

MEDI-CAL MANUAL

For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries

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CALIFORNIA
DEPARTMENT OF
SOCIAL SERVICES



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If you have questions regarding obtaining ICC, IHBS, or TFC for an eligible child or youth, please contact your County Mental Health Plan (MHP). A list of County MHP's toll free numbers can be located at:

<http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx>

You also may contact the Mental Health Services Division, at the Department of Health Care Services (DHCS), at (916) 322-7445, or email your questions to DHCS at: KatieA@dhcs.ca.gov.

In addition, you may email your questions to the California Department of Social Services (CDSS) at: CWSCoordination@dss.ca.gov.

CHAPTER 1: PURPOSE AND BACKGROUND

PURPOSE

The purpose of this manual is to provide Mental Health Plans (MHPs), Medi-Cal providers, children and youth, families, county representatives, and other stakeholders with information regarding Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Specialty Mental Health Services (SMHS) service activities provided through the Therapeutic Foster Care service model (referred to as “TFC” hereinafter). These services are available, when medically necessary, to correct or ameliorate defects and mental illnesses or conditions through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

This benefit is available to beneficiaries, up to age of 21, who are eligible for full scope Medi-Cal (42 U.S.C. § 1396a (a) (43) and 42 U.S.C. § 1396d (r)).

This manual provides information and guidelines for the delivery and billing of ICC, IHBS, and TFC. Please note that MHPs and providers should continue to provide other existing SMHS to children and youth, when medically necessary.

In addition to this manual, other federal and state documents related to the delivery of SMHS in the State of California should be consulted to obtain more information on SMHS. These documents include, but are not limited to:

- Federal Medicaid [laws](#) and [regulations](#)
- [California Code of Regulations \(CCR\), Title 9, Division 1, Chapter 11,](#)
- [California Medicaid State Plan,](#)
- [DHCS contract with MHPs,](#)
- [DHCS/CDSS Core Practice Model \(CPM\) Guide¹;](#)

[DHCS Mental Health Substance Use Disorder Services \(MHSUDS\) Information Notices](#), as well as former [Department of Mental Health Policy Letters](#) and [Department of Mental Health Information Notices](#).

This manual will be maintained by DHCS and reviewed and updated, as needed. The most recent version of this manual can be found on the [DHCS Katie A. webpage](#). Any questions concerning the information contained in this manual should be directed to: KatieA@dhcs.ca.gov.

¹ As of January 2018, a draft of the ICPM is being finalized.

BACKGROUND

SPECIALTY MENTAL HEALTH SERVICES (SMHS)

California administers a Section 1915 (b) Freedom of Choice Waiver for SMHS, using a managed care model of service delivery. DHCS operates and oversees this waiver, and contracts with county MHPs for the provision of SMHS. Each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries (children, youth, and adults) who meet medical necessity criteria.

The following is a list of available SMHS (see the glossary for descriptions):

- Mental Health Services,
- Crisis Intervention Services,
- Crisis Stabilization Services,
- Day Treatment Intensive Services,
- Day Rehabilitation Services,
- Adult Residential Services,
- Crisis Residential Services,
- Medication Support Services,
- Psychiatric Health Facility Services,
- Psychiatric Inpatient Hospital Services,
- Targeted Case Management Services,
- Therapeutic Behavioral Services,
- Intensive Care Coordination,
- Intensive Home Based Services, and
- Therapeutic Foster Care.

² As defined in the Settlement Agreement.

KATIE A. V. BONTÁ SETTLEMENT

As a result of the Settlement Agreement in Katie A. v. Bontá, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement,² receive access to mental health services. The settlement specifically changed the way a defined group of children and youth with the most intensive needs, referred to as “Katie A. subclass members”, are assessed for mental health services.

Pursuant to the settlement, subclass members were required to be provided an array of services, and specifically medically necessary ICC, IHBS, and TFC, consistent with the Core Practice Model (CPM).³

The Settlement Agreement had the following objectives:

- Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach;
- Support the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described in the previous bullet;

³ Now referred to as the “Integrated Core Practice Model”

- Support an effective and sustainable solution, that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;
 - Address the need for certain class members with more intensive needs (hereinafter referred to as “Katie A. subclass members”) to receive medically necessary mental health services in the child’s or youth’s own home, a family setting, or the most homelike setting appropriate to the child’s or youth’s needs, in order to facilitate reunification, and to meet the child’s or youth’s needs for safety, permanence, and well-being;
 - Utilize the CPM principles and components, including:
 - A strong engagement with, and participation of, the child/youth and the family;
 - Focus on the identification of child/youth and family needs and strengths when assessing and planning services;
 - Teaming across formal and informal support systems; and
 - Use of Child and Family Teams (CFTs) to identify strengths and needs, make plans and track progress, and provide intensive home-based services;
 - Assist, support, and encourage each eligible child/youth to achieve and maintain the highest possible level of health, well-being, and self-sufficiency;
 - Reduce timelines to permanency and lengths of stay within the child welfare system; and
 - Reduce reliance on congregate care.
- While the Katie A. Settlement only concerned children and youth in foster care, or at imminent risk of placement in foster care, **membership in the Katie A. class or subclass is no longer a requirement for receiving medically necessary ICC, IHBS, and TFC.** Therefore, a child or youth need not have an open child welfare services case to be considered for receipt of ICC, IHBS, or TFC.⁴

⁴ See MHSUDS Information Notice 16-004.

CHAPTER 2: TARGET POPULATION

ICC AND IHBS

ICC and IHBS are provided through the EPSDT benefit to all children and youth who:

- Are under the age of 21;
- Are eligible for the full scope of Medi-Cal services; and
- Meet medical necessity criteria for SMHS.⁵

ICC and IHBS must be provided to all children and youth who meet medical necessity criteria for those services. Membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS. (DHCS MHSUDS Information Notice No: 16-004.).⁶

MHPs must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs. As discussed below, these services are appropriate for children and youth with more intensive needs who are in, or at risk of, placement in residential or hospital settings, but could be effectively served in the home and community.

Child welfare departments have an affirmative responsibility to screen and refer children and youth who are in the child welfare system, and may be in need of ICC and IHBS.

Other entities, such as juvenile probation, have an affirmative responsibility to screen and refer children and youth who may be in need of ICC and IHBS.

MHPs have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need ICC and IHBS.

The following criteria should be considered as indicators of need for ICC and IHBS, and are intended to be used to identify children and youth who should be assessed for whether ICC and/or IHBS are medically necessary. Thus, ICC and IHBS are very likely to be medically necessary for children and youth who meet the following criteria. These criteria are not requirements or conditions, but are provided as guidance, in order to assist counties in identifying children and youth who are in need of ICC and IHBS.

ICC and IHBS are very likely to be medically necessary for children and youth who:

- Are receiving, or being considered for, Wraparound;
- Are receiving, or being considered for, a specialized care rate due to behavioral health needs;

⁵ To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria: 1. have a condition that would not be responsive to physical health care based treatment; and 2. the services are necessary to correct or ameliorate a mental illness and condition discovered by a screening.

⁶ This clarification is not intended to decrease the utilization of ICC and IHBS amongst Katie A. subclass members. The State and counties have made significant strides in providing these services to Katie A. subclass members over many years. **It is expected that Katie A. subclass members will continue to receive ICC, and IHBS when medically necessary.**

- Are being considered for other intensive SMHS, including, but not limited to, TBS, or are receiving crisis stabilization/intervention services;
- Are currently in, or being considered for, high-level-care institutional settings, such as group homes or Short-Term Residential Therapeutic Programs (STRTPs);
- Have been discharged within 90 days from, or currently reside in, or are being considered for placement in, a psychiatric hospital or 24-hour mental health treatment facility [e.g. psychiatric inpatient hospital, psychiatric health facility (PHF), community treatment facility, etc.];
- Have experienced two or more mental health hospitalizations in the last 12 months;
- Have experienced two or more placement changes, within 24 months, due to behavioral health needs;
- Have been treated with two or more antipsychotic medications, at the same time, over a three-month period [Healthcare Effectiveness Data Information Set (HEDIS) Specification for Antipsychotics in Children and Adolescents (APC)];
- If the child is zero through five years old and has more than one psychotropic medication, the child is six through 11 years old and has more than two psychotropic medications, or the child is 12 through 17 years old and has more than three psychotropic medications;
- If the child is zero through five years old and has more than one mental health diagnosis, the child is six through 11 years old and has more than two mental health diagnoses, or the child is 12 through 17 years old and has more than three mental health diagnoses;
- Have two or more emergency room visits in the last 6 months due to primary mental health condition or need, including, but not limited to, involuntary treatment under California Welfare and Institutions (W & I) Code section 5585.50;
- Have been detained, pursuant to W&I sections 601 and 602, primarily due to mental health needs⁷; or
- Have received SMHS within the last year, and have been reported homeless within the prior six months.

ICC is intended to link beneficiaries to services provided by other child-serving systems; to facilitate teaming; and to coordinate mental health care.

If a beneficiary is involved with two or more child-serving systems, the child should be getting ICC, and the MHP should utilize ICC to facilitate cross-system communication and planning.

⁷ This criterion does not alter the suspension of Medi-Cal coverage of services for juveniles, under age 21, while the Medi-Cal beneficiary is an “inmate of a public institution,” which is a term defined in state and federal law. However, youths who are physically in juvenile hall, *not due to criminal activity*, and who are awaiting

placement, or are there temporarily under a specific plan for care or protection, are not considered to be “inmates of a public institution,” and are eligible for coverage of all Medi-Cal, provided they meet all other eligibility. For more information, please refer to DHCS ACWDL 12-22 and DHCS ACWDL 10-06.

Children and youth receiving SMHS, who also are involved with the child welfare system, special education, juvenile probation, drug and alcohol, and other health and human services agencies or legal systems, should have improved outcomes from receiving ICC. These examples illustrate various child-serving agencies that may be involved in a child's or youth's care, and result in a need for ICC, but are not an exhaustive list.

TFC

TFC is provided under the EPSDT benefit to all children and youth who:

- Are under the age of 21;
- Are eligible for the full scope of Medi-Cal services; and
- Meet medical necessity criteria for SMHS.⁸

Membership in the Katie A. subclass is not a prerequisite to receiving TFC. It is not necessary for a child or youth to have an open child welfare case, or be involved in juvenile probation, to be considered for TFC.

In addition, TFC must be provided to all children and youth who meet medical necessity criteria for TFC.

The MHP must make individualized determinations of need for TFC based on each child's or youth's strengths and needs. TFC is appropriate for children and youth with more intensive needs, or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community.

Child welfare departments have an affirmative responsibility to identify, screen, and refer children and youth who are in the child welfare system, and may be in need of TFC.

Other entities, such as juvenile probation, have an affirmative responsibility to identify, screen, and refer children and youth who may be in need of TFC.

MHPs have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

⁸ To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria: 1. have a condition that would not be responsive to physical health care based treatment; and 2. the services are necessary to correct or ameliorate a mental illness and condition discovered by a screening.

⁸ This clarification is not intended to decrease the utilization of ICC and IHBS amongst Katie A. subclass members. The State and counties have made significant strides in providing these services to Katie A. subclass members over many years. **It is expected that Katie A. subclass members will continue to receive ICC and IHBS when medically necessary.**

The following are the circumstances in which TFC may be appropriate to address the child's or youth's mental health needs. These circumstances should be considered as indicators of need for TFC, and are intended to be used to identify children and youth who should be assessed to determine if TFC is medically necessary. These indicators of need are not requirements or conditions, but are provided as guidance in order to assist counties in identifying children and youth who are in need of TFC.

1. The child or youth is at risk of losing his or her placement and/or being removed from his or her home as a result of the caregiver's inability to meet the child's or youth's mental health needs; and, either:
 - a. There is recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the child's or youth's mental health needs, and the child or youth is immediately at risk of residential, inpatient, or institutional care; or
 - b. In cases when the child or youth is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the child or youth, or support effective rehabilitation.

CHAPTER 3: PRINCIPLES OF THE INTEGRATED CORE PRACTICE MODEL

ICPM DESCRIPTION

The Integrated Core Practice Model (ICPM) builds on the foundation of the Core Practice Model, and is a set of practices and principles that provide practical guidance and direction to the delivery of timely, effective, and collaborative services to children/youth and their families. The ICPM sets specific expectations for practice behaviors for staff involved in direct services to children/youth and their families, as well as for supervisory and leadership staff.

