SECTION 4: SERVICE DEFINITION

An organizational provider is a provider of Specialty Mental Health Services (SMHS), other than psychiatric inpatient hospital services or psychiatric nursing facility services that provide services to beneficiaries utilizing licensed, registered or waivered non-licensed Mental Health staff members.

4.0 Definitions of Service Providers

Under an organizational set up, the following mental health staff may provide specialty mental health services as defined within their scope of practice:

- Licensed Mental Health staff member

  Any mental health professional licensed in the State of California as a Psychiatrist, Psychologist, Clinical Social Worker, Marriage, Family Therapist, or a Registered Nurse.

- Registered/Waivered Mental Health staff member

  Any mental health professional who has a waiver of psychologist licensure issued by the State Department of Mental Health or has registered with the applicable state licensing authority to obtain supervised clinical hours for Marriage, Family Therapist or Social Worker licensure.

- Non-licensed Mental Health staff member

  A mental health staff member who has a baccalaureate degree or four years' experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment, but is not licensed or registered/waivered, is considered to be a non-licensed mental health staff member. Up to two years of graduate professional education may be substituted for the experience on a year-to-year basis; up to two years of post associate arts clinical experience may be substituted for the required education.

Service Definition

4.1 Service Types

Organizational providers can provide **rehabilitative** and **case management** services as defined below:

Rehabilitative Mental Health Services

These are medical and remedial services recommended by a physician or other licensed mental health practitioners, within their scope of practice under state law, for the maximum reduction of mental disability and restoration of the client to the best possible functional level, when provided by local public community mental health agencies and other mental health service providers licensed or certified by the State of California. These services are provided in the least restrictive setting appropriate for reducing psychiatric impairment, restoration of functioning consistent with the requirements for learning and development, and/or independent living and enhanced self-sufficiency.

Case Management

These activities are provided by program staff to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services for eligible individuals.

4.2 Service Activities

4.2.1 Mental Health Services

Mental Health Services are those individual or group therapies and interventions that are designed to reduce mental disability and improve or maintain functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. They are not provided as a component of the adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive services. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral.

Service Definition

Site and contact requirements for mental health services:

Mental health services may be either face-to-face or by telephone with the client or significant support person(s), and may be provided at any location in the community.

Billing unit:

The billing unit is by minute based on staff time.

Billing requirements based on minutes of time:

The exact number of minutes used by the person providing a reimbursable service shall be reported and billed. In no case shall more than 60 minutes of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.

When a person provides service to, or on behalf of, more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides the service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed will not exceed the actual time utilized for claimable services.

When two or more providers are billing for the same service at the same time for the same beneficiary, all staff who provided the service must document separately the specific intervention provided, justifying the need for each staff's presence. Each staff involved may bill individually for the entire time spent in rendering the service. The FCMHP will disallow claims if there is no documented justifiable reason or intervention for each staff member who billed for the service. An example of a justifiable reason is a crisis situation where the presence of two staff is necessary for the safety of the beneficiary and staff.

The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

Lockouts:

Mental Health Services are **NOT REIMBURSABLE**:

- On days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facilities are reimbursed, except on the day of admission;

- When provided by Day Treatment Intensive staff during the same day that Day Treatment Intensive services are being provided;

- When provided by Day Rehabilitation staff during the same day that Day Rehabilitation services are being provided;

- Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time;

  OR

- When provided during the same times that Crisis Stabilization-Emergency Room or Urgent Care is provided.

Direction of Services:

Co-signature requirement: Within county scope of practice guidelines, mental health services provided by unlicensed staff without a bachelor's degree in a mental health related field or four years of experience delivering mental health services must have all progress notes co-signed by one of the following professional staff, until the experience/education requirement is met:

- Physician
- Licensed/waivered Psychologist
- Licensed/registered Clinical Social Worker
- Licensed/registered Marriage Family Therapist
- Registered Nurse

4.2.1.1 Assessment

An assessment is a service activity that may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavior disorder;

relevant cultural issues and history; diagnosis; and the use of testing procedures.

4.2.1.2 Plan Development

Plan development is a service activity that consists of development and approval of the client's plan, and/or monitoring of the client's progress.

4.2.1.3 Therapy

Therapy is a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. This service activity may be delivered to a client or group of clients, and may include family therapy where the client is present.

4.2.1.4 Rehabilitation

Rehabilitation is a service activity that includes assistance in improving, maintaining, or restoring a client or group of clients' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and medication education.

4.2.1.5 Collateral

Collateral is a service activity to a significant support person in a client's life with the intent of improving or maintaining the mental health status of the beneficiary. Collateral services include, but are not limited to, helping significant support persons to understand and accept the client's condition and involving them in service planning and implementation of the Plan of Care. Family counseling or therapy, which is provided on behalf of the client, may be considered collateral.

4.2.1.6 Therapeutic Behavioral Services

See Section 4A for a detailed description.

4.2.1 Medication Support Services:

Medication support services are those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The services may also include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, medication education and plan development related to the delivery of the service and/or assessment of the client.

Site and contact requirements:

Services may be either face-to-face or by telephone with the client or significant support person(s), and may be provided at any location in the community.

Billing unit:

The billing unit is by minute, based on time. Medication Support Services that are provided within a residential or day program shall be billed separately from those services.

Lockouts:

A maximum of four (4) hours of Medication Support Services per calendar day is reimbursable. Medication Support Services are **NOT REIMBURSABLE** on days when Inpatient Services or Psychiatric Health Facility Services are reimbursed except for the day of admission to these services.

Staffing:

Medication Support Services shall be provided within the provider's scope of practice as a Physician, Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician, and/or Pharmacist.

4.2.2 Crisis Intervention

Crisis Intervention is a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities may include, but are not limited to, assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the State Department of Mental Health or a Mental Health Plan to provide crisis stabilization.

