EPSDT INTENSIVE SERVICES* TRAINING 2017

*PATHWAYS TO WELL-BEING

Fresno County Department of Behavioral Health

TRAINING OBJECTIVES

After this training, participants will be able to:

- Define the *Core Practice Model* (CPM) and its value to clients and families as well as human service professionals
- Articulate how the values, principles, and teaming process of the CPM direct the integrated practice for children and families in Fresno County
- Define the mental health activities of *Intensive Care Coordination* (ICC) and *Intensive Home-Based Services* (IHBS) and describe how these services differ from other specialty mental health services
- Document the different types of teaming activities that constitute ICC
- Document the different types of treatment activities that constitute IHBS

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT - WHAT IS EPSDT?

- A comprehensive and preventive child health program for individuals under the age of 21. It was introduced by the federal government in 1989 to broaden and enhance mental health delivery services for children under State Medicaid plans.
- EPSDT specialty mental health services are those services that are provided *to correct or ameliorate* the diagnoses listed in 9 CCR Section 1830.205, and that are not otherwise covered..

ESPDT "Mental Health Services" means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency for Medi-Cal beneficiaries under the age of 21.

This most often includes assessment, plan development, psychotherapy, rehabilitation, collateral, and case management.

EPSDT INTENSIVE SERVICES THAT MAKE UP THE PATHWAYS TO WELL-BEING: ICC AND IHBS

Intensive Care Coordination and Intensive Home-Based Services (formerly known as Katie A. services) are intensive, needs-driven, and strength-based services intended for children and youth and their families in addition to other EPSDT mental health services.

These children and youth qualify to receive a more intensive array of ***medically necessary*** mental health services ***in their own home, a family setting, or the most home-like setting*** in order to meet their needs for safety, permanence, and well-being. Service provision is guided by the Core Practice Model (CPM).

HISTORY OF EPSDT INTENSIVE SERVICES AND THE KATIE A. SETTLEMENT AGREEMENT: WHO IS KATIE A.?

Katie A. was a child in the Los Angeles Child Welfare System. Katie A. was removed from her home at age 4 and spent 10 years in the foster care system. She was moved through 37 different placements, which included:

- 4-group homes
- 19-psychiatric hospitals
- 2-Metro State Hospital
- 2-McLaren Hospital

An early assessment indicated services were needed. However, she did not receive treatment for trauma nor individualized mental health services. The four other children named in the Katie A. lawsuit had similar experiences.

Katie was 14 years old when the lawsuit was filed in Los Angeles County in 2002. It became a class action lawsuit in 2003. L.A. County settled in 2003 and implemented services. The Department of Social Services and Health Care Services (formerly the Department of Mental Health) settled in November 2011. A Special Master appointed by the Court oversees the settlement agreement.

CURRENT SERVICE DELIVERY OF EPSDT INTENSIVE SERVICES BY FRESNO COUNTY CWMH PROGRAMS (CPM: PATHWAY TO INTENSIVE CARE COORDINATION AND INTENSIVE HOME BASED SERVICES)

CORE PRACTICE MODEL

Shared Responsibility, Collaboration, Cultural Competence and Humility, Child Centered and Family Focused/Driven Systems, Permanency, Evidence-Based Practices, Transparency, Disproportionality/Disparity, Accountability

CHILD AND FAMILY TEAM (CFT)

Child, youth and family; Formal/Informal Supports, Advocate, Social Worker, ICC Coordinator, Treatment Providers (as appropriate), other agencies (i.e., Education, Probation, CVRC, others)

INTENSIVE CARE COORDINATION (ICC)

Facilitated by the ICC Coordinator and includes the Social Worker, mental health treatment provider(s), wraparound, TFC representative, the child/youth and caregivers, others as appropriate

EPSDT SERVICES
TBS, CWMH Programs
All FCMHP (DBH and Contracted Providers)

ICC Services

Intensive Home Based Services

SB 163 Wraparound

Therapeutic Foster Care

TRANSITION FROM SUBCLASS

No longer meets Subclass criteria

CW Case Closed

Medically necessary mental health services

Discharge from treatment

Note: Medically necessary EPSDT mental health services will continue whether the CW case is open or closed for Medi-Cal children/youth