The ICPM should be used to guide the delivery of integrated and coordinated services.

To effectively provide medically necessary ICC, IHBS, and TFC, MHPs, child welfare and juvenile probation departments, and providers should utilize the principles of the ICPM. Specifically, there must be a CFT established to guide the services provided to children/youth and their families.

ICPM VALUES AND PRINCIPLES

The ICPM values and principles are summarized as follows:

- Children and youth are, first and foremost, protected from abuse and neglect, and maintained safely in their own homes;
- Services allow the child or youth to achieve stability and permanence in his/her home and community-based living situations;
- Services are needs-driven, strengths-based, and family-focused, from the first conversation with or about the family;
- Services are individualized and tailored to the strengths and needs of each child or youth and his/her family;
- Services are delivered with multi-agency collaboration that is grounded in a strong, shared preference for community-based services and resources;
- Family voice, choice, and preference are respected throughout the process, and can be seen in the development of formal plans and intervention strategies where the child or youth and family have participated in the design;

- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions beyond system services, to ensure long-term success;
- Services are respectful of, and informed by, the culture of the child or youth and his/her family; and
- Services and supports are provided in the child's or youth's and family's local community, and in the least restrictive and most normative settings.

CHAPTER 4: THE CHILD AND FAMILY TEAM

CFT OVERVIEW

A Child and Family Team (CFT) is a group of individuals who are engaged in a variety of processes to identify the strengths and needs of the child or youth and his or her family, to help achieve positive outcomes for safety, permanency, and well-being⁹. The CFT process should follow the principles, values, and practices of the ICPM, and reflect the culture and preferences of the child, youth, and family.

In addition to the required participation of involved public agency representatives, the composition of the team is driven by family members' preferences. Typical CFT participants include: the child or youth, parents, caregivers, other family members, professionals, natural community supports (such as teachers, Court Appointed Special Advocates, coaches, and youth group leaders), and other individuals identified by the family, who are invested in the child's/youth's and family's success.

Successful CFTs include persons with natural supportive relationships with the family, so that the family's support system will continue to exist after formal services are completed.

The CFT's role is to include family members in defining and reaching identified goals for the child/youth. The individuals on the team work together to build trust, and identify each family member's strengths and needs, based on relevant life domains, to develop a child/youth and family-centered plan.

The CFT is a team that shares a vision with the family and is working to advance that vision, while a CFT meeting is how the members communicate. No single individual, agency, or service provider works independently. Working as part of a team positively impacts decision-making.

The plan articulates specific strategies for achieving the child's/ youth's, and/or family's goals, based on addressing needs identified and building on or developing strengths. The CFT typically conducts and coordinates its work through the CFT meeting.

⁹ See ALL COUNTY LETTER NO. 16-84 and MHSUDS INFORMATION NO. 16-049

It is important to recognize that the CFT and the CFT meeting are not the same. A CFT is a group of people, whereas a CFT meeting is a functional structure and process of engaging the family and its service teams in thoughtful and effective planning.

The CFT process reflects a belief that families have the capacity to address their problems and achieve success, if given the opportunity and supports to do so. Engagement with families is fundamental to the CFT process. Working with children, youth, and families, as partners, results in plans that are developed collaboratively, and in a shared decision-making process. The family members hold significant power of choice when strategies are defined.

In addition, the CFT process reflects the culture and preferences of children/ youth, and their families, building on their unique values and capacities, and eliciting the participation of everyone on the team. It is important to recognize that the child/youth and his/her family have their own, unique culture. Therefore, care must be taken to integrate or address this unique culture into the plan.

CFT meetings provide meaningful opportunities for children/youth and their families to participate in the development and implementation of individual case or treatment plans, or other related services that are designed to meet their needs. Similarly, CFTs promote collaboration and cooperation among child-serving individuals and agencies.

Team meetings can help CFT members recognize when interventions and treatment plans are working, and when they may require revision. By sharing decision-making and working together, professionals and children/youth and their families can achieve positive and lasting outcomes.

Team members should help children/youth, and their families recognize their strengths, and encourage and support them to develop solutions that match their preferences. The team must respect and support the power of learning from mistakes, when strategies do not work as intended, so that the plan can be revised to improve outcomes.

Evidence-based and promising practices increasingly rely on youth and family engagement and teaming processes as effective methods to support children/youth and their families. In addition, evidence-based and promising practices include system partners in the planning, delivery, and management of necessary services.

COMPOSITION OF CHILD AND FAMILY TEAMS

For children and youth in the child welfare or juvenile probation systems, the placing agency is responsible for convening and engaging members of the CFT. MHP representatives also are important CFT resources to support care coordination and collaborative decision-making. Fostering engagement, interagency collaboration,

uniform services planning, and behaviorally based case planning are essential to increasing well-being and improving the outcomes of children and youth in foster care.

The CFT composition always should include the child or youth, family members, and representatives from the following ***(as appropriate to every child or youth and his/her family)***:

- A representative from the placing agency;
- A representative of the child's or youth's tribe or Indian custodian;
- A representative of the MHP and/or a representative from the mental health treatment team;
- A foster family agency social worker;
- A short-term residential therapeutic program (STRTP) representative;
- Youth partners/mentors or parent partners;
- Public health providers;
- Court Appointed Special Advocates; and/or
- School personnel.

In addition to formal supports, effective CFT processes support and encourage family members to invite the participation of individuals who are part of their own network of informal support. This may include extended family, friends, neighbors, coaches, clergy, co-workers, or others who the child/youth and/or family have identified as a potential source of support.

Family members may be reluctant, for a variety of reasons, to identify and invite friends or neighbors to participate in a CFT. For example, family members may be angry or ashamed of being involved in child welfare, MHPs, juvenile probation, and/or other systems. Family members also may subscribe to cultural norms that do not accommodate sharing of personal information with "outsiders". In addition, engagement may be challenging for families experiencing serious mental illness and/or substance use disorders, and/or further complicated by the historical or current impact of trauma.

Professionals can work to mitigate family member reluctance by being patient, offering reassurance and encouragement, and demonstrating respect and cultural humility. It is important to explain how the inclusion of others can directly support the family members in achieving their goals in a timely and effective manner.

Individuals with similar/shared/common life experience (e.g. parent partners, youth partners/mentors) can be useful to the team process by being mentors and advocates to parents and youth, as they have personally experienced many of the same challenges and feelings. The parent partner's or youth partner's/mentor's unique role often promotes clarity and understanding for the child/youth and his/her family.

As families move through the CFT process, they often will come to recognize their own strengths, and experience the power of strengths-based support that comes without judgement. Over time, and with growing trust, reluctance may fade, and inclusion of natural supports will grow.

Team membership is intentionally flexible (other than the required membership in statute), so team members will continue to change as needs change. Identified natural supports will move into a more significant role, as professionals work toward transitioning off of the team.

CONFIDENTIALITY

Confidentiality and information sharing practices are key elements throughout the CFT process, and must be designed to protect the child's/youth's and family's rights to privacy, without creating barriers to receiving services.

When the CFT convenes, members will discuss and address any concerns related to sharing information, openly and transparently, and appropriate and applicable release of information must be obtained.

Working together as a team to discuss necessary information, such as strengths and challenges, will help the child/youth and family determine specific goals, and implement a plan to meet those goals.

Sharing relevant information allows families and professionals to build trust in each other and in themselves. This strengths-based, collaborative engagement with families is fundamental to the CFT process.

CFT MEETING

It is important to recognize that a CFT meeting does not represent the entire process, but is simply one part of a larger strategy, which involves children, youth, and families in all aspects of care planning, evaluation, monitoring, and adapting, to help them successfully reach their goals. The child/youth and family voice, choice, and preferences are an integral part of the CFT process. It is only a CFT meeting if decisions about goals and strategies to achieve them are made with involvement of the child/youth and family members.

For a child or youth in the child welfare or juvenile probation systems, the placing agency worker typically is responsible for:

- Convening the initial CFT meeting, (unless the team already is established by another agency);and
- Coordinating with the family, other child and youth serving system partners, and others identified by the child/youth and his/her family, to convene the team and initial meetings.

If the child/youth and his/her family already have an established team through another agency, such as behavioral health, or a program such as Wraparound, the placing agency will support the existing team process to expand and evolve, so that the needs and services indicated under the child welfare or probation case are included. Cross system planning and coordination will ensure that there is only one team process for any single family.

WHEN TO CONVENE A CFT MEETING

For children and youth without an existing CFT, team membership should be identified as soon as possible.

For children and youth in the child welfare or juvenile probation system, an initial CFT meeting must be convened as soon as possible, and prior to the development of the case plan, in order to address placement decisions and case planning activities.

For children and youth already in a foster care placement prior to January 1, 2017, who have not had a CFT convened, the initial CFT meeting should occur prior to the next status review hearing.

For children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems, the MHP is responsible to convene the CFT.

In addition, a CFT meeting will be convened to discuss any placement changes and service needs for the child or youth in out-of-home care. The team must be consulted to identify the most appropriate placement for the child or youth, while always considering the least restrictive placement option.

Children and youth in the child welfare system are screened for potential behavioral health needs by the placing agency (at intake and every year thereafter). When mental health issues are identified, or are a concern, referrals to appropriate treatment professionals should be made, so that the child's/youth's needs can be assessed, even if services are not presently being provided.

MHP professionals (which may include county staff or county contracted providers for children eligible or enrolled in Medi-Cal) are important CFT resources, and their involvement is especially critical when:

- The team is unsure about a child's or youth's need for SMHS, or whether the child or youth should continue receiving SMHS;
- There is a need to provide information to the team or family regarding how the child's/youth's behavior or functioning is impacted by his/her mental health status;

- The team is considering the need for placement for the child or youth in a family relative, non-related extended family member, or any other family-type setting, a Short-Term Residential Therapeutic Program (STRTP), foster care, or Intensive Treatment Foster Care (in the future to be known as Intensive Services Foster Care);
- The team is considering a recommendation for TFC; and/or
- A child or youth is prescribed psychotropic medication(s), or psychotropic medication(s) is being considered for the child or youth.

CFT MEETING FREQUENCY, LOCATION, AND LOGISTICS

For children or youth who are receiving ICC, IHBS, or TFC, a CFT meeting must occur at least every 90 days.

For children and youth in child welfare or juvenile probation systems who are not receiving ICC, IHBS, and TFC, the placing agency will convene a CFT meeting according to the needs of the child and family, but no less than once every six months

Best practice indicates that CFT meetings should be held, as needed, to address emerging issues; provide integrated and coordinated interventions; and refine the plans. Therefore, frequency of meetings and timeframes should be decided by CFT members.

The CFT meetings also should be scheduled at times and locations convenient for family member participation.

CFT meetings should be conducted in a way that establishes a safe environment that engenders trust, and reflects the child's/youth's and family's cultural preferences and norms. If needed, CFT meetings could include an interpreter or translator, to ensure effective communication and clear understanding.

The CFT meeting should have a clear purpose and follow a structured format. Since services and supports to the family always should be individualized to meet their needs, CFT meeting frequency and duration will look different for each family.

CFT MEETING PREPARATION

It is important to prepare a child, youth, and family, as well as professionals, to participate in a CFT meeting. Prior to the start of a meeting, an explanation of the purpose, people involved, and structure of the meeting should occur. This preparatory discussion should include an opportunity for all team members to ask questions and share concerns.

Meeting agendas should be developed with the team, and reflect the voice of the child/youth and family. Children/youth and their families are the best experts about their own lives, and their preferences. In addition, the child's/youth's and family's natural

supports have valuable information and resources to share, and their ideas should be considered.

The team should routinely measure and evaluate child/youth and family member progress and emerging needs. Team meetings can help team members recognize when interventions and treatment plans are working, and when they require revisions. The team's role in providing encouragement to continue the work to achieve family goals is a critical component of success.

CFT MEETING FACILITATION

Each CFT meeting must have a facilitator. The role of the facilitator is to:

- Help to identify needed contacts;
- Build consensus within the team around collaborative plans;
- Actively support the agenda; and
- Ensure that family voice and choice is heard throughout the entire teaming process.