Site and Contact Requirements:

Crisis Intervention may either be face-to-face or by telephone with the beneficiary or significant support person(s) and may be provided anywhere in the community.

Billing Unit:

The billing unit is by minute, based on staff time.

Lockouts:

Crisis Intervention is **NOT REIMBURSABLE** on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

Claims must be submitted with supporting documentation. Provider must submit crisis intervention progress notes with the claims when claiming crisis intervention hours. The FCMHP will reimburse provider for crisis intervention visits only when the service is provided to resolve an immediate mental health crisis.

Providers should refer beneficiaries to the County's contracted 23-hour crisis stabilization center (for both Adults and Adolescents), located at 4411 East Kings Canyon Road, Fresno, CA 93702, if their mental health crisis may potentially continue beyond two hours. Provider may also need to reassess the appropriateness of current mental health services received by beneficiary if the need for crisis intervention services occurs on almost a daily basis.

Staffing:

Crisis intervention services may be provided by:

- Physicians
- Psychologists or related waivered/registered professionals
- Licensed/Registered Clinical Social Worker
- Licensed/Registered Marriage, Family Therapist
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Staff with a bachelor's degree in a mental health related field

4.2.3 Case Management

Case Management means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Site and Contact Requirements:

Case Management may be either face-to-face or by telephone with the beneficiary or significant support person(s) and may be provided in-office, or anywhere in the community.

Billing Unit:

The billing unit is by minute, based on staff time.

Lockouts:

Case Management is **NOT REIMBURSABLE** on days when the following services are reimbursed, except for a day of admission or for placement services as provided in the following:

- Psychiatric Inpatient Hospital Services
- Psychiatric Health Facility Services

- Psychiatric Nursing Facility Services

  Case Management services solely serve the purpose of coordinating placement of the beneficiary on discharge from the psychiatric inpatient hospital, psychiatric health facility or psychiatric nursing facility and may be provided during the 30 calendar days or less per continuous stay in the facility.

  Staffing:

  - Physicians
  - Psychologists or related waivered/registered professionals
  - Licensed/Registered Clinical Social Worker
  - Licensed/Registered Marriage Family Therapist
  - Registered Nurse
  - Licensed Vocational Nurse
  - Psychiatric Technician
  - Mental Health Rehabilitation Specialist
  - Staff with a bachelor's degree in a mental health related field

SECTION 4A: THERAPEUTIC BEHAVIORAL SERVICES

This section provides a detailed description of Therapeutic Behavioral Services (TBS) in Fresno County and intended for use by organizational providers contracted with the FCMHP to provide TBS only. Organizational providers contracted with FCMHP to provide other specialty mental health services may use the information outlined in this section in understanding TBS and its eligibility requirements.

4A.0 General Program Description

The Department of Behavioral Health currently provides a wide range of mental health services to the youth population of Fresno County through county operated programs and contracts with individual, group, or organizational providers. These services include individual, family and group therapy, individual and group rehabilitation, rehabilitative and intensive day treatment, mental health assessment, hospitalization, medication support, and case management services.

In August of 1999, all counties in the state were instructed by the California Department of Mental Health (now known as the Department of Health Care Services) to prepare and implement a plan to provide a new supplemental specialty mental health service known as Therapeutic Behavioral Services (TBS) for full-scope Medi-Cal beneficiaries under the age of 21. This service consists of one to one intensive behavioral intervention, provided up to 24 hours per day, 7 days a week.

TBS is a part of the beneficiary's existing Plan of Care. When a youth (beneficiary) in need of TBS has been identified and has agreed to the service, a TBS team is formed. The TBS team consists of TBS service provider, (called the Coach), the youth's assigned therapist (Mental Health Clinician), the youth's parents, foster parents or the group home staff (Caretakers) and the county oversight staff (Advisor). The Plan of Care is reviewed and appropriate inventions and goals for TBS are identified. The service is initiated and continued until the targeted behaviors are reduced or eliminated.

4A.1 Managed Care's Responsibilities

Notifying Providers of Responsibilities

Managed Care is responsible for notifying TBS providers of their responsibilities through the following mechanisms:

a. DHCS letters and other written communications regarding TBS.
b. Individual consultation on a regular basis.
c. Procedures for TBS referral and provision of service as outlined in this Procedure Manual will be distributed to all organizational contract providers.

Organizational Provider Contract

The FCMHP has an established contractual agreement with an organizational provider who will provide all TBS services.

TBS Coordinator

Managed Care assigns Mental Health Clinicians with extensive experience on behavioral interventions with very seriously disturbed youth. The Coordinator's responsibilities include reviewing all applications for Coach certification, developing and disseminating all TBS guidelines, forms, and procedures. If request for TBS is denied after a mental health assessment, the TBS Coordinator is responsible for ensuring that the Notice of Action (NOA) and appeal process is understood and utilized by the beneficiary.

4A.2 Organizational Contract Provider's Responsibilities

Administrative Responsibilities

The TBS organizational provider is responsible for all aspects of TBS, just as it is for individual therapy, family counseling or other types of service. The organizational provider hires Coaches, supervises them, documents and bills the service(s), and reports the costs associated with the service(s) to the FCMHP for reimbursement. The organizational providers are expected to follow all policies and procedures that apply to treatment services. In most aspects, TBS should be handled like any other Medi-Cal funded service.

Since TBS is an intensive and expensive service designed for the most seriously disturbed beneficiary, FCMHP provides support and oversight beyond other Medi-Cal Services. The FCMHP responsibilities do not

substitute for organizational provider's obligations but supplement them. The following are examples of those providers' obligations:

- Staff education about TBS and engaging their cooperation.
- Identifying potential sources of Coaches, selecting and orienting the Coaches.
- Reviewing and coordinating the above activities with the TBS Coordinator.
- Ensuring that Coaches attend required consultation and planning meetings. Coaches meet with their Advisor weekly. Other residential staff involved with a TBS beneficiary may also need to join some team meetings to ensure coordination of services.
- Tracking costs for TBS.
- Tracking hours worked against progress notes.