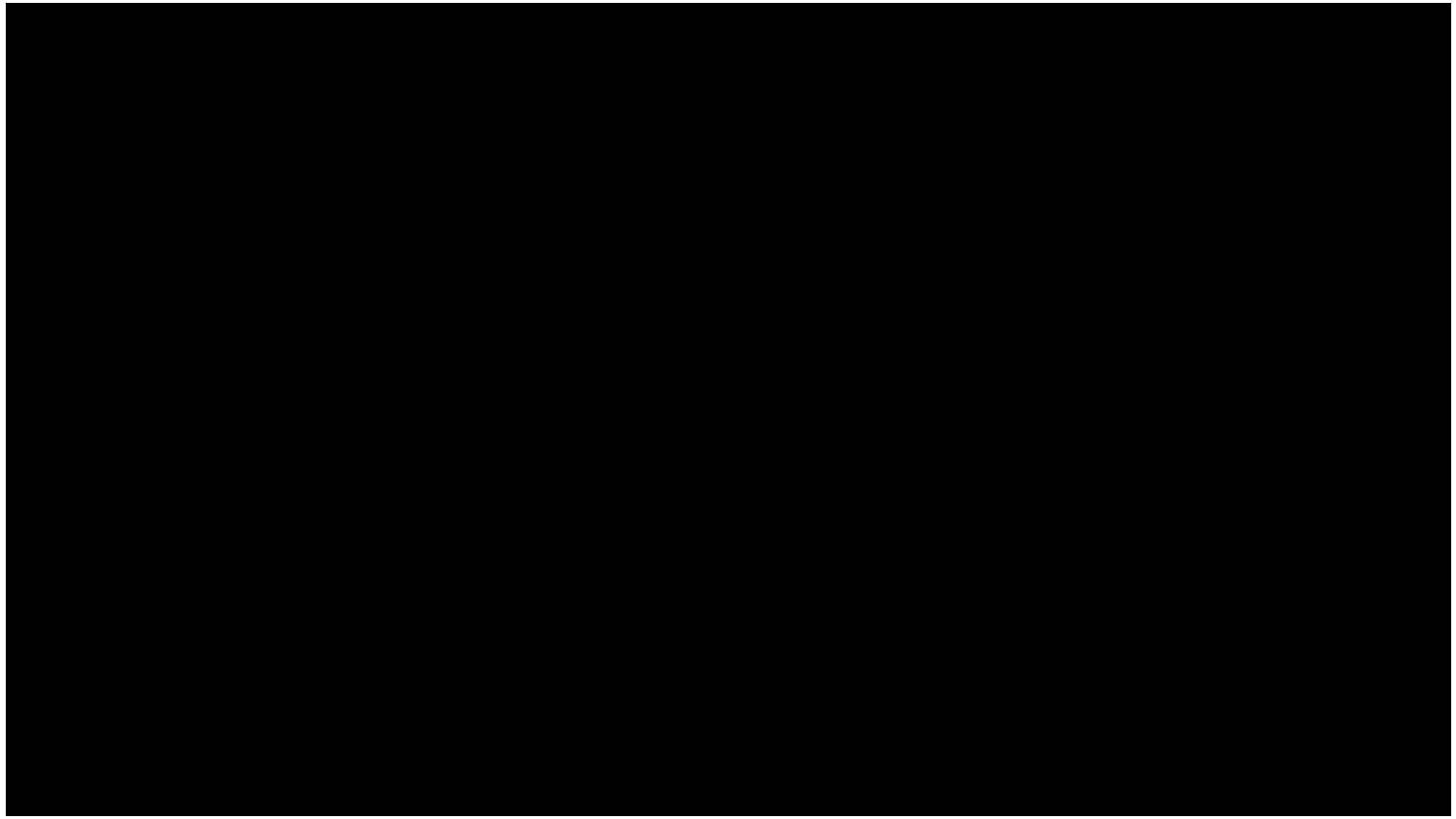
2016 UPDATE: INFORMATION NOTICE 16-004 PROVISION OF ICC AND IHBS AS MEDICALLY NECESSARY THROUGH EPSDT

- MHSUDS Information Notice 16-004 opens up ICC and IHBS to all EPSDT clients as Katie A. Class and Subclass are no longer medically necessary criteria for these intensive services and the guidelines state a client no longer need to have an open child welfare case;
- *However,* Fresno County's 4 *CWMH programs* are still designed to service children connected to Fresno County DSS, and all referrals to these programs still need to come from the DBH CWMH Team.
  - There has been no change to the CWMH programs' target population; *their* target population of children and families still need involvement in the child welfare system. *It is just that they do not have to wait for the minor client to be identified in Avatar before beginning ICC and IHBS*.
- The FCMHP will be opening up these intensive *services* to other programs as appropriate in the near future for those children who do not have an open child welfare case, but otherwise meet eligibility.