The decision of who should facilitate the CFT meeting should consider the preferences of the child/youth and family members. The choice of a CFT facilitator also may be influenced by the focus of the CFT meeting. In addition, for the child welfare population, local county practices and CDSS policy guidance determine who facilitates the CFT meeting.

CLAIMING AND REIMBURSEMENT

Each participating provider in a CFT meeting may claim for the time he or she contributed to the CFT meeting, up to the length of the meeting, plus documentation and travel time, in accordance with Title 9, CCR, Chapter 11, Section 1840.316 (b) (3).

Participation in the CFT meeting is claimed as ICC¹⁰. Time claimed, which may include active listening time, must be supported by documentation showing what information was shared, and how it can/will be used in providing, planning, or coordinating services to the client (i.e. how the information discussed will impact the client plan).

Each participating provider in a CFT meeting may bill for the total number of minutes during which a client (or clients) with whom that provider has a client/provider relationship is discussed. Such a provider may claim for minutes during which one of his/her clients is being discussed, up to the length of the meeting.

When multiple providers are participating in a CFT meeting, and each provider's participation is appropriately documented for the amount of time claimed, the total number of all of the providers' minutes claimed may exceed the length of the meeting.

¹⁰ Information regarding claiming for participation in CFTs for children and youth not receiving

ICC, IHBS, or TFC will be provided by DHCS in an upcoming Information Notice.

Although the child and family must be in attendance for a CFT meeting to take place, it is not necessary that all CFT members be in attendance in order for a CFT meeting to take place.

It is important to keep in mind that team membership will expand throughout the case planning process. While in-person attendance is always preferable, the child or youth, parent(s), and team members may agree to allow participation by video conferencing or phone.

Although it is encouraged for everyone on the team to participate, there will be times when not all of the team members are able to attend, and the meeting should take place as scheduled. Before the CFT meeting ends, team members should identify someone to provide updates to absent team members in a timely manner.

CHAPTER 5: ICC, IHBS, AND TFC

PLANNING FOR ICC, IHBS, AND TFC

Planning within the Integrated Core Practice Model (ICPM) is a dynamic and interactive process that addresses the goals and objectives necessary to assure that children and youth are safe, and live with caring families, in home environments that meet their needs for safety, permanence, and well-being. In addition, there is an expectation that the planning process and resulting plans reflect the child's/youth's and family's own goals and preferences, and that the child/youth and family have access to necessary services and resources that meet their needs.

There should be an ICC coordinator, who is responsible for working within the CFT to ensure:

- Components of plans from any of the system partners (including the mental health client plan, and plans from child welfare, special education, juvenile probation, etc.) are integrated and unified, to comprehensively address all identified goals and objectives; and
- The activities of all parties involved with service to the child or youth and/or family are coordinated, to ensure that all team members work in cooperation with one another to support and promote successful and enduring change.

Although a CFT must be in place to guide the ICC planning and service delivery process, it is not required that the ICC coordinator facilitate CFT meetings. The ICC coordinator and a CFT facilitator may be two, different individuals. In addition, the provision of ICC is not limited to when the CFT meeting takes place. ICC services may be provided in-between, after, and before CFT meetings.

INTENSIVE CARE COORDINATION (ICC)

ICC GENERAL DESCRIPTION

Intensive Care Coordination (ICC) is an intensive form of Targeted Case Management (TCM) that facilitates assessment of, care planning for, and coordination of services for children and youth. ICC includes urgent services for beneficiaries with intensive needs.

While the key service components of ICC are similar to TCM, a difference between ICC and the more traditional TCM is that ICC is intended for children and youth who:

- Are involved in multiple child-serving systems;
- Have more intensive needs; and/or
- Whose treatment requires cross-agency collaboration.

ICC also differs from TCM in that there needs to be a CFT in place, to provide feedback and recommendations to guide the provision of ICC services. A key element of ICC is the establishment of an ICC coordinator, who often is an MHP employee or contractor.

The difference between ICC and the more traditional TCM service functions is that ICC is intended for children and youth with more intensive needs, and/or whose treatment requires cross-agency collaboration.

The ICC Coordinator serves as the single point of accountability to:

- Ensure that medically necessary services are accessed, coordinated, and delivered in a strengths-based, individualized, and culturally and linguistically relevant manner, and that services and supports are guided by family voice and choice and the needs of the child/youth;
- Ensure that medically necessary mental health services included in the child's/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned, and/or reassessed, as necessary, in a way that is consistent with the full intent of the ICPM;
- Facilitate a collaborative relationship among the child or youth, his/her family, and involved child-serving systems;
- Provide support and validation to gain trust to develop and maintain a constructive and collaborative relationship among the child or youth, his/her family, and involved child-serving systems;
- Support the parent/caregiver in meeting his/her child's or youth's needs;
- Ensure services are provided that equip the parent/caregiver to meet the child's/youth's mental health treatment and care coordination needs, as described in the child's/ youth's plan;
- Help establish the CFT and provide ongoing support; and
- Provide care planning and monitoring to ensure that the plan is aligned with, and coordinated across, the mental health and child/youth-serving systems, to allow the child/youth to be served in his/her community, in the least restrictive setting possible.

ICC SERVICE COMPONENTS AND ACTIVITIES

As previously stated, having a CFT is a key element for ICC. The CFT will provide feedback and recommendations to guide the provision of ICC services. In addition, ICC requires more active participation by the ICC provider, in order to ensure that the needs of the child/youth are appropriately and effectively met.

Engaging the child/youth and his/her family is foundational to building trust and mutually beneficial relationships between the family and the ICC service provider. This process must be nurtured and developed throughout. Therefore, it is critical to allow CFT members to work to reach agreement about needed services, including ICC.

The following examples illustrate how a CFT meeting allows providers and participants to work together to identify needed changes in a child's or youth's plan and services.

Planning within the CFT Example 1:

A clinician attends a CFT meeting and learns from Maria's parent and the Therapeutic Behavioral Services (TBS) coach that Maria recently suffered a panic attack while in school. Based on this shared information, the clinician suggests that the plan be revised to include:

- Exploring with Maria what triggered this panic attack; and
- Practicing relaxation techniques with Maria, to reduce levels of anxiety.

Planning within the CFT Example 2:

During the CFT meeting, Maria's parent reported that the school counselor said Maria continues to withdraw and stand along the back fence during recess. Based on this information, the ICC coordinator works with the IHBS provider to:

- Observe Maria during recess, and assess why Maria continues to withdraw and stand along the back fence;
- Explore, with Maria, what types of recess activities she would like to participate in; and
- Help Maria develop the interpersonal skills to ask other students if she can join them in games.

ICC Service components include the following:

PLANNING AND ASSESSMENT OF STRENGTHS AND NEEDS

The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (MHPs, child welfare, juvenile probation, education, etc.) are integrated to comprehensively address the identified goals and objectives. In addition, the activities of all parties involved with service to the child/youth and/or family are coordinated to support and ensure successful and enduring change. This includes gathering information and determining the needs of the child/youth and family, including strengths and underlying needs.

Assessment activities within the CFT must align with the client plan, and are different from the clinical assessment process, which incorporates the use of a standardized psychological assessment tool and a clinical interview to establish medical necessity for SMHS.

Planning and Assessment of Strengths and Needs Example: Rick's parents talked about the different circumstances that were going on when Rick becomes so anxious he cannot handle the situation, and thus feels that his only alternative is to flee to a location where he is isolated from others. Situations that cause Rick to feel anxious include:

- When someone physically touches him; and
- When there is a lot of noise and activity from the younger children in the house.

The ICC coordinator and parent partner assisted Rick's parents and Rick to identify what circumstances are going on when Rick seems calmer. Rick's parents reported:

- Rick appears to be more in control in the morning than later in the day;
- Rick responds better when there are fewer people; and
- Rick prefers not to be touched when he is talking and giving feedback.

Therefore, the ICC Coordinator and the parent partner determined that morning time, when Rick typically is calmer, is the best time to teach Rick relaxation exercises.

It also was noted that Rick is working with his therapist to understand how past life events led to the establishment of these environmental triggers.

REASSESSMENT OF STRENGTHS AND NEEDS

The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth and their families, at least every 90 days, and as needed. The team will utilize this information to determine if changes are needed to continue to support and address the needs of the child or youth.

Intervention strategies should be continually monitored, so that modifications can be made based on results. These modifications include incorporating approaches that work, and refining those that do not.

Reassessment of Strengths and Needs Example: The ICC coordinator, behavior specialist, Molly, Molly's parents, the child welfare worker, and the teacher's aide discussed potential strengths identified by the California Child and Adolescent Needs and Strengths (CANS) tool. They used these identified strengths to form the basis of positive intervention strategies that Molly can use to manage her anxiety, when she is feeling stressed and frustrated by her school work:

- Molly can tell that she is getting frustrated before she lashes out, and is able to communicate her frustration to her teacher with an agreed upon signal, a wave of her hand.

- Molly can read and use a list of reminders of what to do when she is frustrated, such as moving to a quiet area for a time out, and doing breathing exercises.
- The teacher's aide recognizes that, when Molly's leg jiggles fast, Molly is becoming agitated. The teacher's aide then reminds Molly to breathe slowly. Molly is able to hear the reminder, respond, and settle down.
- All present at the CFT meeting agreed that the behavior specialist will work with the teacher's aide to develop a list of coping strategies that Molly can use when she is becoming agitated.
 - The teacher's aide will track the number of times she notices that Molly is agitated, and how many of those times Molly is able to use her strategies to calm down.
 - The CFT members will evaluate the success of this intervention at the next CFT meeting.

REFERRAL, MONITORING, AND FOLLOW-UP ACTIVITIES

Monitoring and adapting is the practice of evaluating the effectiveness of the plan; assessing circumstances and resources; and reworking the plan, as needed. The ICC coordinator conducts referral, linkages, monitoring, and follow up activities, to ensure that the child's/youth's needs are met. This includes ensuring that services are being furnished in accordance with the child's/youth's client plan, and that services are adequate to meet the child's/youth's needs.

The ICC coordinator also makes recommendations to the CFT members regarding necessary changes to the client plan, and works with the CFT and other providers to make these adjustments.

Referral, Monitoring and Follow-up Activities Example:

The ICC coordinator and the CFT members discussed Susie's level of participation and progress at the Boys and Girls (B&G) Club, over the past month. They identified; what Susie likes about participating in B&G Club activities. In addition, the CFT members discussed aspects of Suzie's participation at the B&G Club that are not going as well.

Susie reported that she likes the art activities at the B&G Club, but she does not want to go back there. She further explained that two girls at the B&G Club bully her, by constantly telling her that her ideas for art projects are "stupid" and "crazy".

The ICC coordinator suggested strategies to increase support at the B&G Club. These strategies included observing and coaching Susie to:

- Use a confident voice to tell the girls to stop making fun of her and calling her names;
- Move away from the girls who are calling her names, and find a friend to be near; and/or
- Talk to a B&G Club staff member about the situation.

Susie agreed to try these strategies, and her client plan was refined accordingly. The behavior specialist also was assigned to support Susie on Tuesdays and Thursdays, for the next month.

The CFT members agreed to review Susie's revised client plan in two weeks.

TRANSITION

When the child or youth has achieved the goals of his/her client plan, the CFT should engage in developing a transition plan for the child/youth and family, to promote long-term stability. This transition plan includes the effective use of natural supports and community resources.

Transition Example: CFT meeting participants, including the ICC coordinator, the IHBS provider, Susie's parents, Susie, and Susie's teacher, reviewed Susie's and her family's gains and progress.

To better assist Susie's transition away from formal supports, the CFT participants also reviewed Susie's and her family's personal strengths and external resources.

The CFT members identified the presence and effectiveness of the following natural supports:

- Susie's church youth group;
- Susie's soccer team; and
- The B&G Club leadership group that Susie participates in.

The CFT members also identified ways of maximizing community resources and activities, to ensure long-term stability for Susie and her family.

MEDI-CAL DOCUMENTATION REQUIREMENTS OF ICC SERVICE COMPONENTS AND ACTIVITIES

ICC documentation requirements should be consistent with the MHP's policies and procedures, and in accordance with the contract between DHCS and the MHP.

ICC PROVIDER QUALIFICATIONS

Provider qualifications for ICC are the same as those allowed for TCM services, and as approved by the MHP.

ICC SERVICE AUTHORIZATION

ICC service authorization should be consistent with the MHP's policies and procedures.