Clinical Responsibilities

The organizational provider is responsible for the supervision of the TBS Coach. This must be a licensed mental health clinician. The FCMHP TBS Coordinator will also be available to Coaches to provide regular specialized consultation about their TBS duties.

Hiring Coaches

Minimum Requirements: The minimum requirements for a Coaching position are the same as for a group home counselor. The large majority of Coaches have experience well beyond this minimum. There is no upper limit with respect to education and experience for a Coach.

The TBS Coordinator approves/denies potential Coaches. A Coach Application Form must be filled out by each Coach and submitted to the TBS Coordinator for review and filing. Decision to approve or deny a Coach application depends on Coach's experience and education, and prior work history. (Refer to end of this section for a copy of this form.)

Some Group Home agencies may have reassigned current staff to new responsibilities as Coaches. This works best if the Coach works in a cottage or hall different from their prior assignment as children often

become very jealous if current staff seems to be devoting all of their time to just one child. These assignments have been part and full time, temporary and continuing. The advantages to this model are that the staff are familiar with the program and procedures, that it can be a way of recognizing top staff and/or providing a model for other staff. The disadvantage is the possible jealousy noted above and the possibility that negative staff attitudes about the TBS beneficiary may be difficult to abandon.

Some group homes have hired new staff to work as Coaches. As the Coaching job is often not full time, and is most often needed in the afternoons, this is an attractive job for graduate students and for experienced childcare workers with night or morning shifts. For those who are hired full time, duties other than TBS must be guaranteed for those times when TBS is not needed. Hiring this type of Coach is more difficult and time consuming but the possible prejudices of staff are avoided and there is more flexibility in assignments. However, the lack of knowledge of the program and identification with staff may lead to more serious "splitting" between the Coach and residential staff if there is no careful and ongoing coordination of treatment.

A fingerprint check request must be initiated and training in confidentiality and child abuse reporting must be completed before a Coach can begin providing TBS. When the Coach is already a current employee of a local facility licensed by Social Services that requires a fingerprint check, a letter from that facility saying that the Coach is currently an employee in good standing can substitute for a new fingerprint check. The following must be in the organizational provider's personnel file and available to the TBS Coordinator upon request.

- Completed and approved Coach application
- Supporting documents regarding education or experience
- Fingerprint check request
- Signed statement regarding training on confidentiality
- Signed statement regarding training on child abuse reporting

4A.3 Process for Determining TBS Eligibility

A beneficiary, parent, legal guardian or staff may request an assessment for TBS services. The process is initiated by calling 1-800-654-3937, or completing the TBS Screening and Referral form and then forwarded to the TBS Coordinator.

The TBS Coordinator reviews the application for the following items:

a. Beneficiary is under age 21
b. Beneficiary has full-scope Medi-Cal.
c. Beneficiary meets one of the class requirements:
    i. Has been admitted to a psychiatric hospital during the past 24 months.
    ii. Is currently residing in a Level 12 – 14 Group Home
    iii. Is in danger of being placed in a Level 12 – 14 Group Home
    iv. Has received TBS within the past 12 months
d. Beneficiary is currently receiving Specialty Mental Health services and thus
    i. Meets medical necessity criteria
    ii. Has had a complete assessment or is currently being assessed
e. Beneficiary is exhibiting behaviors that are
    i. Jeopardizing placement or blocking transition to a lower level of care.
    ii. These behaviors are amenable to interventions by a TBS provider and not due solely to an ongoing chronic condition such as developmental delay, autism or other conditions.
    iii. Not the reason for placement in the current facility.
f. Treatments less restrictive than TBS have been attempted.

The TBS Coordinator contacts the person initiating the referral with one of the following decisions:

a. The beneficiary is a member of the class who may benefit from TBS. The TBS request is approved, and a TBS team will be formed.
b. Additional information is requested. TBS request is pended.
c. A recommendation for alternative service may be made. This occurs when less restrictive interventions have not been attempted. The TBS Coordinator identifies possible interventions and assists the referring party to secure those interventions within the FCMHP. The beneficiary is then placed on the "Inactive List." The request for TBS is reactivated if the recommended alternative interventions are not successful in addressing the problem behaviors.

<u>TBS Notice of Action</u>

If the referring provider does not agree with the recommendation for alternative service, an NOA process is initiated. The NOA process for TBS

is the same as for any other Specialty Mental Health Service except that a copy of the NOA is sent to DHCS.

4A.4 Service Delivery

TBS is a Medi-Cal Specialty Mental Health Service (SMHS), thus all of the regulations and procedures that apply to individual, group and other forms of SMHS apply to TBS. The procedures and responsibilities outlined below are additional guidelines.

Parameters of Service

The amount of time scheduled per week varies per beneficiary. Some beneficiaries have required more than eight hours per day or more than 40 hours per week and thus more than one Coach. This is acceptable if justified clinically.

Initial Authorization Request

The initial TBS authorization will not exceed 30 days or 60 hours, whichever is less. The initial authorization covers the initial TBS assessment, development of the initial TBS plan, and initial delivery of direct one-to-one TBS. The initial TBS assessment must identify at least one symptom or behavior that TBS will address, and the initial TBS plan must identify at least one TBS intervention. The FCMHP will make an authorization decision within 14 calendar days of receipt of the TBS request.