PART ONE: CORE PRACTICE MODEL

The Driving Force of EPSDT Intensive Mental Health Services

THE CORE PRACTICE MODEL (LOS ANGELES COUNTY DCFS)



https://www.youtube.com/watch?v=MCxF7shqcwY

CORE PRACTICE MODEL (CPM)

The CPM is a set of practices and principles for children/youth served by both the child welfare and the mental health systems that promotes a set of values, principles, and practices that is meant to be shared by all who seek to support children/youth and families involved in the child welfare system, including, but not limited to education, probation, drug an alcohol and other health and human services agencies or legal agencies with which the child/youth is involved.

-Pathways to Mental Health Services; Core Practice Model Guide

To understand how to implement ICC and IHBS, the mental health staff must first understand the underlying purpose via the CPM.

CORE PRACTICE MODEL (CPM)

- The CPM *requires* collaboration between child welfare and mental health staff, service providers, and community partners working with the children, youth, and families.

- The CPM should not be viewed as a practice model specific to a single agency, nor is it a program.

- The CPM is guided by specific values and principles related to working with children, youth and families in the child welfare and mental health systems.

CPM: VALUES AND PRINCIPLES

Children are first and foremost protected from abuse and neglect, and maintained safely in their own homes

Services are needs driven, strength-based, and family focused from the first conversation with or about the family

Services are individualized and tailored to strengths and needs of each child and family

Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base

Parent/Family voice, choice, and preference are assured throughout the process

CPM: VALUES AND PRINCIPLES

Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success

Services are culturally competent and respectful of the culture of children and their families

Services and supports are provided in the child and family's community

Children have permanency and stability in their living situation

All children/youth, regardless of identification of "Katie A. Class/Subclass," if interacting with both CWS and MH are entitled

CORE PRACTICE MODEL & CHILD AND FAMILY TEAMS

- ***Teaming*** *for all youth* involved in Child Welfare (or other system connection outside of mental health) *who have an identified mental health concern*

- The Child and Family Team (CFT) process ***brings a team together to make mental health decisions and plans with the youth/family***

- The CFT supports the youth/family in working toward their mental health goals and their transition out of the Child Welfare System or other connected system)

- The CFT meeting structure provides a problem-solving, solution-focused approach to decision making

2016 UPDATE: INFORMATION NOTICE 16-049 REQUIREMENTS AND GUIDELINES FOR CREATING AND PROVIDING A CHILD AND FAMILY TEAM

- All County Letter No. 16-84/MHSUDS Information Notice 16-049 provides mandatory guidelines for creating and maintaining "Child and Family Teams" (CFTs) as required by California Assembly Bill 403, part of the broader Continuum of Care Reform package.
- The CFT is the basis for ICC activities, as the CFT process reflects the culture and preferences of children, youth, and families in the direction and planning of treatment and linkage to community resources.

What you need to know: In order to provide Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS), a child or youth must first have a CFT formed and active to direct these service activities.

THE CHILD AND FAMILY TEAM (CFT)

- The CFT is a team of people – it is comprised of the child/youth and family and all of the ancillary individuals who are working with them towards their mental health goals and their successful transition out of the child welfare system.

- **Each individual team member has his or her unique role and responsibilities**, but they are always working as part of the team.

- It is important to distinguish between CFTs, which are people, and CFT meetings, which are the vehicles the CFT uses to communicate and coordinate their work.

- The CFT develops an ICC Plan collaboratively, which is reviewed by the CFT at least every 90 days. **ICC activities will surround the development, implementation, and monitoring of this ICC Plan**.

PATHWAYS TO WELL-BEING: ICC AND IHBS

Intensive Care Coordination and Intensive Home-Based Services (formerly known as Katie A. services) are intensive, needs-driven, and strength-based services intended for **children and youth who are in foster care or are at imminent risk of foster care placement**, and their families.

These children and youth qualify to receive a more intensive array of ***medically necessary*** mental health services ***in their own home, a family setting, or the most home-like setting*** in order to facilitate reunification and to meet their needs for safety, permanence, and well-being. Service provision is guided by the Core Practice Model (CPM).