COORDINATION OF ICC WITH OTHER SPECIALTY MENTAL HEALTH SERVICES

Children and youth who are receiving ICC are eligible for other SMHS, if medical necessity criteria are met. The MHP and providers should consider the full array of services, as well as the needs of the child or youth.

Certain services may be part of the child's or youth's course of treatment, but may not be provided during the same hours of the day as ICC services are being provided to the child or youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive, and
- Group Therapy.

ICC and TBS may be provided and claimed for when provided at the same time, by different, individual, qualified providers, to or on behalf of the same client. The following is an example of appropriate claiming during these instances.

Example of Coordination of ICC with Other Specialty Mental Health

Services: During a CFT meeting, Johnny becomes upset. Johnny and his TBS provider leave the room, and the TBS provider applies an intervention to calm Johnny. Meanwhile, the CFT meeting continues.

In this example, the TBS provider may claim for TBS during the time that the provider is out of the CFT meeting room, applying an intervention to calm Johnny. In addition, the TBS provider can claim

for ICC during the time that the provider is participating in Johnny's CFT meeting. The ICC coordinator may claim for ICC for the entire time spent at Johnny's CFT meeting. Therefore, TBS and ICC would be claimed for at the same time by different, qualified, individual providers, for the services provided to, or on behalf of, the same client.

Medi-Cal reimbursement must be based on staff time, including the length of the meeting, plus any documentation and travel time (e.g., a single staff member who participates in the CFT meeting cannot claim for more time than was provided).

Please see Appendix B for examples of progress notes for ICC services.

ICC SERVICE SETTINGS / LIMITATIONS / LOCKOUTS

Effective July 1, 2017, ICC may be provided to Medi-Cal beneficiaries, under the age of 21, who are placed in group homes or Short-Term Residential Therapeutic Program (STRTPs), if medically necessary. There is no limitation on the number of days that ICC may be provided or reimbursed. (Prior to July 1, 2017, ICC was available to children and youth in group homes and STRTPs, solely for the purposes of discharge planning, and only for a limited number of days. These limitations are no longer in effect.)

When ICC is provided in a hospital, psychiatric health facility, community treatment facility, or psychiatric nursing facility, it will be used solely for the purpose of coordinating placement of the child or youth on discharge from those facilities. In this circumstance, ICC may be provided for the purpose of discharge planning, during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days, or less, per continuous stay in the facility.

ICC CLAIMING AND REIMBURSEMENT

Claims for ICC must use¹¹:

- X12N 837 Health Care Claim Professional (837P) transaction set;
- Procedure code T1017;
- Procedure modifier “HK”;
- Mode of Service 15; and
- Service Function Code 07.

All other claiming and reimbursement requirements that apply to TCM apply to ICC.

Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for other applicable claiming rules.

INTENSIVE HOME BASED SERVICES (IHBS)

IHBS GENERAL DESCRIPTION

Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child’s or youth’s functioning. These interventions are aimed at: helping the child/youth build skills for successful functioning in the home and community, as well as improving the family’s ability to help the child/youth successfully function in the home and in the community.

The difference between IHBS and more traditional outpatient Specialty Mental Health Services (SMHS) is that IHBS is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the child’s or youth’s client plan, and will be predominantly delivered outside an office setting, and in the home, school, or community.

IHBS activities support the engagement and participation of the child/youth and his/her significant support persons. In addition, IHBS activities help the child/youth develop skills and achieve the goals and objectives of the plan.

¹¹ See MHSUDS INFORMATION NO. 13-11

IHBS SERVICE COMPONENTS AND ACTIVITIES

IHBS service activities include, but are not limited to:

- Medically necessary, skill-based interventions for the remediation of behaviors or improvement of symptoms, including, but not limited to, the implementation of a positive behavioral plan, and/or modeling interventions for the child's/youth's family and/or significant others, to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments, by intervening to decrease or replace non-functional behavior that interferes with daily living tasks, or to avoid exploitation by others;
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans, including, but not limited to, the client plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications, as appropriate;
- Education of the child/youth and/or his/her family or caregiver(s) about, and how to manage, the child's/youth's mental health disorder or symptoms;

- Support of the development, maintenance, and use of social networks, including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a child's or youth's success in achieving educational objectives in a community academic program; and
- Support to address behaviors that interfere with transitional independent living objectives, such as seeking and maintaining housing and living independently.

IHBS Example 1: The IHBS worker met with Sam and his mother, at their home, to teach Sam to pay attention to his behavior, and to identify behaviors that Sam needs to learn to self-manage (such as not throwing objects and slamming doors when he is upset).

The IHBS worker explained and modeled, to both Mother and Sam, different self-calming techniques for Sam to use when he is upset, including:

- Deep breathing exercises;
- Taking a walk to "cool off"; and
- Writing a letter to express his anger.

IHBS Example 2: The IHBS worker met with and observed Sam at his school, during recess. Sam became upset with a peer, and started banging his own head on the playground climbing structure.

The IHBS worker prompted Sam to walk away and use one of the self-calming techniques that Sam has been practicing (deep breathing exercises, taking a walk to cool off, and writing a letter to express his anger.)

- Sam used deep breathing exercises and was able to calm himself down.
- The IHBS worker praised Sam for walking away, and doing the deep breathing exercises to calm himself.

IHBS Example 3: The IHBS worker met with Sam's mom to assist her in learning how to develop strategies for not losing her temper in response to Sam's angry outbursts (and making the situation worse). The IHBS worker used skill-building and role play exercises to teach Mom how to respond appropriately when Sam has an angry outburst, including:

- The IHBS worker taught Mom to speak to Sam in a calm tone of voice, and to wait until Sam has calmed down to discuss how Sam could have handled the situation better.
- The IHBS worker explained to Mom how her anger impacts Sam's reaction, and taught her different ways of expressing herself when she is upset.

MEDI-CAL DOCUMENTATION OF IHBS SERVICE COMPONENTS AND ACTIVITIES

IHBS documentation requirements should be consistent with the MHP's policies and procedures, and in accordance with the contract between DHCS and the MHP.

IHBS PROVIDER QUALIFICATIONS

Provider qualifications for IHBS are the same as those allowed for mental health services, and as approved by the MHP.

IHBS SERVICE AUTHORIZATION

IHBS service authorization should be consistent with the MHP's process for authorizing mental health services.

COORDINATION OF IHBS WITH OTHER SMHS

Children and youth who are receiving IHBS are eligible for other medically necessary SMHS, if medical necessity criteria are met. The MHP and providers shall consider the full array of services and the needs of the child or youth.

Certain services may be part of the child's or youth's course of treatment, but may not be provided during the same hours of the day as IHBS services are being provided to the child or youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive,
- Group Therapy, and
- TBS.

In addition, multiple providers, including IHBS providers, may claim for their time and participation at the CFT meeting. The IHBS provider's participation at the CFT meeting is claimed as ICC, since this is the service being provided.

- The IHBS provider in a CFT meeting may claim for the total number of minutes during which one of his/her clients is being discussed, and client plan goals and/or information gleaned during the meeting contributed to the formation of the mental health client plan or revisions.
- The IHBS provider may NOT claim for minutes during which clients with whom the provider does not have a provider/client relationship are being discussed.
- Medi-Cal reimbursement must be based on staff time, including the length of the meeting, plus any documentation and travel time (e.g., a single staff member who participates in the CFT meeting cannot claim for more time than was provided).

IHBS SERVICE SETTINGS

IHBS may be provided in any setting where the child or youth is naturally located, including the home (biological, foster, or adoptive), schools, recreational settings, child care centers, and other community settings. IHBS is available wherever and whenever needed, including weekends and evenings.

IHBS is typically (but not only) provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS.

IHBS SERVICE LIMITATIONS AND LOCKOUTS

IHBS is intended to be provided to children and youth living and receiving services in the community. Effective July 1, 2017, IHBS may be provided to Medi-Cal beneficiaries, under the age of 21, who are placed in group homes or Short-Term Residential Therapeutic Program (STRTPs), if medically necessary. (Prior to July 1, 2017, IHBS could not be provided in a group home or STRTP. This limitation is no longer in effect¹².)

IHBS CLAIMING AND REIMBURSEMENT

Claims for IHBS must use¹³:

- X12N 837 Health Care Claim Professional (837P) transaction set;
- Procedure code H2015;
- Procedure modifier "HK";

¹² See MHSUDS Information Notice No: 17-055

¹³ See MHSUDS INFORMATION NO. 13-11

- Mode of Service 15;
- Service Function Code 57; and
- All other claiming and reimbursement requirements that apply to Mental Health Services apply to IHBS.

Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for other applicable claiming rules.

Please see Appendix B for examples of progress IHBS progress notes.

THERAPEUTIC FOSTER CARE (TFC)

TFC GENERAL DESCRIPTION

TFC is a short-term, intensive, highly coordinated, trauma- informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC is available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit to children and youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria.¹⁴

¹⁴ See ALL COUNTY LETTER NO. I-05-17 and MHSUDS INFORMATION NO. 17- 009

¹⁵ Board and care would be provided by other sources including private pay.

¹⁶ “Under the direction of” means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review,

Membership in the Katie A. class or subclass is not a prerequisite to receiving TFC. Therefore, a child or youth who does not have an open child welfare services case, and is not in foster care or involved in the juvenile probation system, may be considered for TFC, in an approved TFC resource home ¹⁵.

TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. TFC should not be the only SMHS that a child or youth receives. Children and youth receiving TFC also must receive ICC and other medically necessary SMHS, as set forth in the client plan. Similar to ICC and IHBS, there must be a CFT in place to guide and plan TFC service provision.

ROLE OF THE TFC AGENCY

The TFC Agency is responsible for ensuring that the TFC parent meets both Resource Family Approval (RFA) program standards and the required qualifications as a TFC parent. The TFC parent will work under the supervision of the TFC Agency, and ***under the direction of***¹⁶ a Licensed Mental Health Professional (LMHP) or a

approval, and signing client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the services provided. Services are provided under the direction of: a physician; a licensed or waived psychologist; a licensed or registered marriage and family therapist; a licensed,

Waivered or Registered Mental Health Professional (WRMP)¹⁷ employed by the TFC agency. The LMHP/WMHP will provide direction to the TFC parent, and ensure the TFC parent follows the client plan.

The TFC Agency's LMHP/WRMHP assumes ultimate responsibility for directing the interventions provided by the TFC parent, and ensuring that the TFC parent follows the client plan.

The TFC Agency will provide oversight of a network of TFC parents. The TFC Agency activities include:

- Recruiting, approving (unless already approved by the county), and annually re-approving TFC parents, following the RFA process, as well as Medi-Cal SMHS requirements as a TFC parent who has the ability to meet the diverse therapeutic needs of the child or youth;
- Providing, at a minimum, 40-hours of required training for the TFC parent, prior to the TFC parent providing TFC;

- Actively participating in the CFT to identify supports for the child/youth and family, including linking the child or youth with a TFC parent who can best meet the child's or youth's individual needs;
- Integrating the TFC parent and appropriate staff into the existing CFT;
- Providing competency-based training to the TFC parent, both initially and ongoing;
- Providing ongoing supervision and intensive support to the TFC parent;
- Monitoring the child's/youth's progress in meeting client plan goals related to TFC;
- Maintaining documentation (progress notes) related to interventions used by the TFC parent to assist the child/youth in meeting the child's/youth's client plan goals;
- Providing Medi-Cal-related reports to the MHP or designee, as required;
- Providing other supports to the TFC parent and child or youth (i.e. parent partner and/or youth mentor); and

waivered, or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner.)

¹⁷ Waivered/Registered Professional means— For a psychologist candidate, “waivered” means an individual who either 1. is getting the experience required for licensure or 2. was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law. For a social worker candidate, a marriage and family therapist candidate, or a professional counselor candidate, “registered”

means a candidate for licensure who is registered with the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, and “waivered” means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination, and who has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law.

- As it relates to the care of the individual child/youth, the TFC Agency is responsible for the following:
 - Collaborating and coordinating with the ICC coordinator and the CFT in the development and implementation of the client plan;
 - Assessing the child's/youth's progress in meeting client plan goals related to the provision of TFC, and communicating progress through the CFT; and
 - Incorporating evidence-informed practices in the training of TFC parents and the treatment of the child or youth.
- The TFC Agency also may be responsible for providing other non-TFC, medically necessary SMHS, if included in its contract with the MHP.¹⁸

A TFC Agency may be a Foster Family Agency (FFA). If so, the FFA will need to be a California licensed FFA that meets licensure and accreditation requirements, established by the California Department of Social Services (CDSS), to approve foster homes and accept children and youth for placement from county placing agencies.