Reauthorization Request

TBS reauthorizations will not exceed 30 days or 60 hours, whichever is less. The FCMHP will not approve the provider's reauthorization request unless the request includes a TBS Plan of Care that meets the requirements as listed on 4A8. In addition, reauthorization requests will be based upon clear documentation in the client's medical record of the following:

a. The beneficiary's progress towards the specific goals and timeframes of the TBS plan. A strategy to decrease the intensity of services and/or initiate the transition plan and/or terminate services. When TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness.

b. If applicable, the beneficiary's lack of progress towards the specific goals and timeframes of the TBS plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the alternatives will be effective.

c. The review and updating of the TBS Plan as necessary to address any significant changes in the beneficiary's environment (e.g., change in residence).

d. The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

Expedited Authorization Request

In cases when the provider or the FCMHP determines that following the 14 calendar day timeframe could jeopardize the beneficiary's life or health, or ability to attain, maintain, or regain maximum function, the FCMHP will process the request within 3 working days of receipt of the request. The provider will mark the "Expedite Referral" box at the bottom of the TBS Screening and Referral form, and include the clinical justification for the expedited request.

The FCMHP will use the following standards to determine whether TBS authorization should be expedited:

- Without TBS, the beneficiary is likely to be placed in a higher level of care or require acute psychiatric hospitalization within the next 14 days.
- The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.
- The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap of services, and the request is being made before the end of the previously authorized service period.

Planning Meeting

After the TBS request has been screened for TBS eligibility, a planning meeting is usually held that includes the beneficiary, the caretakers, the therapist, the Coach and the TBS Supervisor. The TBS Supervisor arranges for this meeting. This group is called the TBS team. The purpose of the meeting is to identify target behaviors, possible interventions and expected outcomes. If the critical times for these behaviors can be identified, the coaching schedule is set at these times (for example, before dinner, at bedtime, Sunday evening, etc.) Other logistical arrangements are made and all necessary signatures, permissions and releases completed. A tentative length of service in weeks is also discussed. The TBS Plan of Care is completed as an addendum to the Plan of Care, and a progress note detailing all of the items discussed. In almost all cases, this meeting will take place before TBS is started. In emergency cases, TBS may be started if the meeting takes place during the first week of the service.

Coach Responsibilities

The Coach is responsible for meeting with the beneficiary at the agreed upon times and following the intervention plan. Sample interventions successfully used by Coaches are used in the methodologies section. The Coach completes a progress note for every day of service using the TBS Progress Notes form. The note is reviewed and countersigned by the supervising Clinician. The Coach also notes the hours spent in TBS in progress notes, timecard or some other record.

The Coach is also responsible for attending a group consultation meeting with the TBS Supervisor where the interventions are reviewed and fine-tuned. The Coach completes a progress note describing these discussions and also records the beneficiary's Serious Incident Reports (SIR) for the week. A coordination meeting with the therapist occurs at least monthly. This can be conducted individually or as part of the organizations treatment team meeting. The TBS Supervisor joins these meetings as needed. The Coach also prepares a progress note on these meetings. Consistency in meeting these obligations is necessary to continue coaching.

Therapist Responsibilities

The Mental Health Therapist may be a contract provider or Department of Behavioral Health staff. The role of the therapist is critical to the success of TBS. Ideally, the TBS intervention plan is an extension of the

Plan of Care and the Coach and therapist work as a team. Regular and extensive communication between the Coach and therapist is the best way of accomplishing this, thus a weekly or biweekly meeting is essential to the plan.

As the therapist is ultimately responsible for the coordination of the Plan of Care, the therapist oversees the provision of TBS and works with the Coach to develop the goals, interventions and desired outcomes for the service. The therapist is responsible for meeting with the Coach on a regular basis and for attending those planning and consultation meetings as agreed upon with the TBS provider.

Termination

It is the responsibility of the TBS team to plan for termination from the beginning of service. The interventions should always be planned so that they can be generalized to situations where the Coach is not present. A major part of the TBS plan must also be to incorporate others – parents, residential staff – into the interventions with the beneficiary. If this is done consistently, termination can be a natural rather than painful process.

4A.5 Clinical Process and Methodology

Role of the Coach

The primary duty of the Coach is to implement the TBS Plan of Care that was developed by the beneficiary, parent or caretaker, therapist, Advisor and Coach. This can take many forms and depends on the needs and strengths of the beneficiary as well as the creativity and expertise of the TBS team. However, across all beneficiaries, three types of interventions usually have been successful:

1. Identification of the early signs of distress. These beneficiaries are often described by caretakers as "unpredictable," "exploding/running away for no reason," and when asked, often do not know what triggered a particular incident. The Coach role is uniquely suited to be able to observe the beneficiary minutely and identify the external signs of agitation, and often, the probable precipitant. This information is continuously shared with the beneficiary until the beneficiary is able to make these observations themselves.
2. Development of self-soothing and self-controlling behaviors. Simultaneously, the Coach is working with the beneficiary to

identify behaviors to use instead of "blowing up", "running away" or to reduce the level of agitation once it is identified.

3. Positive reinforcement. Success on the above tasks is supported initially with both verbal and concrete positive reinforcement. Over time, the concrete becomes less important, as does any type of external reinforcement. The Coach then begins to support the beneficiary's self-rewarding observations and statements.

These interventions are often accompanied by activities designed to enhance the self-esteem of the beneficiary and may take place where the beneficiary lives in the community.

Some of the topics that have most often been the focus of the intervention are explosive outbursts, AWOL behaviors, medication compliance and social interactions. Coaches in different settings have been very creative in the development of activities that support the principles above. Group activities, outings and special events that require maximum planning and responsibility by the beneficiaries have been very successful.

Selection of Coaches

Good Coaches can come from a wide range of backgrounds. The ability to connect with kids, being non-threatening to caregivers, and ability to think positively are more critical than degrees or background.

