx		Medical Record	xxxxxxx			
PROGRESS NOTE: EXAMPLE 2 : Represents an adequate note with suggested enhancements		Service Date	xx/xx/xxxx			
Provider:		Location	Home			
Procedure:	Therapeutic Behavioral Services	Number of client(s)	1			
Child						
Name of Clinician		Staff Time	1	HR	45	Min(s)

GOAL/REASON FOR SERVICE

TBS scheduled in-home client visit with Specialist. Face-to face time, travel time, and documentation time included. Target Behavior Goal #1: To increase self-soothing skills to decrease unsafe behaviors (cutting, scratching people’s name in arm, running away) so that client will have 0 incidents of unsafe/self-injurious behaviors over next 30 days.

INTERVENTIONS/CLINICAL DECISIONS

TBS arrived for scheduled visit and was greeted by client. Client completed tracking chart and reported 1 incident of unsafe/self-injurious behaviors over the past 3 days. Specialist utilized open-ended questions to gather more information regarding client’s report. Client shared she started to scratch her boyfriend’s name in her arm but stopped after thinking about consequences to her actions, including moving down level system in group home. Client further shared she was able to speak with group staff to ask for help. Specialist highlighted client’s increased ability to link her actions with outcomes she does not want, and verbally praised client for making positive choice to utilized coping skill of asking for help and sharing her feelings. Specialist then facilitated discussion to explore possible triggers to client’s target behaviors. Client shared she was sad that she would not see her boyfriend for one week. Specialist provided client with supportive environment by actively listening and validating her feelings.

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Specialist and client then identified positive coping skills she can use when faced with similar situation where she feels sad including reading, writing poetry, and drawing. Specialist verbally praised client for visit Specialist checked-in with group home staff regarding client's report. Staff identified knowing about incident and highlighted client's increased ability to ask for help when having urge to engage in unsafe/self-injurious behavior.

Suggested Enhancements: It would be helpful if the TBS specialist would document whether the client had a significant history of self-injurious behavior.

NOTE: TBS is not appropriate for "suicide watch" consisting solely of supervision. TBS can be utilized to assist a child /youth, who is not actively suicidal or at imminent risk of self-harm, with behavioral interventions identifying, increasing and supporting his/her coping skills.

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EXAMPLE 3: Represents an adequate note with suggested enhancements.		Medical Record	xxxxxxx			
Child:		Service Date	x/xx/xxxx			
Provider:		Location	Home			
Procedure:	Therapeutic Behavioral service	Number of client(s)	1			
Name of Clinician:		Staff Time	2	hr(s)		Min(s)

GOAL/REASON FOR SERVICE

TBS scheduled home visit with TBS Specialist. Creation of feeling log, face to face time, documentation time, travel time included. Goals: Target Behavior #1: Increase compliance with house rules and parental expectations so that client has at least one day per week, where client can follow house rules (such as yelling, name-calling, and not being able to “keep hands and feet to self”. Target Behavior #2: Increase self-soothing coping skill to decrease self-injurious tantrums so that tantrums occur no more than 1 time per week over next 30 days.

INTERVENTIONS/CLINICAL DECISIONS

Upon specialist arrival client was available for home visit. Client’s mood was sad as evidence by client’s expression and body posture. Client stated she didn’t want to do any TBS activities and only wanted to play. Specialist then implemented open ended questions to assess client’s mood and possible triggers to client’s mood.

Client stated she didn’t want to talk about it. Specialist provided client with the option of doing outside activities. Client was open to engage in outdoor activities. Specialist validated client’s feelings of being upset and client’s choice of not wanting to talk about it. Specialist then presented client with a feeling log and prompted client to utilize to the log to identify the different feelings client felt throughout the day. Specialist encouraged client to use the feeling log on her own to assist in feeling identification and informed client she would receive

reinforcement for utilizing the log. Client was receptive to the intervention. Specialist then coached client to utilize self soothing coping skill of playing a game. Client was receptive to specialist's suggestion and agreed to play a game. At the end of game specialist implemented open-ended questions to assist client with self awareness of feelings before and after playing game. Client was able to respond that she was upset before playing the game and she felt better after the game was over and was not upset. Specialist reinforced client's response and encouraged client to utilize such coping skills when experiencing similar feelings. Specialist then ended visit by coaching client to utilize feeling log. Client was able to identify her feelings for the day on the log including feeling sad, smart, and happy. Specialist reinforced client's participation in the day's session.

Suggested Enhancement: It would be helpful if the TBS specialist identified what kinds of outside activities were used in order to facilitate a discussion with the client. This note demonstrates how the TBS specialist used flexibility (allowing client to engage in outdoor activities) as a means of introducing an intervention (use of game as self-soothing behavior, recommendation regarding use of "feeling log").