UPDATING THE CLIENT'S TREATMENT PLAN WITH ICC AND IHBS (FRESNO COUNTY)

- Either at the time of initiating treatment or after determining the appropriateness of EPSDT intensive services, the treating clinician will meet with the client and parent/caregiver to discuss the benefits of IHBS and ICC and obtain their agreement to receive these services.

- **IHBS and ICC services are voluntary and client may decline services.**

- Upon agreement by client or guardian, the treatment plan should be updated to add IHBS and ICC as separate service type to those interventions on the current treatment plan

- **The client's signature or the reason for the absence of a signature must be obtained/noted in accordance with the Fresno County Mental Health Plan (MHP) documentation and billing standards.**

- The treating therapist may bill this as a Plan Development service.

PART TWO: INTENSIVE CARE COORDINATION

Defining, providing, and claiming

INTENSIVE CARE COORDINATION

Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for, and coordination of service, including urgent services using a teaming process (CFT) to support a youth's identified mental health needs and treatment goals.

Intensive Care Coordination Plan (ICC Plan) refers to the plan developed by the CFT to support the youth's behavioral health needs (as defined by the treatment plan/POC). The ICC Plan is not the same as the client's mental health treatment plan as developed by the treating clinician. The ICC Plan must clearly identifies the mental health ICC Coordinator and members of the Child and Family Team (CPT).

The ICC Coordinator (facilitator) is a mental health provider able to claim for Medi-Cal services through the FCMHP. The ICC Coordinator (facilitator)must be clearly identified in the client record (not necessarily in every ICC progress note).

Though a client may have several MH providers, each with their own POC, the CFT creates only one ICC Plan

At the CFT, the ICC Coordinator is responsible to write up and distribute the ICC Plan

Fresno County Department of Behavioral Health
CFT Summary/ICC Plan

Date: Meeting Start Time: Meeting Stop Time:
Client's Name:
Facilitator:
Team Members Present:

Summary of Meeting

1. What's working

2. Needs and Concerns

3. ICC Plan:

Need/Concern	Planned action, intervention and frequency	By whom/Agency

4. For discussion at the next meeting:

5. Next Meeting (date, time, location, other invitees):

Facilitator's Signature Printed Name Date

Client Name:		ID#:	

CFT SUMMARY/ ICC PLAN

CWMH Information Notice No. 2: Providing and Claiming for Intensive Home-Based Services and Intensive Care Coordination (09/14/2015)

CFT Summary/ICC Plan

- ICC Coordinator (facilitator) is clearly identified.
- ICC Coordinator (facilitator) must be a mental health professional with the FCMHP
- ICC Plan is developed and then updated at least every 90 days
- ICC Plan/activities support the youth's mental health needs and treatment plan goals

DEVELOPING AND DOCUMENTING THE ICC PLAN

- The purpose of the meeting is to ensure that *medically necessary mental health services* are accessed, coordinated, and delivered *in a strength-based, individualized, family/youth-driven, culturally and linguistically relevant manner.* It supports the parent/caregiver in meeting the needs of the youth, provides a care planning process across providers and formal and natural supports *to achieve the goals of the client's treatment plan* and the DSS case plan

- The facilitator will complete the CFT Summary/ICC Plan form as approved by the County that includes the name of the participants, duration of meeting and the actions and *assigned responsibilities of team members* that collectively comprise the ICC Plan.

- The CFT Summary/ICC Plan will be given to team members to retain in their client files for documentation and audit purposes.

- To claim for ICC activities, a copy of the client's clinical assessment, current treatment plan, and CFT Summary/ICC Plan must be in the client file if the provider is other than the treating clinician.

INTENSIVE CARE COORDINATION

207 Notes (Intensive Care Coordination - ICC) show a service that ***facilitates development and implementation of cross-system/multi-agency collaboration*** as described by the Child and Family Team (CFT)to support the client's mental health needs per POC, and contains on at least one of the following:

1. **Assessing**

- Assessing client's and family's needs and strengths; Assessing the adequacy and availability of resources; Reviewing information from family and other sources; Evaluating effectiveness of previous interventions and activities

OR

2. **Service Planning and Implementation**

- Developing a plan with specific goals, activities, and objectives; Ensuring the active participation of the client and involved individuals and clarifying the roles of these individuals; Identifying the interventions / course of action targeted at the client's and family's assessed goals