Assignments

Less than full time, 20 hours of TBS a week works in many cases. The extreme lower limit appears to be 10 hours per week. For most cases, afternoons and early evenings are the critical times, occasionally weekends or very early in the morning.

It has been found that in group homes, the Coach should be someone who works in that agency, perhaps from a different cottage or section from where the beneficiary is located. Problems can arise if the Coach is from another agency or is very unfamiliar with the residential program.

Only one beneficiary must be assigned to a Coach at a time. If two beneficiaries in the same residential program are assigned to the same Coach, intense "sibling rivalry" is evoked, precipitating crises rather than resolving them, even if the Coach is assigned to the two beneficiaries at

different times of the day or week. With the rare exception, more than one case at a time is also too much for a Coach.

Use of Coaches in Schools, Community Events and Hospitals

The use of a Coach in a public school is a common practice. TBS in school may be approved on a case-by-case basis.

Coaches have been widely used to allow a beneficiary to participate in events in the community that they otherwise would be unable to attend. This has been successful to date, with no incidents occurring in these outings.

Hospitalization constitutes a lock-out (i.e. a period for which TBS can not be billed to Medi-Cal.) When clinically appropriate, the Coach can visit the beneficiary in the hospital several times before discharge. The Coach is paid but Medi-Cal cannot be billed for the visits.

Role of Therapist

The close collaboration of the Coach and Therapist is critical for success. A common format is for the therapist to work with the beneficiary on critical concepts in the session and for the Coach to help the beneficiary identify specific instances of those ideas in the "real world" and to apply the agreed upon intervention. Conflict resolution is the most common topic in therapy. Coaches often use rehearsal, reflection, self-control techniques and positive rewards to support the beneficiary's steps towards conflict resolution in the "real world."

To many therapists, TBS appears as a non-traditional approach to treatment. In its focus on strengths, it may also present a different philosophy than that of the therapist. It is not uncommon for the perception to arise that the Coach is supplanting rather than supplementing the work of the therapist. It is very critical that, from the start, the therapist and Coach work as a team and that the therapist sees the Coach's work as an extension of the therapist's work. This will occur naturally if TBS is based on the Plan of Care and if the Coach and therapist meet regularly.

Role of Caretaker

A critical role in TBS service delivery is that of the Caretaker(s), such as the parents, foster parents, or group home staff, who are responsible for the daily care of the beneficiary. Success of TBS requires active

involvement of the Caretakers in planning and implementation. The Caretaker makes a major contribution in identifying the target behaviors and the critical times for TBS. In both family and group home settings, the Coach is usually in daily contact with Caretakers. At the very least, the interventions of the Coach foster a more positive relationship between the Beneficiary and Caretaker because of the reduction of conflict. In most cases, the impact is considerably greater as the Caretakers learn new ways of interacting and intervening from the Coach. This learning takes place through both modeling and direct instruction. The Caretakers are also keys to determining whether the gains the beneficiary has made are generalizing – i.e. do the behaviors seen while the Coach is present still occur when the coach leaves. If not, further refinement of the plan is needed.

Caretakers can be very jealous of the Coach's relationship with the beneficiary. A tension that arises at the initiation of service in a home or facility is the perception of supplanting, as noted above in the section on therapists.

The most difficult aspect of the Coach's role is to remain unconditionally aligned with the beneficiary while also working positively and co-operatively with caretakers. As the majority of these beneficiaries are referred because they have failed to progress in their placement, the level of conflict around them and their treatment is often high.

Although the caretaker may be absent for part of the time the Coach is present, it has generally been a requirement that caretaker be present in the home for the majority of the time the Coach is working with the beneficiary. This not only avoids possible liabilities, but also allows a broader interpretation of the Coach's role – i.e. that of a model and assistant to the caretaker as well as to the beneficiary.

Role of Residential Staff

An equally critical role in the success of TBS is that of the residential staff. Residential staff should be in agreement that the Coach is needed and at a minimum, be aware of the goals for TBS. Programs where the Coach, therapist, Advisor and residential staff all meet together weekly regarding TBS goals are more successful than when staff are peripheral to the process. TBS interventions have a greater impact when they can be at least partially continued by residential staff in the Coach's absence and where they have been developed in consultation with the staff.

Supervision of Process

Oversight by someone in addition to the therapist is critical to a successful outcome. This supervision can be within the Coach's organization, from the county or from an outside consultant, and provides a degree of perspective that may be missing in the TBS team for these beneficiaries.

A major task of the supervisor is to get everyone on board at the beginning – anyone who is left out tends to obstruct the process at worst or delay it at best. Regular consultation or supervision resolves problems inherent in the process before they become disruptive.

Group supervision is a good format for learning. In some settings these meetings have become the forum for the discussion of intervention tactics and philosophy and are attended by other program staff.

The most demanding task of the supervisor is to address the problems of "splitting" which is common in residential settings and is often manifested in a split between the Coach and the caretakers. This can be effectively handled in supervision by using the analogy of children splitting parents. Focus on how it is necessary for the child to learn to deal with different views from different people is helpful. This empowers the Coach and the beneficiary without automatically condemning the residential staff or "rescuing" the beneficiary from "them," both of which are tempting positions for Coaches to take.

The development of a clinical perspective in staff is the most powerful, unanticipated impact of TBS. The assignment of a Coach seems to re-evoke the observational and clinical skills of the staff member who has not had an opportunity to use them previously in their tasks as group manager. In some cases, staff who were previously confrontational with beneficiaries may have changed their style as a result of functioning as a Coach.

Generalization

The greatest clinical challenge is to have the process started by the Coach continue into the period when the coach is not there. This is true whether the Coach is simply leaving for the day or week, or whether the service is ending. The interventions noted below have been found to be helpful in promoting generalization and eventually termination.