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Individual Service : xxxxxxxx		Medical Record	xxxxxxx			
EXAMPLE 4: Represents an adequate note with suggested enhancements.		Service Date	xx/xx/xxxx			
Provider:		Location	Home			
Procedure:	Therapeutic Behavioral Services	Number of client(s)	1			
Client						
Name of clinician		Staff Time	1	HR	40	Min(s)

GOAL/REASON for SERVICE

TBS scheduled home visit with TBS Specialist. Face to face time, documentation time, travel time included. Goals: Target Behavior #1: Increase compliance with house rules and parental expectations sot that client has at least one hour each day (when with family) where client can follow house rules (such as yelling, name-calling, and not being able to “keep hands and feet to self). Target Behavior #2: Increase self-soothing coping skills to decrease self-injurious tantrums so that tantrums occur no more than 2 times per week over 1st 30 days.

INTERVENTIONS/CLINICAL DECISIONS

Plan Development

Before scheduled home visit specialist met with Asst. Clinical Supervisor, to engage in plan development. Caregiver and child participated in plan development. Antecedents to behavior, information gathered during observations and assessment visits, parenting skills of parents, and the formulation of various TBS interventions were discussed. Interventions to include trigger and coping skill development and rehearsal, emotion regulation exercises, feeling identification, trigger identification (thoughts and body), assertiveness and communication training, impulse control skills (stop-think-choose), token economy reinforcement system, parent education and support, coaching and training, self soothing techniques, relaxation training (deep breathing, cognitive restructuring), mood tracking, coping strategies training (including replacement

phrases for negative self-talk), strength based interventions, self-esteem coaching and activities, parent training: (e.g. positive activity scheduling) and problem solving. Discussion with the clinical supervisor resulted in the modification of the client plan.

Home Visit:

Upon arrival client was open to meet as evidenced by verbal feedback. Specialist noticed client's tracking chart had a number of stickers indicating that client has been doing well with Target behavior goals: Specialist praised client's ability to earn stickers by meeting TBS goals. Specialist then engaged client in an art activity to assist client with feeling identification. Specialist prompted client to draw lines that she associated with feelings such as happy, sad, excited, etc. Client was able to appropriately draw line for each feeling. Specialist then engaged client in another art activity to assist client with decreasing self injurious tantrums. Specialist prompted client to list a number of positive self statements. Client was able to appropriately identify positive statement such as "I'm happy, I'm friendly and I'm Cool." Specialist reinforced client's participation in the day's session with an art activity.

Suggested Enhancements: It would be helpful if the TBS specialist identified and documented the specifics of the information gathered during the observation and assessment visit and how the information was used to modify the client plan.

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Individual Service : xxxxxxxx		Medical Record	xxxxxxx			
EXAMPLE 5: Represents a note with suggested enhancements.		Service Date	xx/x/xxxx			
Provider:		Location	Field			
Procedure:	Therapeutic Behavioral Services	Number of client(s)	1			
Client						
Name of clinician		Staff Time	1	HR	30	Min(s)

GOAL/REASON for SERVICE

TBS scheduled home visit with TBS Specialist. Face to face time, documentation time, travel time included. Goals: Target Behavior #1: Increase problem-solving skills to decrease opposition to classroom expectations (not following directives, arguing back, not staying in seat, making inappropriate noise, etc) so that client has no more than 4 referrals and 0 suspensions due to his opposition over the next 30 days. Target Behavior #2: Increase anger management skills to decrease aggression (hitting, punching, cussing, spitting, calling names, harassment) so that the client has at least 5 days a week w/out aggression over the next 30 days.

INTERVENTIONS/CLINICAL DECISIONS

Middle School Principal spoke to TBS specialist before client’s scheduled home visit to update on client’s behaviors. As evidenced by principal’s verbal report, client did not meet target behavior goal #1. Out of 2 days tracked, client received 1 referral and 1 suspension from school for engaging in oppositional behaviors. The opposition included, making inappropriate noises, not staying in seat, arguing back and not following directives.

TBS SPECIALIST MET WITH CLIENT FOR HOME VISIT. Upon TBS arrival client’s mood was calm as evidenced by a relaxed facial expression. Client greeted TBS specialist and sat down to join the session. Specialist facilitated

discussion receiving an update on client's progress. As evidenced by client's classroom expectations tracking chart and father's verbal report, client did not meet target behavior goal #1 as follows. Out of 2 days tracked, client received 1 referral and 1 suspension from school. As evidenced by client's aggression tracking chart and father's verbal report client did not meet target behavior goal #2 as follows. Out of 4 days tracked client had 3 incidents of aggression (e.g. hitting and name-calling). To aid client with target behavior #2 specialist then implemented open-ended questions to facilitate client identifying his compliance or lack of compliance with client's system of rewards and consequences. As evidenced by client's verbal report, client was not complying with the consequences established for his aggression. Specialist reviewed the behavioral expectations tied to his system of rewards and consequences (e.g. client will lose privileges for 1 week if he does not comply with the consequences established for his aggression; if client does not give his phone to his father, TBS will no longer reinforce client with phone cards). As evidenced by client's verbal report, client understood the behavioral expectations but was not willing to give up his phone. Specialist acknowledged client's choice and informed him that TBS would no longer reinforce him with phone cards. As evidenced by client's verbal report, client accepted the consequence implemented by specialist. At the end of the visit, specialist reinforced father's participation with services.

Suggested Enhancements: In this case the TBS specialist and client should be encouraged to review the goals and objectives of the client plan together and discuss why the identified goals and objectives were not met.

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