OR

3. **Monitoring and Adapting**

- Monitoring to ensure that identified services and activities are progressing appropriately; Changing and redirecting actions targeted at the client's and family's assessed needs, not less than every 90 days

OR

4. **Transition**

- Developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

ICC PROGRESS NOTE

MEDI-CAL MANUAL FOR INTENSIVE CARE COORDINATION, INTENSIVE HOME BASED SERVICES & THERAPEUTIC FOSTER CARE

Date: 1/10/13 Staff Service Duration: :40 Travel Duration :15 Documentation: :09 Telephone Contact: Y N

Procedure Code: T1017:HK Service: Intensive Care Coordination Location of Service: Client's Home

Goal: John will increase replacement behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder to reduce client's kicking and punching siblings and peers from 5x per day to 1x per week.

John reported no angry outbursts at school for the last 5 days. Has been playing basketball with peers after school. John also shared that he was invited to a classmate's birthday party on Saturday and is looking forward to going to the party.

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

Parent Partner informed team that Mrs. T continues to participate in school conferences and IEP meetings, which has helped mother better understand the context of John's behavior. Parent Partner also reported fewer altercations between client and mother because of improved communication styles between the two. ICC Coordinator led discussion regarding potential of IHBS worker decreasing amount of sessions at the home but continuing to reinforce anger management plan. John smiled at the idea of the IHBS worker coming less. When the ICC Coordinator prompted John to share why he was smiling, client 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 shared that she thought working on other ways to express feelings might be helpful to the John and his family.

Parent Partner acknowledged mother's appropriate communication skills, discussed with mother importance of consistency in dealing with John's outbursts. Parent Partner will assist mother in developing a plan to support and recognize appropriate behavior and social interaction. IHBS worker will meet with John, reinforce his anger management plan and teach alternative ways in expressing feelings.

Mrs. T. reported feeling much more confident in her own response when John is struggling and that she understands the importance of her response to John in helping him to stay calm.

_____ _____ _____ _____

Signature & Discipline Date Co-signature & Discipline Date

ICC PROGRESS NOTE

COURTESY OF THE *MONTEREY COUNTY BEHAVIORAL HEALTH 2014 CLINICAL DOCUMENTATION GUIDE*

S: Care Coordinator (CC) met with the Client Family Team (CFT) which consisted of the client, the client's foster parents, Child Welfare Services social worker and the client's County Behavioral Health Aide.

O: CC thanked all individuals for attending today's meeting for the purpose of review the progress that the client has made thus far with regard to managing angry feelings in a more constructive manner and decreasing threats of self harm. The CC encouraged the client and each individual present to speak to the progress that the client has made and encouraged each individual to provide input regarding "next steps" in the treatment process to ensure the client's continued success. The CC noted several community resources that were discussed and reported that he would follow up on these resources for the client and report back to the team when additional information is gathered. The CC reported that based on the client's progress toward his treatment goals that the treatment plan would be updated to reflect current baselines and would be presented to the client and the team next week. The CC provided positive feedback to the client for his hard work toward addressing his goals and encouraged the client to continue to verbalize his needs to his support persons as necessary.

A: The client was actively engaged in the CFT as evidenced by his eye contact and remaining seated at the table. He was able to report that the extra support he has been receiving from his foster parents over the past month has been helpful and that sometimes he needs to be reminded of his goals. Each individual present reported that the client has been better able to manage his feelings of frustration in the school and home setting and discussed community resources they feel may be of additional support to the client. All present agree to review the updated treatment plan at the CFT scheduled next week.

P: The CC will review and update the client's current treatment plan to reflect current needs and baselines and will present the updated plan to the CFT during next week's scheduled meeting.

CLAIMING FOR ICC SERVICES

FRESNO COUNTY'S CWMH INFORMATION NOTICE NO. 2: PROVIDING AND CLAIMING FOR INTENSIVE HOME-BASED SERVICES AND INTENSIVE CARE COORDINATION

- **Multiple providers may claim for their time and participation at the Teaming meeting.**

- Each provider may claim for the time he or she contributed to the meeting, up to the length of the meeting, plus documentation and travel time. Any 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).