- Reward system developed in conjunction with caretakers and used by them when the Coach is absent.
- If the beneficiary is capable of verbalization, generalization is easier. Explicit support self-talk is a very useful tactic.
- If the beneficiary cannot internalize, establishing very predictable external routines with the caretakers will be very helpful.
- Reiteration of what constitutes a good day and how the beneficiary achieved that helps to solidify the gains made that day and makes it more likely that the positive behaviors will remain.
- Praise, support and active efforts towards the expansion of outside activities and relationships are crucial. The beneficiary not only benefits from these directly but the Coach's active encouragement in this helps to allay the beneficiary's fears that the Coach will be jealous of other relationships.

Termination

Often, the beneficiary will say, "I've really learned something, I can do something, I can handle this problem, etc." The beneficiary may even say, "You know, I'm not always going to need you." The most definitive sign that the beneficiary is ready for termination is the regular and automatic generalization of the behavior with the Coach to other people and times. For those beneficiaries who do not verbalize as much, the scores on the BAF will often reflect progress before caretakers or therapists remark on it.

The staff around a beneficiary may be reluctant to have a Coach leave, even when they see the progress that has been made. Staff concerns that the beneficiary's old behaviors will re-surface may be confirmed when the beneficiary's conduct temporarily deteriorates when the topic of termination is broached. These "termination blues" on the part of the beneficiary and those around the beneficiary are not any different than what occurs at the end of any type of therapeutic service and needs to be handled in the same way.

Development Phases

There are clearly several phases to starting a TBS program. The first set of tasks involves locating the potential beneficiaries and Coaches and education of the participating agencies. During this period discussion of many potential problems abound. Initial concerns can be minimized by

discussion, accommodation to individual needs and persistence. A focus on TBS as not something rare and unusual but as an extension of the treatment plan is an effective argument for many staff. At some point, however, an executive decision to proceed may be necessary as all fears can not be addressed before the service mode is started. In fact, few of these anticipated problems actually materialize.

The second phase of program implementation, service delivery, is a period of excitement, but also widespread confusion. Procedures previously developed have to be modified to meet the demands of reality and new ones created to handle unanticipated issues. Staff and agencies are seeing the benefits of the program, however and concerns about possible disasters recede.

The third phase of the program is program solidification. The major task here is to decide which procedures and processes to keep and which to abandon, which support effective service delivery and intervention and which do not. The litmus test of effectiveness is seeing if the behaviors learned from the Coach generalize to other settings and times, and, eventually, if the beneficiary can be "weaned" from TBS. The beneficiary, staff and parents are understandably reluctant to have the Coach depart but to be considered successful, this must occur. The successful termination of service is the final test of the program. This aspect may well be the most difficult phase to date.

TBS is not so different from other forms of therapeutic intervention such as individual, family, group, etc. therapy. The same phases, phenomena and problems occur but the processes occur much more rapidly with TBS. There is likely a direct correlation between the number of service hours per week and how quickly problems are resolved. Fortunately, the principles learned in other forms of therapy apply to TBS as well and solutions to problems work whether applied to family therapy or TBS.

4A.6 WHAT A TBS COACH IS NOT

A Taxi Service

Although the Coach may transport the beneficiary to an activity, with the permission of the caretaker and supervisor, the Coach should not be expected to provide regular transportation for activities such as school, therapy, doctor appointments, etc. unless this is an agreed upon part of the treatment intervention.

A Spy

Although the Coach is a Mandated Reporter with respect to Child Abuse Reporting, the coach is not "the eyes and ears of the court," parent or social worker. The Coach can be considered an extension of the therapist and as such respects the confidentiality of the beneficiary.

A Security Guard

Although a Coach will work to help the beneficiary avoid behaving in threatening or self-abusive ways, the Coach cannot restrain a beneficiary, participate in a "take down," block a beneficiary's attempt to go AWOL, press charges against the beneficiary or protect the beneficiary from other aggressive beneficiaries except to the degree that any concerned adult would.

A Chaperone

Although the Coach will counsel the beneficiary against self-defeating behaviors, the Coach may not always be able to prevent *covert* smoking, drinking, drug use and sexual activity.

A Babysitter

Although the Coach will spend a substantial amount of time with the beneficiary, a parent or a caretaker must be onsite or easily available a majority of the time while the beneficiary is receiving TBS. The Coach may take the beneficiary on an in-county activity, but is not allowed to travel out of county or accompany the family or the beneficiary on an overnight trip.

A Messenger

Although the Coach should actively and regularly communicate with the therapist and others, the Coach should not be the conduit for passing information between the beneficiary, family and treatment team members.

A Gopher

Although a Coach is willing and able to help families or group home staff with projects involving the beneficiary, the Coach should not be expected to run errands, monitor parental visits, fill in for absent staff or parents, make telephone calls for case management or participate in activities that draw the Coach from the beneficiary and the therapeutic goals.

A Date

Although the Coach often becomes "like a member of the family," they are nonetheless performing a therapeutic function and follow the usual expectations for professional behavior. Coaches are not allowed to date beneficiaries, ex-beneficiaries, family members, or close friends of the beneficiary.

4A.7 Ethical Standards for TBS Coaches

Treatment Goals

TBS Coaches negotiate with the beneficiary's Treatment Team regarding the purpose, goals, and nature of the helping relationship prior to the onset of TBS. This includes discussing the limitations of the relationship and the expectations of the beneficiary and/or caretakers. It is the TBS Coach's responsibility to remain focused on agreed treatment goals and to ensure ongoing Treatment Team meetings. The TBS Coach should not make decisions, nor act on decisions concerning treatment goals without consulting with their Supervisor and/or the Treatment Team.