The FFA also must meet applicable Medi-Cal SMHS provider requirements, and be certified by the county Mental Health Plan (MHP) as a Medi-Cal provider¹⁹. Additionally, the FFA must have a contract with the MHP to provide SMHS as a TFC Agency.

If a county does not have an FFA available or suitable to serve as a TFC Agency, the county may assume the functions of the TFC agency which may include establishing a county-owned and operated FFA, or an approved TFC provider.

ROLE OF THE TFC PARENT

The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide TFC under the oversight of a TFC Agency, and ***under the direction of*** an LMHP or a WRMHP employed by the TFC Agency. The TFC parent will assist the child/youth to achieve client plan goals and objectives; improve functioning and well-being; and help the child/youth remain in a family-like home, in a community setting, thereby avoiding residential, inpatient, or institutional care.

¹⁹ If the FFA is county owned and operated, the Department of Health Care Services (DHCS) will conduct the Medi-Cal certification.

TFC is intended for children and youth who require intensive and frequent mental health support in a one-on-one environment. As such, there should only be one child or youth receiving TFC by a TFC parent. Other children or youth (biological, foster care, etc.) may live in that home. However, child welfare statutes (Welfare and Institutions Code Section 18360) regarding the number of children and youth who can reside in a resource family home are applicable, and must be followed.

For children and youth who are in foster care, it is not required that TFC parents be part of the child's/youth's permanent placement plan. The provision of TFC by the TFC parent also would not "prohibit" a TFC parent from becoming that child's/youth's ultimate permanent placement. In addition, a relative caregiver and "non-related" extended family member could become a TFC parent, and provide TFC, if he/she meets the TFC required parent qualifications and training requirements, and all other TFC service elements described in this section.

A TFC parent will need to understand and be aware of:

- His/her role as a Medi-Cal provider;
- His/her role as part of the therapeutic team providing services to a child/youth; and
- His/her role as a foster parent.

For children and youth in the child welfare or juvenile probation systems, counties are encouraged to continue to develop the resources, supports, and services needed to maintain foster children and youth in family-based home settings, while promoting permanency for the children and youth through family reunification, adoption, or legal guardianship. These efforts may include the provision of ICC, IHBS, and Wraparound services, as appropriate.

TFC PARENT REQUIRED QUALIFICATIONS

To qualify as a Medi-Cal provider, the TFC parent must be approved as a TFC provider, and as a resource parent by the TFC Agency.

The TFC parent must meet and comply with all basic foster care or resource parent requirements, as set forth in California Code of Regulations (CCR) Title 22, Division 6, Chapter 9.5 and Welfare and Institutions (W&I) Code 16519.5; and the Written Directives issued by CDSS to administer the Resource Family Approval (RFA) program operated by counties. Every TFC parent will be required to meet RFA standards²⁰.

²⁰ For most updated information, refer to CDSS' RFA Written Directives. The TFC parent must meet this requirement even if the child or youth

receiving TFC does not have an open child welfare or juvenile probation case.

The TFC parent must meet and comply with the following requirements related to his/her role as a TFC parent(s):

- The TFC parent must be at least 21 years old and must meet California's Medicaid rehabilitation provider qualifications for "other qualified provider"²¹ (i.e., has a high school diploma or equivalent degree).
- The TFC parent must meet provider qualifications and other requirements regarding certification, oversight, etc., as established by the county MHP. The process for a resource parent to become a TFC parent will be determined by the TFC Agency, in accordance with its contract with the MHP.
- The TFC parent, including a relative caregiver, must be a resource family. Any additional processes regarding background checks and screenings will be determined by the MHP.
- The TFC parent must have forty (40) hours of initial TFC parent training²² provided by the TFC Agency, which must be completed prior to the parent being eligible to provide services as a TFC parent. An outline and agenda of the 40-hour training shall be provided to, and approved by, the MHP as a part of the contract.

²¹ California State Medicaid Plan, Attachment 3.1 A Rehabilitation Mental Health Services.

²² 40 hours are required in addition to the minimum training that a TFC parent would undertake to become an approved resource parent. For those TFC Agencies that have Intensive Services Foster Care (ISFC), ISFC training resources and curricula may be

- The TFC parent must complete twenty-four (24) hours of annual, ongoing training, provided by the TFC Agency, related to providing TFC. This ongoing, annual training includes an emphasis on skill development and application and SMHS knowledge acquisition, and can be provided in a variety of formats (videos, readings, internet training, and webinars).

THE FORTY (40) HOURS OF INITIAL TFC PARENT TRAINING SHALL INCLUDE THE FOLLOWING, AT A MINIMUM:²³

- Introduction to TFC services and the TFC parent role in mental health treatment planning;
- Working with children who have been abused, neglected and/or delinquent;
- Trauma-informed care;
- Developmental stages and age appropriate interventions;
- Prevention of aggressive behavior and de-escalation techniques;
- Positive behavioral reinforcement techniques;
- Behavior management techniques;

leveraged to toward meeting TFC training requirements.

²³ The TFC Training Resource Toolkit that includes learning objectives for these training topics, as well as linkages to available training resources. See MHSUDS INFORMATION NOTICE NO. 17-069 and ALL COUNTY INFORMATION NOTICE (ACIN) NO. 1-91-17.

- Introduction to individualized mental health treatment of children;
- Effective communication and relationship building techniques;
- Understanding and monitoring medications;
- Crisis management/de-escalation techniques that do not require physical intervention;
- Cultural competence and culturally responsive services;
- Client sensitivity training [including stories and content developed and delivered by peer roles (e.g. foster parents, former foster youth, bio parents, etc.)];
- Training around stress and well-being/self-care;
- Involvement and role in the Child and Family Team (CFT);
- Progress note training/medical necessity criteria;
- Health Insurance Portability and Accountability Act (HIPAA); and
- Access to other medically-necessary Specialty Mental Health Services (SMHS).

ANNUAL TFC PARENT EVALUATION

The TFC Agency needs to conduct an annual TFC parent evaluation, to determine any additional training or needs or issues that must be addressed for that person to continue to be successful in his/her role as a TFC parent. This evaluation will incorporate input from the CFT members, as well as a self-evaluation by the TFC parents. In addition, the evaluation should be strengths-based and solution-focused, and should address:

- The TFC parent's role and performance as a key participant in the therapeutic treatment process of the child/youth, including treatment strategies; and
- Case records and progress note documentation.

The TFC parent also will need to have a National Provider Identifier (NPI) number.²⁴

The home of the TFC parent will **NOT** need to have Medi-Cal certification.

²⁴ The NPI is a unique 10-digit identifier to identify health care providers on all standard transactions, including electronic claims. A HIPAA-covered entity is an individual or organization that electronically transmits health care information related to HIPAA transactions.

Health care providers can obtain a NPI by visiting the Centers for Medicare & Medicaid Services website at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

TFC COMPONENTS AND ACTIVITIES

TFC consists of one or more of the following: plan development, rehabilitation, and collateral. TFC parents will work ***under the direction of*** an LMHP or a WRMHP, who will give direction to the TFC parent regarding the interventions that the TFC parent will provide to the child/youth, as identified in that child's/youth's client plan.

The LMHP/WRMHP is required to meet with the TFC parent, face-to-face, in the TFC parent's home, a minimum of one (1) hour per week. In addition to monitoring the interventions provided by the TFC parent, the LMHP/WRMHP will review and co-sign daily progress notes, ensuring that each progress note meets Medi-Cal SMHS and contractual requirements.

PLAN DEVELOPMENT

Plan development (limited to when it is part of the CFT meeting): The TFC parent will participate in care planning, monitoring, and review processes, as a member of the CFT meeting. The TFC parent also will observe, monitor, and alert the TFC Agency and members of the CFT about changes in the child's or youth's needs.

Plan Development Example 1: Johnny is an eight-year-old boy who experienced domestic violence between his parents, as well as physically violent episodes directed at him.

The TFC parent attended a CFT meeting, and advised the team that Johnny has been exhibiting the following symptoms and behaviors that have escalated over time:

- Johnny often loses his temper and throws objects at the wall, at glass windows, and at other objects in the room, when he is asked to follow simple directions (e.g. washing his hands before meals and joining the family at the dinner table);
- Johnny is easily annoyed, and, if interrupted while watching television or playing a video game, shouts at others around him;
- In the classroom, Johnny frequently ignores the teacher, when she asks him to answer a question or requests that he stop disrupting the class (e.g., by shouting something at another student); and
- During school recess, Johnny frequently gets into fights or arguments with other children, because he cuts into lines, interrupts games, and/or engages in name calling.

The CFT members present at the meeting discussed approaches and interventions the TFC parent will implement with Johnny (under the direction of an LMHP or a WRMHP), to address the previously described symptoms and behaviors:

- The TFC parent will work with Johnny to reinforce the identification of behaviors Johnny needs to learn to self-manage, and to help him become proficient in using self-calming techniques, such as deep breathing exercises.
- The TFC parent will utilize time outs, in a safe place, when Johnny loses control at home and in school.
 - At Home: The TFC parent will identify where in the home Johnny feels the safest, and create, with Johnny, a setting for him to go to when he becomes anxious and upset. This created space will include activity tools, such as paper and crayons to draw a picture to describe what he is feeling. The TFC parent then will have Johnny describe his picture and his feelings.
 - At School: The TFC parent will meet with the teacher and the IHBS worker to create an area in the classroom for Johnny to go to when he becomes anxious and upset. This created space will include activity tools, such as paper and crayons to draw a picture to describe what he is feeling, and a plan on how the teacher will determine when Johnny is ready to re-join the class.
- The TFC parent and Johnny will meet with the IHBS worker to discuss behaviors that Johnny needs to learn to self-manage.
- The IHBS worker will observe Johnny's behavior at school, meet with the TFC parent and teacher, and assist Johnny in recognizing when his behavior is inappropriate.
- The IHBS worker also will assist Johnny in using self-calming techniques when he is upset (such as having paper and crayons to use to draw a picture to describe his feelings), to avoid conflicts and promote more positive interactions with his teacher and peers.

Plan Development Example 2: Diana is a ten-year-old girl. From birth until age five, she and her mother led a nomadic life, traveling from town to town in search of shelter and employment. Diana's mother is an alcoholic, and was using while pregnant with Diana, as well as during Diana's childhood.

The TFC parent attended a CFT meeting and advised the team that Diana has been exhibiting the following symptoms and behaviors:

- Diana is frequently hyperactive at home and when on an outing (as exhibited by getting up and down when eating, leaving personal items scattered throughout the house, not completing tasks without prompts, and interrupting, as though unaware that others are talking). She often seems not to listen, and does not acknowledge when the TFC parent speaks to her.

- Diana often screams and yells insults at the TFC parent, and refuses to complete simple, assigned chores (such as putting her dirty clothes in the hamper, hanging up her coat in the closet, and putting away personal items she left scattered throughout the house); and
- At school, Diana frequently leaves her seat in the classroom, provokes arguments with other students when instruction is occurring, and often blurts out answers before the teacher has finished stating the questions.

The TFC parent attends a CFT meeting, at which the team discusses approaches and interventions the TFC parent will implement with Diana (under the direction of a LMHP or a WRMHP) to address the previously described symptoms and behaviors:

- The TFC parent will help Diana to recognize when her behavior is inappropriate, by using a special, raised palm hand signal to alert Diana, without embarrassing her, when Diana is being disruptive;
- The TFC parent will teach Diana basic progressive relaxation and deep breathing techniques and other self-soothing activities (such as positive self-talk, *silently* repeating a positive phrase, such as “I am okay, I am okay”, to help her calm herself when she is feeling as if she is beginning to lose control);

- The TFC parent will arrange for a meeting with the teacher and the IHBS worker, to discuss interventions at school.
 - The IHBS worker will make weekly visits, to observe Diana in the classroom and during recess, to assist in teaching Diana how to recognize when her behavior is becoming inappropriate.
 - The TFC parent will meet with the teacher, IHBS worker, and Diana to determine verbal and nonverbal cues the teacher can use, and that Diana will recognize, to decrease the interruptions. They agree that there will be time for Diana to ask questions, and be recognized for her proactive desire to understand the task. There also will be time set aside to work with Diana to reinforce the use of time outs and relaxation exercises, to calm herself.