- **If multiple clients are discussed, the participating provider may only bill for the minutes during which one of his/her clients is being discussed, but cannot claim for minutes during which clients are being discussed with whom he/she has no provider/client relationship.**

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

- **If during the meeting, the client's behaviors escalate and require immediate intervention by his/her therapist, the service and time spent will be billed and documented as a crisis intervention and not as ICC.**

- ICC cannot be billed for a youth in a group home, except for the purpose of coordinating placement of the youth on discharge from the group home during the 30 calendar day periods immediately prior to the day of discharge as part of discharge planning. This should not be confused with the ability to claim for Targeted Case Management services to clients in group homes provided as a component of their treatment plan.

- **Providers will claim ICC services using Avatar service code 207.**

ADDITIONAL ICC TIPS

ICC Activities should to address Item 3 of the Fresno Co CFT Summary/ICC Plan

ICC is a mental health activity – ICC goal must be linked to treatment goal when used for claiming

ICC is more than just the CFT meeting – follow-through & monitoring should be documented, too

ICC should be directed by expressed ICC plan; reference the ICC Plan in PN

If the activity is not clearly linked to the ICC Plan and members of the CFT, it is probably case management

"Intensive" means you are communicating/monitoring more frequently than with traditional SMHS

COMMON QUESTIONS ABOUT ICC AND THE ICC PLAN

- How do we connect the ICC Plan and the client's Plan of Care/Treatment Plan?
  - *The ICC Plan may contain needs/concerns that are focused on social service issues (i.e. visitation; family reunification) as well as mental health issues (i.e. engaging a sports coach in understanding and implementing anger management techniques with the client at afterschool practice). Remember that ICC for MH providers needs to be activities that are medically necessary and support the treatment goals as stated on your POC. If the activity of planning or implementation does not address mental health needs, even if on the ICC Plan, it is not a claimable activity; however, part of your ICC Plan may be updating the treatment plan to target newly identified MH goals for the client. In these instances, the treatment plan may be adjusted to reflect the CFT and ICC Plan when clinically appropriate.*
- Sometimes the ICC need/concern is simply, "The child will see the therapist regularly." What kind of follow-up ICC activity would be needed?
  - *If the client/family is regularly attending and participating with the therapist, the only follow up would be an affirmation report at the next CFT. Additional ICC activities would only be needed if there is an identified barrier. (Recommend always being specific with the barrier, problem, concern on the ICC Plan if more intensive follow up is discussed at CFT.)*
- When there are multiple MH providers on the CFT, which POC do we follow?
  - *Every MH provider/agency still follows its own treatment plan. The purpose of a CFT is to openly communicate – which means multiple MH providers can share their observations and planned interventions collaboratively, so all the client's needs are ultimately addressed.*

PART THREE: INTENSIVE HOME-BASED SERVICES

Defining, providing, and claiming

INTENSIVE HOME-BASED SERVICES (IHBS)

127 Notes (Intensive Home-Based Services - IHBS) **show a service in the home or home-like setting** that is targeted to a minor client (or their significant support person) **with significant intensity to address the intensive mental health needs of the child/youth** consistent with the POC. ***The IHBS activity contains medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, and focuses on at least one of the following:***

- Development of functional skills to improve self-regulation or self-care
- Education of the child / youth / family / caregiver about how to manage the client's symptoms
- Improvement of self-management of symptoms (including self-administration of medications as appropriate)
- Support of the development, maintenance and use of social networks and community resources
- Support to address behaviors that interfere with the achievement of a stable and permanent family life and stable housing, obtain and maintain employment and achieve educational objectives

IHBS PROGRESS NOTE

MEDI-CAL MANUAL FOR INTENSIVE CARE COORDINATION, INTENSIVE HOME BASED SERVICES & THERAPEUTIC FOSTER CARE

Date: 1/13/13 Staff Service Duration: :40 Travel Duration :20 Documentation: :09 Telephone Contact: Y N

Procedure Code: H2015:HK Service: Intensive Home Based Services Location of Service: Client's Home

Goal: John will reduce aggressive behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder, including kicking and punching siblings, from 5x per day to 1x per week and will increase use of pro-social replacement behaviors.

IHBS worker met with mother and aunt to identify situations and triggers at home that contribute to client's angry outbursts. Family reported that client has been throwing tantrums: kicking and punching his siblings; when they start playing and teasing each other it escalated and got out of hand.