General Attitude

The TBS Coach respects the integrity and welfare of the beneficiary and the beneficiary's caretakers at all times. Each beneficiary and caretaker is to be treated with respect, acceptance and dignity. Personal issues with beneficiaries and/or caretakers should be addressed in supervision with TBS Advisor before being acted upon with the beneficiary/caretaker.

Confidentiality

The TBS Coach protects the beneficiary and caretaker's right to privacy and confidentiality except in those cases in which harm to the beneficiary or others has taken place or is determined eminent, or when agency guidelines state otherwise (this can be discussed with the TBS Supervisor). During initial meetings with beneficiary and/or caretakers, the limits of confidentiality should be discussed thoroughly. These limits include duty to report child abuse, elder abuse, dependent adult abuse, and any situation in which the beneficiary poses a serious danger of violence to self or another. Should details of the TBS work with the beneficiary need to be discussed with a Treatment Team member not employed by the county or a county contract agency (i.e. a private therapist), an informed consent form must be signed by the caretakers and/or beneficiary.

The TBS Coach is also responsible for ensuring the integrity, safety, and security of beneficiary records while in the Coach's possession. The assigned TBS Supervisor should review all written beneficiary information. Once co-signed by the Coach's supervisor, written material should then be securely filed at the treatment facility or agency responsible for the case. Should the TBS Coach wish to retain copies of any such notes, the Coach is responsible for securing such documents in a manner that prevents loss or breach of confidentiality.

Dual Relationship

The TBS Coach is in a therapeutically unique relationship with their beneficiary and the beneficiary's caretakers. Services often require working with a family in their home, and/or spending several hours daily with a beneficiary. This can develop into a very intimate and intense relationship. The TBS Coach therefore must recognize that dual or multiple relationships with their beneficiaries may increase the risk of harm to, or exploitation of the beneficiary. This would include developing a friendship outside of the therapeutic relationship, entering into romantic relationships, entering business related relationships, etc.
Such relationships could impair professional judgment and cause great harm. Should any relationship outside of the therapeutic one be suggested by the beneficiary/caretaker, this should be discussed openly with the TBS Supervisor immediately. As a rule, TBS Coaches must support the trust implicit in the relationship by avoiding dual relationships that could impair professional judgment, increase the risk of harm to the beneficiary, or that could lead to exploitation of any kind.

Refusal of Services

Therapeutic Behavioral Services are offered to the beneficiary on an "at will" basis. The beneficiary's right to self-determination is recognized and respected within this relationship. While some beneficiaries can be resistant at times and need some coaxing to engage in treatment, the TBS Coach must recognize the beneficiary's right to refuse services. If the beneficiary presents a strong refusal of services, the TBS Coach should immediately consult with their TBS Supervisor.

Focus of Treatment

The TBS Coach recognizes, draws out and builds upon the beneficiary's strengths. The focus of treatment is to develop a relationship with a beneficiary such that new, more productive behaviors can be explored and developed which are in service to the beneficiary's overall mental

health and stability. The Coach works in tandem with a Treatment Team and/or caretakers to ensure that the beneficiary develops the skills necessary to lead a more functional and fulfilling life. The TBS Coach does not work alone, nor are they solely responsible for the mental health and stability of the beneficiary. Close supervision and teamwork ensure that the TBS Coach is supported and that proper focus is maintained.

Multicultural Issues

The TBS Coach should be knowledgeable about the cultures and communities in which they work and be sensitive to and aware of multicultural issues. TBS Coaches should respect individuals and groups, their cultures and their belief systems. Coaches should also have an awareness of their own cultural background, beliefs and values and should continuously recognize the potential for such to have an impact on their beneficiaries, co-workers and Treatment Team members. Issues of a cultural nature can and should be discussed with the TBS Supervisor openly.

4A.8 Documentation

The TBS documentation follows all of the rules established for any SMHS. The items noted below are additional local requirements or interpretations of Medi-Cal regulations as they apply to TBS. The TBS documents should be segregated into a separate section of the beneficiary's medical record.

TBS Screening and Referral Form

The TBS Screening and Referral form must be completed by the referring clinician. It must be accompanied by a signed copy of the current clinical assessment and copy of the signed treatment plan indicating TBS as an authorized intervention. The potential TBS beneficiary's Medi-Cal eligibility must be verified before approval of the application, as TBS requires the beneficiary to have full-scope Medi-Cal. A copy of this form is provided at the end of this section.

TBS Assessment

Assessment activities are both initial and on-going components of all specialty mental health treatment. Initial and on-going assessments of the need for TBS may be accomplished as a part of the overall assessment of a child or youth's mental health needs or through a

separate assessment specifically targeted to determine whether TBS is needed.

Consistent with DMH Letter No. 99-03, Section III, "Criteria for Medi-Cal Reimbursement for Therapeutic Behavioral Service", an assessment for specialty mental health services, focused either on TBS or with TBS consideration as a component, must be comprehensive enough to identify the following:

a. That the child or youth meets medical necessity criteria
b. Is a full-scope Medi-Cal beneficiary under 21 years of age
c. Is a member of the certified class
d. That there is a need for specialty mental health services in addition to TBS
e. That the child or youth has specific behaviors and/or symptoms that require TBS

In addition, TBS Assessments must:

a. Identify the child or youth's specific behaviors and/or symptoms that jeopardize continuation of the current residential placement or the specific behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.

b. Describe the critical nature of the situation, the severity of the child or youth's behaviors and/or symptoms, what other less intensive services have been tried and /or considered, and why less intensive services are not or would not be appropriate.

c. Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition to a lower level of residential placement and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care.

d. Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated.

e. Identify skills and adaptive behaviors that the child or youth is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

Concrete identification of behaviors and interventions in the assessment process is the key component necessary to developing an effective TBS Plan of Care.