Plan Development Example 3: Mark is a 5-year-old boy who was raised by a Mom diagnosed with Paranoid Schizophrenia. Mom was preoccupied with the concern that Mark would be stolen from her. Therefore, she put him in unsafe and terrifying situations, believing it was actually for his safety. Mom also was unable to provide for her son’s nutritional needs, failing to prepare consistent meals, and causing Mark to be malnourished when he entered TFC.

The TFC parent attended a CFT meeting and advised the team that Mark has been exhibiting the following symptoms and behaviors:

- Mark eats everything on his plate at meal times, but also has been taking food from the table, and hoarding it in his pants pockets;
- Mark is very reluctant to go to bed, and afraid to be alone in his bedroom; and
- Mark has exhibited difficulty going to sleep, and often awakens from nightmares.

To address Mark's food hoarding behaviors, the TFC parent will:

- Provide Mark with a smaller serving (in a plastic container with a lid and a utensil), that he can take with him after he finishes his meals, and a small snack container (dry cereal or nuts) to have at school;
- Meet with Mark's Head Start teacher to develop a hand signal to use when Mark feels he needs to go to a pre-arranged place in the classroom, to give himself a time out, to calm himself, and/or eat from the container; and
- Provide verbal reinforcement, reminding Mark that he does not need to place food in his pant pockets because he has his container.

To reduce the level of anxiety that Mark experiences in connection with preparing for bed, the TFC parent will:

- Allow Mark to choose a favorite stuffed animal to sleep with, to provide additional comfort and support;
- Guide Mark through progressive relaxation and breathing exercises, when he initially lies down on his bed;
- Provide bedding that has weight, allowing a "snug" feeling when Mark is under the covers;
- Let Mark personally turn on the night light, before he gets into bed;
- Emphasize to Mark that his bedroom door always will remain open; and
- Emphasize to Mark that the TFC parent will be there all night, and will check on him periodically, to ensure he is safe and not alone in the house.

REHABILITATION

The TFC parent will implement interventions, as directed by the LMHP/WRMHP, which include trauma-informed rehabilitative treatment strategies set forth in the child's or youth's client plan. Examples of rehabilitation services include:

- Providing skills-based, medically necessary interventions (including coaching and modeling);
- Providing skills training, including developing functional skills to improve self-care; and
- Improving self-management in areas of anger management or self-esteem or peer relations.

Rehabilitation Example 1: Based on the goals established for Johnny, the TFC parent will implement the following interventions:

- Practice talking, by first having Johnny shout and discussing what it feels like, and then talking in a normal voice and discussing the difference.
- Teach Johnny to report what he is feeling, using “I” statements, in a normal tone of voice, rather than shouting;
- Teach Johnny to use relaxation techniques to deal with feelings of anger and frustration; and
- Following time out periods, verbally reinforce Johnny for being able to calm himself, and encourage him to talk about what he was feeling when he did not comply with the request, using “I” statements, in a calm tone of voice.

Rehabilitation Example 2: Based on the goals established for Diana, the TFC parent will implement the following interventions:

- Talk with Diana to determine the extent of her awareness of her hyperactivity and inattention;
- Assist Diana in identifying situations that are more challenging than others (e.g., interacting with groups, rather than just one or two individuals), and what situations tend to trigger inattentive behavior; and

- Teach Diana basic progressive relaxation exercises, deep breathing techniques, and work with her in becoming proficient in using these self-control strategies as response substitutes for hyperactivity.

Rehabilitation Example 3: Based on the goals established for Mark, the TFC parent will implement the following interventions to eliminate his food hoarding:

- Have Mark accompany the TFC parent to the grocery store, and assist Mark in selecting healthy snack foods, making him feel more in control of what food is available to eat; and
- Assist Mark in preparing snacks for himself, by putting the healthy snack foods he selected into plastic containers to take with him after he finishes his meals at home, and to take to school with him.

Based on the goals established for Mark, the TFC parent will implement the following interventions to assist Mark in reducing his bedtime anxiety:

- Tuck Mark into bed, after he selects a stuffed animal to sleep with, to make him feel more secure, along with the heavy bedding;
- Teach Mark to position a doorstop in his bedroom door, to ensure that the door stays open while he is asleep;
- Practice guided exercises, at bedtime, to supplement progressive relaxation exercises, by taking Mark’s mind to his favorite, safe place; and

- Do periodic checks after Mark is in bed (frequency to be decided with Mark), including one time before the TFC parent goes to bed (so Mark will know there is follow-through, and with the frequency decreasing with time).

COLLATERAL

The TFC parent will meet the needs of the child or youth in achieving his or her client plan goals by reaching out to significant support person(s), and by providing consultation and/or training for needed medical, vocational, or other services to assist in better utilization of SMHS by the child or youth. Collateral includes one or more of the following:

- Mentoring, consultation, and/or training of the significant support person(s) to assist the child/youth in increasing resiliency, recovery, or improving utilization of services;
- Mentoring, consultation, and/or training of the significant support person(s) to assist in better understanding of mental illness and its impact on the child/youth, and to improve the child's/youth's functioning. (The child/youth may or may not be present for this service activity.)

Collateral Example 1: To help Johnny interact positively with staff and peers at his afterschool program, the TFC parent meets with Johnny's group leader and:

- Discusses Johnny's symptoms and behaviors (e.g. not following direction, being easily annoyed, and losing his temper);

- Explains interventions that have been successful in the home setting, including encouraging Johnny to report what he is feeling by using "I" statements, and having Johnny take a ten-minute time out, so that he can use relaxation exercises to calm himself; and
- Demonstrates to the group leader the deep breathing exercises Johnny uses to calm himself during time outs, in the area created for him, so that the group leader can incorporate this intervention to assist Johnny in self-managing his behavior at the afterschool program.

Collateral Example 2: The TFC parent meets with Diana's teacher to discuss Diana's failing grades in school, due to her inattention to classroom assignments:

- The TFC parent discusses Diana's symptoms and behaviors, and identifies interventions that have been successful in assisting Diana in calming herself and focusing on her school work (including talking with Diana to determine her awareness of her hyperactivity and inattention; and helping Diana identify situations that tend to make her anxious and agitated);
- The TFC parent and the teacher develop verbal and non-verbal cues the teacher can use that Diana will recognize, to decrease the interruptions;

- The TFC parent and the teacher agree that there will be time for Diana to ask questions in the classroom, and to be recognized for her proactive desire to understand the task; and
- The TFC parent demonstrates relaxation techniques that Diana has been taught to use to help her calm down, so that the teacher can encourage and assist Diana to use these relaxation techniques to calm herself at school.

Collateral Example 3: Mark's Head Start teacher reported to the TFC parent that Mark takes extra snacks at snack time and puts them in his pocket. The TFC parent meets with the teacher to discuss how to intervene with Mark:

- Check in with Mark, to determine if he is hungry or merely anxious that no food will be available;
- Verbally praise Mark when he takes only one snack; and
- Have Mark be in charge of passing out one snack to each student, including himself, and verbally praise him for a job well done.

DOCUMENTATION OF TFC COMPONENTS AND ACTIVITIES

Documentation of TFC shall meet Medi-Cal documentation requirements and MHP policies and procedures, in accordance with the contract between DHCS and the MHP.

²⁵ TFC will not be reimbursed if a progress note is not written and available.

The TFC parent(s) must write and sign a daily progress note for each day that TFC is provided.²⁵ The progress note must meet Medi-Cal documentation standards consistent with the MHP's policies and procedures, and in accordance with the contract between DHCS and the MHP.

The TFC Agency's LMHP/WRMHP must review and co-sign each progress note, to indicate interventions are appropriate and that Medi-Cal documentation requirements are met. The TFC Agency must comply with the mental health documentation requirements prescribed by the county MHP in accordance with the contract between DHCS and the local MHP.

Please see Appendix C for a sample TFC progress note template. MHPs and TFC Agencies are not required to use this template. Rather, the progress note template is provided as a sample tool to assist with documentation needs.

TFC SERVICE AUTHORIZATION

TFC service authorization should be consistent with the MHP process for authorizing SMHS.

The progress of TFC should be reviewed, in coordination with the CFT, at least every three **(3)** months, and as needed.

COORDINATION OF TFC WITH OTHER SMHS

Children and youth who are receiving TFC are eligible for other SMHS, if medical necessity criteria are met. Children and youth receiving TFC must receive ICC and other medically necessary SMHS, as set forth in the client plan.

The MHP and providers should consider the full array of services and the needs of the child or youth. TFC must not be the only SMHS that a child or youth receives.

TFC SETTINGS / LIMITATIONS / LOCKOUTS

TFC is primarily provided in the home where the child or youth resides. However, TFC may be provided in any setting where the child or youth is naturally located, including schools, recreational settings, and other community settings. TFC will be provided daily, up to 7 days a week, including weekends, at any time of day, as medically necessary.

TFC is an Early Periodic Diagnosis and Screening (EPSDT) Specialty Mental Health Service, and, as such, does NOT include:

- Reimbursement for the cost of room and board, which will be paid separately to the TFC parent utilizing federal, State, or local foster care or education funding sources, or through private pay;
- Other foster care program related services (e.g., assessing adoption placements, serving legal papers, home investigations, administering foster care subsidies), or
- Other parenting functions such as providing food or transportation.

TFC is not reimbursable under the following circumstances:

- When the child or youth is receiving Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services, **EXCEPT** for the day of admission or discharge to/from these facilities;
- While the child or youth is detained in juvenile hall or is otherwise considered an inmate; or
- While the child or youth is in an STRTP or other residential setting, except for the day of admission or discharge.

TFC CLAIMING AND REIMBURSEMENT²⁶

Claims for TFC must use:

- a. X12N 837 *Health Care Claim: Professional* (837P) transaction set;
- b. Procedure code “S5145;” and
- c. Procedure modifier “HE.”

Claims for TFC also must include the TFC Parent’s NPI in the applicable segment on the 837P.

The unit of service for TFC is a calendar day. A day shall be claimed only for each calendar day in which TFC is provided. If there has not been a daily progress note written, there cannot be billing for that day.

The per diem rate for TFC includes:

- The TFC Agency’s administrative and LMHP/WRMHP staff costs; and
- The payment to the TFC parent for the provision of TFC.

The interim per diem rate depends on whether or not the TFC Agency is a contractor of the MHP or is county owned and operated.

- If the TFC Agency is a contractor of the MHP, the TFC Agency will be paid by the MHP a rate that is negotiated between the MHP and the TFC Agency.

- If the TFC Agency is county owned and operated, DHCS will reimburse the MHP the federal share of the MHP’s interim rate. As of March 2017, the county interim rate is set at \$87.40 per day. Each county’s interim rate will be updated annually based on its most recently filed cost report.
- The TFC Agency will be reimbursed in accordance with the terms of the contract with the MHP.

²⁶Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for applicable claiming and reimbursement rules

APPENDIX A

GLOSSARY

Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.²⁷

California Department of Social Services (CDSS) is the state agency charged with serving, aiding, and protecting needy and vulnerable children, youth, and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence.

Child and Family Team (CFT): A Child and Family Team is a group of individuals that includes the child or youth, family members, professionals, natural community supports, and other

individuals identified by the family who are invested in the child, youth, and family's success. The CFT's role is to include family members in defining and reaching identified goals for the child. The individuals on the team work together to identify each family's strengths and needs, based on relevant life domains, to develop a child, youth, and family-centered plan. The plan articulates specific strategies for achieving the child, youth, and/or family's goals based on addressing identified needs.

Client Plan as defined by Title 9 CCR §1830.205.2, means a plan for the provision of SMHS to an individual beneficiary who meets the medical necessity criteria in the California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1830.205 or 1830.210.

Collateral as defined by Title 9 CCR § 1810.206, means a service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the

²⁷ This service may be provided to youth, ages 18 to 21.

significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support persons(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity.

Crisis Intervention Services are services that last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person, and may be provided anywhere in the community.