IHBS worker assessed home situation and assisted mother in identifying situations that lead to John's angry outbursts. IHBS worker and family discussed alternative ways to deal with John's frustration such as talking to client in a firm but calm tone of voice, and suggesting alternative options. IHBS worker also assisted mother in gaining a better understanding of client's behavior and need to recognize the behavior she wants to see at least once every 5 minutes from both boys, so that they know what they should do. Also, John agreed that he will take a short client time out when becoming angry. If he becomes violent towards self/family members, he will go to his room for a 15 minute period to calm himself. 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 as well as modeling appropriate responses to client's outbursts.

_____ _____ _____ _____

Signature & Discipline Date Co-Signature & Discipline Date

IHBS PROGRESS NOTE

COURTESY OF THE *MONTEREY BEHAVIORAL HEALTH 2014 CLINICAL DOCUMENTATION GUIDE*

S: Clinician met with the client at his home in order to assist the client with continuing to learn and utilize coping skills to effectively manage feelings related to depression and isolation. The client appeared to be in low spirits as evidenced by his hushed tone of voice and stating that "there is nothing anyone can do to help me."

O: Clinician greeted client and modeled pro social communication skills by engaging the client in a discussion about how his weekend had gone and if he was able to get out of the house at least once as planned. To determine the client's current level of depression this clinician asked the client to rate his depression on a scale of 1 to 10 (ten being "very depressed"). This clinician encouraged the client to process what coping skills have and have not worked with regard to managing sadness and encouraged the client to verbalize if he would be interested in attending a support group for individuals who have lost a child as a means to address the sadness related to the death of his daughter. This clinician encouraged the client to review his safety plan to ensure that the client is clear regarding steps he can take if he feels he needs assistance between sessions and reviewed the various coping skills that can decrease depressive symptoms such as going for a walk, attending his psychiatry appointments regularly and asking for support when it is needed.

A: Client reported that his weekend was "okay" but stated that he did not really go anywhere as planned because he "just did not feel like it". The client reported that his depression was currently at a 5 and that he just wishes that people could understand him. Clinician struggled to verbalize what coping skills help him and continued to state that all he needed was "time" to get over his sadness. Client reported that he would be willing to attend a support group for people who have lost a child and stated that he planned to attend next week. The client reviewed his safety plan and agreed to follow the steps necessary to request support if needed.

P: Clinician will continue to meet with the client 2x per week to assist him with developing and utilizing coping strategies to assist him with decreasing depressive symptoms and isolation.

CLAIMING FOR IHBS

FRESNO COUNTY'S CWMH INFORMATION NOTICE NO. 2: PROVIDING AND CLAIMING FOR INTENSIVE HOME-BASED SERVICES AND INTENSIVE CARE COORDINATION

- **IHBS can only be billed after the Teaming process has occurred and the ICC Plan has been developed**
- IHBS services can be billed in any setting where the youth is naturally located including the home (biological, foster, or adoptive) schools, recreational setting, child care centers and other community settings)
- **IHBS may be provided by telephone or telehealth, but providers are encouraged to provide services face-to-face to meet the intensity required by the child and family/caregiver's needs**
- IHBS are typically provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS if they meet the minimum educational and experience requirements of a Community Mental Health Specialist . More complex cases may require service delivery by a clinician rather than a paraprofessional.
- IHBS are available wherever and whenever needed, including in the evenings and on weekends
- **IHBS cannot physically be provided in a group home, but can be provided to these youth outside of the group home setting (e.g., therapist provides IHBS services during a home visit, on a school campus, etc. to help facilitate transition to a community setting or to a permanent home environment.)**
- The amount of time claimed for IHBS is determined in the same way as mental health services (i.e., actual service time + documentation time + travel = total time claimed)
- **Providers will claim IHBS using Avatar service code 127.**

ADDITIONAL IHBS TIPS

IHBS must be included (w/frequency & duration, techniques) on the treatment plan

IHBS looks like rehabilitation, therapy, and/or collateral – perfect for many EBPs