Crisis Residential Services are services that provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

Crisis Stabilization Services are services that last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely

response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

Day Rehabilitation (Half-Day and Full-Day) are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

Day Treatment Intensive Services (Half-Day and Full-Day) are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service

activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

Department of Health Care Services (DHCS) is the state agency charged with preserving and improving the health status of all Californians. DHCS works closely with health care professionals, county governments, and health plans to provide a health care safety net for California's low-income and persons with disabilities. The DHCS is the state agency responsible for the Medi-Cal program.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. Medicaid law requires states to provide EPSDT services to beneficiaries under the age of 21 who are eligible for the full scope Medicaid services, as medically necessary, to correct or ameliorate defects and physical and mental illnesses or conditions. This requirement obligates states to provide Medicaid-covered services, whether included in a State's Medicaid State Plan or not.

Family Foster Agency (FFA) is any organization engaged in the recruiting, certifying, and training of, and providing professional support to foster parents (including TFC parents), or in finding homes for placement of children for temporary or permanent care.

Foster Care Placement is 24-hour substitute care for all children and youth who are placed away from their parent(s) or guardian(s), and for whom the State agency has placement and care responsibility. (Section 1355.20 Code of Federal Regulations).

Health Insurance Portability and Accountability Act (HIPAA) was signed into US law in 1996, and was designed to provide privacy standards to protect medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Additionally, HIPAA required simplification and standardization of healthcare electronic data; prohibited group health plans from denying coverage to individuals with specific diseases and pre-existing conditions; and changed several related tax laws associated with health insurance coverage.

Katie A. et al v. Bontá et al Lawsuit refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children and youth in California, who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. The Settlement Agreement formally ended, with the jurisdiction of the federal court ceasing, in December 2014.

Licensed Mental Health Professionals (LMHP) are licensed physicians, licensed psychologists, licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists, registered nurses

(includes certified nurse specialists and nurse practitioners), licensed vocational nurses, and licensed psychiatric technicians.

Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks, and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.

Mental Health Plan (MHP) as defined by Title 9 CCR § 1810.226, means an entity that enters into a contract with the Department of Health Care Services to provide directly, or arrange and pay for, specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.

Mental Health Services (MHS) are individual or group therapies and interventions that are designed to provide a reduction of mental disability and restoration, improvement, or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are

separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Mental Health Services activities may include, but are not limited to:

- **Assessment** - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis, and the use of mental health testing procedures.
- **Plan Development** - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.
- **Therapy** - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group, and may include family therapy at which the client is present.
- **Rehabilitation** - A service activity that includes, but is not limited to, assistance improving, maintaining, or restoring functional skills, daily living skills, social and leisure skills, grooming, and personal hygiene skills; obtaining support resources; and/or obtaining medication education.

- **Collateral** - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client; consultation and training of the significant support person(s) to assist in better understanding of mental illness; and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

Natural Supports are individuals who can further support the child or youth and the family with developing a sustainable system of supports that is not dependent on formal systems supports. Examples of natural supports are extended family members, friends, members of the clergy/spiritual leaders, community members, and others, as identified by the child or youth and family.

Open Child Welfare Services Case means that if a child and family is to be monitored by, or receive services from, the child welfare system following an investigation, the child welfare agency opens a child welfare case with the family ([U.S. Department of Health and Human Services](#)). A child or youth has an open child welfare services case if:

- a) child/youth is in foster care; and/or
- b) child/youth has a voluntary family

maintenance case (pre- or post-returning home in foster or relative placement), including both court-ordered and by voluntary agreement.

Parent Partners/Advocates are key individuals who work with children, youth, and families within the public child welfare, juvenile probation or mental health systems. Parent partners/advocates are past consumers, and can convey information on how systems and programs can instill the family-centered and family-driven philosophy and principles necessary to engage children, youth, and families.

Psychiatric Health Facility (PHF) is a facility licensed under the provisions beginning with Section 777001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations.

Psychiatric Health Facility (PHF) Services are therapeutic and/or rehabilitative services provided in a psychiatric health facility, on an inpatient basis, to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated general acute care hospital, or in outpatient settings. These services are separate from those categorized as "Psychiatric Inpatient Hospital". (Psychiatric Health Facilities are licensed under the provisions beginning with Section 77001.)

Psychiatric Inpatient Hospital Services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

Resource Family Approval (RFA) is a new family-friendly and child-centered caregiver approval process that combines elements of the current foster parent licensing, relative approval, and approvals for adoption and guardianship processes, and replaces those processes. RFA is a process used by the TFC Agency to determine whether the family-based foster caregiver meets the home environment assessment and permanency assessment standards adopted pursuant to Welfare and Institutions Code, Section 16519.5.

Short-Term Residential Therapeutic Programs (STRTPs) are residential facilities operated by a public agency or private organization, and licensed by CDSS pursuant to Section 1562.01 [Health and Safety Code]. STRTPs provide an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term, 24-hour care and supervision to children. STRTPs provide nonmedical services, except as otherwise permitted by law. Private organizations operating STRTPs must be organized and operated on a nonprofit basis.

Significant Support Person refers to persons, in the opinion of the beneficiary (i.e., the client) or the person providing services, who have, or could have, a significant role in the successful outcome of treatment, including, but not limited to: the parents or legal guardian of a beneficiary who is a minor; the legal representative of a beneficiary who is not a minor; a person living in the same

household as the beneficiary; the beneficiary's spouse; and relatives of the beneficiary.

Targeted Case Management (TCM) is a service that assists a beneficiary in accessing 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 services and the service delivery system; and monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons, and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

Therapeutic Behavioral Services (TBS) is a one-to-one, brief behavioral mental health service targeting one to two behaviors. TBS is available to children/youth with serious emotional challenges, who are under age 21, and who have full scope Medi-Cal. TBS can help children/youth and parents/caregivers, foster parents, group home staff, and school staff learn 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 is designed to help children/youth and parents/caregivers (when available) manage these behaviors, utilizing short-term, measurable goals based on the needs of the child/youth and family. TBS is never a stand-alone therapeutic intervention. It is used in conjunction with another SMHS. TBS is one to one, short-term, intensive, behavioral intervention provided in the home, school, or community.

Under the Direction of means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval, and signing client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service provided. Services are provided under the direction of: a physician; a licensed or waived psychologist; a licensed or registered marriage and family therapist; a licensed, waived, or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).

Waivered/Registered Mental Health

Professional for a psychologist candidate, “waivered” means an individual who either 1. is getting the experience required for licensure or 2. was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law. For a social worker candidate, a marriage and family therapist candidate, or a professional counselor candidate, “registered” means a candidate for licensure who is registered with the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, and “waivered” means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination, and who has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law.

APPENDIX B

SAMPLE ICC AND IHBS PROGRESS NOTES

Note: Sample ICC and IHBS Progress Notes contained in this appendix include detailed narrative sections, with multiple examples. This narrative format was included as a learning tool, to provide the reader with several examples of the types of appropriate information to be included in ICC and IHBS progress notes.

SAMPLE 1: ICC PROGRESS NOTE

Date: 1/10/18 Staff Service Duration: :40 Travel Durations: :15 Documentation: :09

Telephone Contact:
Y N Other Staff Duration: :40 Travel Durations: :15 Documentation: :00

Procedure Code: T1017:HK

Service: Intensive Care Coordination

Location of Service: Client's Home

Goal: Rick will increase replacement behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder, to reduce Rick's taking toys, without asking, and angrily pushing siblings and peers, from five times per day to one time per week.

Rick reported only two, angry outbursts, and taking turns at school for the last five days. Rick has been playing basketball with peers after school. Rick also shared that he was invited to a classmate's birthday party on Saturday, and is looking forward to going to the party.

Rick's mother and grandmother reported his progress in self-regulation, at home and in school. With encouragement and prompting from his maternal grandmother, Rick is able to complete his homework, and has been taking care of his hygiene. He has been taking his prescribed medications from his mother, without resistance. Mother is pleased with Rick's behavioral improvement.

The parent partner informed the team that Rick's mother continues to participate in school conferences and IEP meetings, which has helped Mother better understand the context of Rick's behavior. The parent partner also reported fewer altercations between client and Mother, because of improved communication styles between the two. The parent partner would like to work on additional ways for Rick to express thoughts, because that might be helpful to Rick and his family.

The ICC coordinator led a discussion regarding the potential of having the IHBS worker decrease the amount of home sessions, but continuing to reinforce Rick's anger management plan. Rick smiled at the idea of the IHBS worker coming less. When the ICC coordinator prompted Rick to share why he was smiling, he stated "it makes me feel like I am getting better".

Mother was supportive of the idea, but asked if the IHBS worker could still come every week. The IHBS worker thanked the Mother for verbalizing her request, but shared that

she (the IHBS worker) thought it would be good for Rick to try decreasing the frequency, reinforcing Rick's success. Rick's mother agreed to give it a try.

The parent partner acknowledged Mother's appropriate communication skills, and discussed with Mother the importance of consistency in dealing with Rick's outbursts. The parent partner will assist Mother in developing a plan to support and recognize appropriate behavior and social interaction.

The IHBS worker shared that she thought working on other ways to express feelings might be helpful to Rick and his family. The IHBS worker will meet with Rick, reinforce his anger management plan, and teach alternative ways of expressing feelings, such as "I" statements and lowered voice tone.

Rick's mother reported feeling much more confident in her own response when Rick is struggling, and indicated that she understands the importance of her response to Rick in helping Rick to stay calm.

Signature & Discipline:	Date:	Co-signature & Discipline:	Date:

SAMPLE 2: IHBS PROGRESS NOTE

Date: 1/13/18		Staff Service Duration: :40		Travel Durations: :20		Documentation: :09	
Telephone Contact: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N		Other Staff Duration: :00		Travel Durations: :00		Documentation: :00	
Procedure Code: H2015:HK		Service: Intensive Home Based Services					
Location of Service: Client's Home							
<p><u>Goal:</u> Rick will reduce impulsive, aggressive behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder (including kicking and punching siblings), from five times per day to one time per week, as well as increase use of pro-social replacement behaviors.</p> <p>The IHBS worker met with Mother and Aunt to identify situations and triggers at home that contribute to Rick's angry outbursts. The family reported that Rick has been throwing tantrums, kicking and punching his siblings. When they start playing and teasing each other, Rick's behavior escalates and gets out of hand.</p> <p>The IHBS worker assessed the home situation, and assisted Mother in identifying situations that lead to Rick's angry outbursts.</p> <p>The IHBS worker and family discussed the family dynamics and alternative ways to deal with Rick's frustration, such as talking to Rick in a firm, but calm, tone of voice, and suggesting alternative options.</p> <p>The IHBS worker also assisted Mother in gaining a better understanding of Rick's behavior, and the importance of recognizing the target behavior in order to give Rick verbal praise.</p> <p>Rick agreed that he will take a brief time out, in a chair at the kitchen table, when he feels himself becoming angry. If Rick becomes violent toward self/family members, he will go to his room for a 15-minute period to calm himself.</p> <p>The IHBS worker will continue to assist Mother in identifying when the interaction is likely to become out of control, so that she can intervene early. The IBHS worker also will assist Mother in modeling appropriate responses to Rick's outbursts.</p>							
Signature & Discipline:		Date:		Co-signature & Discipline:		Date:	

APPENDIX C

SAMPLE TFC PROGRESS NOTES

Note: Sample TFC Progress Notes contained in this appendix include detailed narrative sections, with multiple examples. This narrative format was included as a learning tool, to provide the reader with several examples of the types of appropriate information to be included in TFC progress notes.

SAMPLE 1: TFC PROGRESS NOTE

<u>Child's/Youth's Name:</u> Johnny Doe	<u>Record Number:</u> 78910
Service Date and Time: 09/12/2017 10:31 pm	Location of Service: Home
<p>1. Presentation</p> <p><i>Observations of the child's/youth's behavior(s) for the day. Include the target behavior(s), as well as appropriate behaviors and interactions the child engaged in.</i></p> <p>Four episodes occurred today, all involving both target behaviors (see below). The first episode occurred when Johnny was asked to get out of bed, and begin getting ready for school. The second occurred when Johnny was asked to turn off the television and get dressed for school. The third occurred when Johnny returned home from school, and I asked him if he would put his toys (which were scattered over the living room floor) into his toy chest. The fourth occurred after dinner, when Johnny was asked to turn down the volume on the television. In all four occurrences, Johnny began yelling, "shut up, shut up," and then threw something at the wall (his pillow, a shoe, a toy, a small bronze statue).</p>	
<p>2. Target behavior(s)</p> <p><i>Behaviors identified in the client plan</i></p> <ul style="list-style-type: none"> • To eliminate throwing objects at wall when loses temper • To decrease refusal to comply with parental requests 	
<p>3. Intervention(s) utilized</p> <p><i>What strategies were used to address the target behavior, based on proposed interventions identified in the client plan?</i></p> <p>On all four occasions, I first offered prompts, encouraging Johnny to take a big breath to calm himself. But Johnny could not calm himself, so he was asked to go to his room for a ten-minute time out. The procedure in place is that Johnny is to use deep breathing exercises to calm himself when he is placed in a time out. The next procedure in place, after the time out period ends and Johnny is calm, is for me to encourage him to express his feelings, using "I" statements.</p>	

4. Child's/Youth's response to intervention(s)

Was the intervention effective? How did the child/youth practice coping strategies? Did the child/youth remember coping strategies/think about the strategies before or after the behavior? Can the child/youth think of what could have gone better? Identify other coping solutions? How did the child/youth respond to strategies utilized?

Although multiple prompts were required, Johnny eventually went to his room for all four time out periods. When Johnny returned from the first three time outs, he was calmer, but his muscles remained tense. I praised him for being able to calm himself down. When Johnny returned from the fourth time out, he was calmer, and his body also was much more relaxed. I praised Johnny for doing an especially good job of calming himself down, and asked if he used the deep breathing exercises that he and I had been working on.

Johnny told me that he always uses the deep breathing exercises to calm down, but the deep breathing exercises don't always work very well. I suggested to Johnny that the deep breathing exercises might have worked better this time because he is becoming better at using them to relax and calm himself down. Johnny smiled and replied, "I am getting better at doing the breathing exercises, but they still are hard for me to do."

I suggested that Johnny try to use the deep breathing exercises as soon as he starts to become upset, so that he won't have to work as hard to calm himself down. Johnny said that he would tell me when he starts to become angry again, so that he and I can practice doing the breathing exercises together. I told Johnny that I am very proud of him for doing such a good job of explaining his feelings, and that I would be happy to do the deep breathing exercises with him, after he first notices that he is beginning to get upset.

TFC Parent Signature/Date:

LMHP/WRMHP Co-Signature/Date:

SAMPLE 2: TFC PROGRESS NOTE

<u>Child's/Youth's Name:</u> Diana Doe	<u>Record Number:</u> 123456
Service Date and Time: 09-12-2017 8:03 pm	Location of Service: Home
<p>1. Presentation</p> <p><i>Observations of the child's/youth's behavior(s) for the day. Include the target behavior(s), as well as appropriate behaviors and interactions the child engaged in.</i></p> <p>Met with Diana to assess her degree of awareness of her hyperactivity, impulsivity and attentional deficits.</p>	
<p>2. Target behavior(s)</p> <p><i>Behaviors identified in the client plan</i></p> <ul style="list-style-type: none"> • To decrease excessive quantity and rate of speech and movement • To develop the ability to recognize attentional deficits, and to understand what is appropriate behavior for the context in which she finds herself 	
<p>3. Intervention(s) utilized</p> <p><i>What strategies were used to address the target behavior, based on proposed interventions identified in the client plan?</i></p> <p>I talked with Diana about what appeared to be hyperactivity, impulsivity, and attentional challenges, and reinforced the use of a special (open palm) hand signal, to alert her when her behavior is becoming out of control. I asked Diana if she was aware of these behaviors.</p>	
<p>4. Child's/Youth's response to intervention(s)</p> <p><i>Was the intervention effective? How did the child/youth practice coping strategies? Did the child/youth remember coping strategies/think about the strategies before or after the behavior? Can the child/youth think of what could have gone better? Identify other coping solutions? How did the child/youth respond to strategies utilized?</i></p> <p>Diana said that she knows that she "moves around a lot," that she "talks more than other kids", and has trouble sitting still and concentrating on her homework. Diana talked about how she got into the habit of moving around all the time when she was</p>	

younger, and she and her mom needed to always be on the lookout for places to live and jobs that her mom could work at, to make money to pay rent and buy food. Diana told me that is it very hard for her to “slow down” and stop “annoying” other people by talking and moving around all the time. I told Diana that must have been hard for her, and thanked her for sharing with me.

Diana told me that she wants to be calmer, so that she can have friends, and that the other kids won’t think she’s “weird” and “annoying”. I reassured Diana that she and I could continue to practice the deep breathing exercises that she can use to calm herself.

I also assured Diana, that I would keep using “our special hand signal” (a raised palm), to remind her when her behavior starts to get out of control, and that the signal would tell her that it was time for her to use the deep breathing exercises to calm herself. Diana told me she is glad that I am willing to help her work on learning to be calmer and not talk as much. She asked if I would work on deep breathing exercises with her now, and then help her with her homework. I told her that I would be happy to help her work on the deep breathing exercises and complete her homework.

TFC Parent Signature/Date:

LMHP/WRMHP Co-Signature/Date:

SAMPLE 3: TFC PROGRESS NOTE

<u>Child's/Youth's Name:</u> Mark Doe	<u>Record Number:</u> 10111213
Service Date and Time: 09-12-2017 8:47 pm	Location of Service: Home
<p>1. Presentation</p> <p><i>Observations of the child's/youth's behavior(s) for the day. Include the target behavior(s), as well as appropriate behaviors and interactions the child engaged in.</i></p> <p>Today was the second day on which the interventions for both target behaviors (see below) were used.</p>	
<p>2. Target behavior(s)</p> <p><i>Behaviors identified in the client plan</i></p> <ul style="list-style-type: none"> • To eliminate food hoarding behavior • To decrease anxiety related to going to bed 	
<p>3. Intervention(s) utilized</p> <p><i>What strategies were used to address the target behavior, based on proposed interventions identified in the client plan?</i></p> <p>With Mark's help, I made a list of healthy snack foods that he likes to eat. Then, he and I went to the grocery store to pick out these foods. When we returned home from the grocery store, Mark helped me put the snack foods into plastic containers, with lids and utensils, so that he could take one snack with him (to school or to bed) after he finished each meal. I praised Mark for doing such a great job of making sure that he had snacks to eat if he got hungry between meals.</p> <p>Before bed, I helped Mark insert a rubber doorstop, to keep his bedroom door open, and to turn on the night light. Next, I had Mark select a stuffed animal to sleep with, and tucked him into bed with, using a weighted cover that made him feel snug. After he was tucked into bed, Mark and I practiced deep breathing exercises. Then, I helped him relax further by using guided imagery to take Mark's thoughts to his favorite, safe place.</p>	

4. Child's/Youth's response to intervention(s)

Was the intervention effective? How did the child/youth practice coping strategies? Did the child/youth remember coping strategies/think about the strategies before or after the behavior? Can the child/youth think of what could have gone better? Identify other coping solutions? How did the child/youth respond to strategies utilized?

Mark liked being in control of picking out healthy snack foods, and packing the snacks in special containers that he can take with him after he finishes his meals. Mark told me that he likes eating the snacks from the plastic containers because the food does not get all "shmooshed up" and "stuck together", like it does when he sticks food in his pockets. Mark also told me that he likes going to the grocery store because the snacks he picks out and packs for himself taste better because he knows best what he likes to eat.

Mark responded well to the bedtime routine, and was very cooperative about placing the doorstop in the door and turning on the night light. When it was time to pick out a stuffed animal to sleep with, Mark insisted that he was not ready to go to sleep, and (unsuccessfully) tried to convince me to let him have extra time watching TV. Mark ultimately found three stuffed animals to sleep with, instead of one, and laid down in bed, and began doing his deep breathing exercises with my assistance. Mark struggled when doing the deep breathing exercises with me, and became a bit frustrated, but kept trying. The guided imagery exercise, (to take Mark to his special, safe place) helped Mark fall asleep within ten minutes. Before I went to bed, I checked on Mark, and he was asleep. At 11pm, I heard Mark scream, "stop, leave me alone", so I rushed into his room and helped him to restart his relaxation breathing exercises and guided imagery. Within about 15 minutes, Mark went back to sleep.

TFC Parent Signature/Date:

LMHP/WRMHP Co-Signature/Date:

INSTRUCTIONS FOR TFC PROGRESS NOTE

The Licensed Mental Health Professional (LMHP) or Waivered or Registered Mental Health Professional (WRMHP) directing the TFC parent(s) in providing this service should use this document to assist the TFC parent in completing the TFC Daily Progress Note. This document contains instructions, explanations, and examples that are intended to aid the TFC parent in completing a progress note that is in compliance with Medi-Cal documentation requirements.

- I. Service Date:** TFC Parent to provide the date that the service being claimed was performed.
- II. Client Plan:** Use the client plan developed with the CFT as a reference to identify the target behavior(s) and/or planned intervention(s).
- III. Progress Note:**
 - 1. Presentation**
 - a. Brief narrative of the child's/youth's day and how targeted activities went.
 - b. Include the target behavior(s), as well as appropriate behaviors and interactions the child/youth engaged in.
 - 2. Target behavior(s)**
 - a. Identify the target behaviors identified in the client plan that the child/youth engaged in that day.
 - b. Be specific.
 - 3. Intervention(s) utilized**
 - a. What strategies were used to prevent the target behavior, or promote the desired behavior, based on proposed interventions identified in the client plan?
 - b. How did you respond when the child/youth engaged in the target behavior?
 - c. How did you utilize interventions identified in the client plan?
 - 4. Child's/Youth's response to the intervention**
 - a. Describe how the child/youth reacted to your intervention? How did the child/youth respond to strategies utilized?
 - b. How did the child/youth practice coping strategies? Did child/youth remember coping strategies/think about the strategies before or after the behavior?
 - c. Can the child/youth think of what could have gone better? Identify other coping solutions.

- d. Describe whether the child's/youth's reaction was positive or negative. (Not all interventions will have the desired result.) This helps guide future treatment planning and interventions.
- e. Include quotes from the child/youth, whenever possible.

5. Signature/Date of TFC Parent and Co-Signature/Date of LMHP/WRMHP

Examples of potential target behaviors, including, but not limited to:

- Noncompliance with house rules
- Refusing to get out of bed
- Refusing to go to school
- Refusing to eat meals
- Interrupting—repeatedly cutting off foster mother as she tried to have a conversation with her friend

Examples of desirable behaviors, including, but not limited to:

- Child/youth follows instructions appropriately
- Child/youth used his/her newly learned coping skills to navigate a difficult issue
- Child/youth plays quietly and shares toys/electronic gaming controls without outburst.
- Child/youth has kept toys/electric gaming parts in good condition, with no breaking.

Possible ways to debrief with the child at the end of the day:

- Explore with the child/youth his/her response to the intervention(s), and if he/she found it helpful.
- Explore with the child/youth possible preferred parental approaches to target behaviors.
- Be mindful of the child's/youth's current mood state at the time of debriefing, in order to have a successful interaction.

APPENDIX D

NON-REIMBURSIBLE ACTIVITIES

CCR, TITLE 9, CHAPTER 11, § 1840.312. NON-REIMBURSABLE SERVICES - GENERAL.

The following services are not eligible for FFP:

- (a) Academic educational services
- (b) Vocational services that have as a purpose actual work or work training
- (c) Recreation
- (d) Socialization is not reimbursable if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.
- (e) Medi-Cal program benefits that are excluded from coverage by the MHP, as described in Section 1810.355:
 - (1) The beneficiary was receiving, prior to his/her twenty-first birthday, services in an institution for mental diseases and the services are rendered without interruption until no longer required, or until his/her twenty- second birthday, whichever is earlier; and
 - (2) The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which FFP may be available include, but are not limited to, acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services.
- (f) Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through 441.156. Facilities at which FFP may be available include acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.

- (g) The restrictions in Subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.
- (h) Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5, to the extent that they are provided to beneficiaries whose Medi-Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services
- (i) The MHP may not claim FFP for specialty mental health services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

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to California's children, youth, and families:

County Behavioral Health Directors Association of California
County Welfare Directors Association of California
Therapeutic Foster Care Implementation Committee
Members of the Pathways to Wellbeing Community Team
Counties
Youth and Parent Partners
Providers
California Institute for Behavioral Health Solutions