"Intensive" means longer or more frequent services than traditional SMHS

IHBS is for children and youth (clients under 21 y o) – do not apply to adults

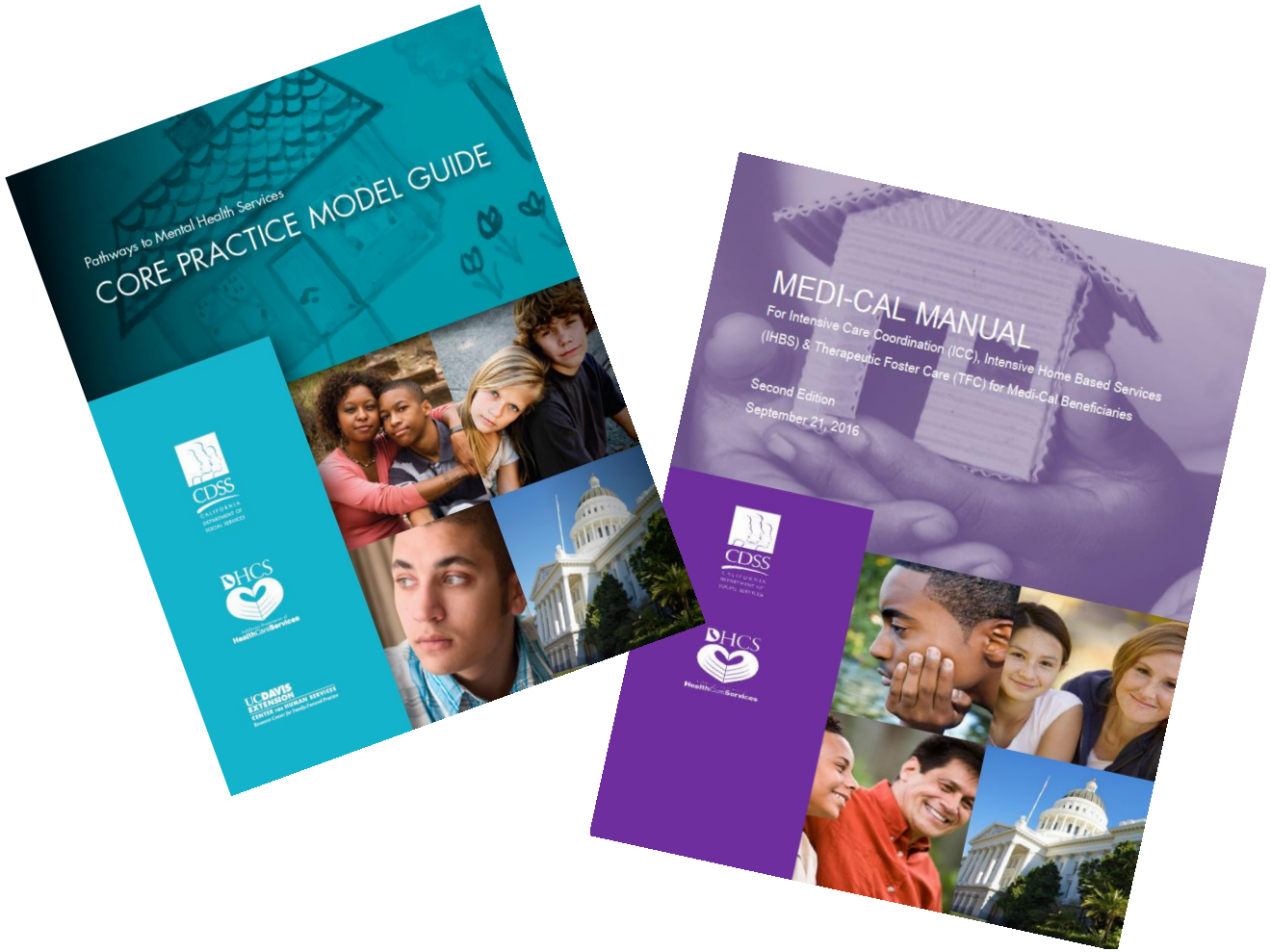
IHBS can be provided by anyone on the treatment team

NON-REIMBURSABLE SERVICES

All staff must understand how services are claimed and know that some services are not claimable. This includes:

- Reviewing a chart for assignment of therapist.
- Preparing documentation for court/court testimony.
- Listening to or leaving voicemail or email messages.
- Mandated reporting such as CPS or APS reports
- When no service is provided (Missed visit).
- Personal care services provided *to* individuals, including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals
- Clerical activities (faxing, copying, calling to reschedule appointments, etc.)
- Recreation or general play
- Socialization – generalized social activities which do not provide individualized feedback
- Academic/Educational services or vocational services
- Supervision of clinical staff
- Interpreting/translation only

DHCS GUIDELINES



Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) Services
and the *Core Practice Model Guide*

DHCS has updated the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services. Both the Core Practice Model Guide and the manual may be accessed at: **http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx**.

THANK YOU FOR YOUR ATTENTION AND PARTICIPATION