Original Plan of Care

TBS must be listed as an added intervention on the original Plan of Care. The therapist is responsible for amending the original Plan of Care.

TBS Plan of Care

The TBS Plan of Care is an Addendum to the original Plan of Care. The TBS Plan of Care is developed and completed by the TBS team at the planning meeting. It is connected to the original plan and ensures that the TBS goals and interventions are addressed. It is intended to provide clinical direction for one or a series of short-term interventions to address very specific behaviors or symptoms of the child/youth as identified during the assessment process. The therapist, in coordination with the TBS team writes the TBS Plan of Care. The original copy of the TBS Plan of Care is kept in the beneficiary's medical record. If the Plan of Care is to be used for an IEP, the TBS Plan of Care should **not** be included as part of the IEP.

The TBS Plan of Care must include:

a. Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

b. A specific plan of intervention for each of the targeted behaviors or symptoms identified in the TBS assessment and the TBS Plan of Care.

c. A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a timeframe for these changes.

d. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

e. A transition plan that describes in measurable terms how and when TBS will be reduced and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the client progresses towards achieving Plan of Care goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgement of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

f. As necessary, a plan for transition to adult services when the client turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

g. If the client is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

A clear and specific TBS client plan is a key component in ensuring effective delivery of TBS.

TBS Plan of Care Addendum

A Plan of Care addendum should be used to document the following situations:

a. There have been significant changes in the child or youth's environment since the initial development of the TBS Plan of Care.

b. The TBS provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the provider indicating that they have considered alternatives, and

only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective.

Parental Consent

This is to be completed and signed by the beneficiary's legal guardian, if applicable.

DHCS Notification

A copy of the notification to the California Department of Health Care Services that TBS has been initiated or renewed is kept at the Managed Care office.

TBS Progress Note

A single note covering all of the interventions and responses during a day is required for every day of service using the TBS Progress Notes form. If the Coach is unlicensed or un-waivered, this note must be countersigned by a licensed professional.

Progress notes should clearly and specifically document the following:

a. Occurrence of the specific behaviors and/or symptoms that threaten the stability of the residential placement or prevent transition to a lower level of residential placement.

b. Delivery of the significant interventions identified in the TBS Plan of Care.

c. Progress being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors.

Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The time of service may be noted by contact/shift.

Non-Billable Services

A note to chart must be completed but not billed, whenever a beneficiary has a break in TBS. This might occur when the beneficiary is hospitalized, a lockout for all SMHS, including TBS. It might also occur when a beneficiary goes out of town, goes to camp or some other

overnight activity that the Coach cannot attend. A break due to extended illness of the beneficiary should also be noted in the chart.

Termination Documentation

When TBS ends, this should be noted in the progress note on the last day of service, with the reason for and beneficiary's response to the termination noted.

4A.9 TBS Staff Training

All staff involved in the TBS service delivery must have completed training on Confidentiality, Child Abuse Reporting and non-violent crisis intervention. In addition, TBS staff must have training in behavioral analysis with emphasis on positive behavioral interventions.

4A.10 FCMHP Monitoring

a. Licensed Clinical Staff Credentialing

The TBS Supervising Clinician and Alternate Supervising Clinician must be credentialed by the FCMHP before employment with the organization begins.

b. TBS Coach Application Checklist

The TBS organizational provider must complete the Coach Application Checklist for each TBS Coach and submit to Managed Care for approval. No TBS Coach can provide TBS until the application form is approved by Managed Care. Refer to end of this section for copy of TBS Coach Application Checklist form.

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Section 4:

Service Definition

Forms and Attachments

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FRESNO COUNTY MENTAL HEALTH PLAN

(TBS) Therapeutic Behavioral Services REFERRAL Form

*TBS MUST be added to current Treatment Plan *Referral MUST include most current full assessment

***Please complete all items and include latest complete assessment, Plan of Care & Most Recent Progress Note**

Child's Name: _____ SSN: _____

Date of Birth: _____ Age _____ Gender: _____

Primary Caregiver: _____ Phone: _____

Relationship: ☐ Bio ☐ Foster ☐ Step ☐ Adoptive Katie A. Subclass YES ☐ NO ☐

Accurate Address: _____ City: _____ Zip: _____

Ethnicity: _____ Caregiver's Preferred Language: _____ Preferred TBS service time: _____

School: Grade: IEP ☐ Yes ☐ No ☐ Enrolled ☐ Suspended/Expelled

To have initial 30 days of TBS, must be a "yes" for both #1 and #2 below:

1. Does child have Full Scope Medi-Cal? ☐ Yes ☐ No County Code: _____ Aid Code: _____

2. Is child currently receiving EPSDT services (**E**arly **P**eriodic **S**creening, **D**iagnosis & **T**reatment services)? ☐ Yes ☐ No

☐ Therapy ☐ Medication ☐ Other: _____ ICD-10/DSM-5 Dx: _____

THERAPIST	COUNTY SOCIALWORKER	PROBATION OFFICER
Name:	Name:	Name:
Phone:	Phone:	Phone:
Email:	Email:	Email:

3. Please list current medications and name of MD/psychiatrist:

To meet class for additional TBS beyond the initial 30 days, must meet criteria for at least one of the following:

4. Is it highly likely that child will be unable to transition to lower level of care? ☐ Yes ☐ No

5. Is child currently placed in or being considered for a Level 12-14 Group Home? Level: ☐ Yes ☐ No

6. Was the child hospitalized or considered for hospitalization in a psychiatric facility during the past 24 months? ☐ Yes ☐ No

Name of hospital and date: _____

7. Without TBS is it highly likely that the child will require higher level of care? ☐ Yes ☐ No

8. Has the child previously received TBS? ☐ Yes ☐ No

CURRENT PROBLEM BEHAVIORS that are jeopardizing placement or transition

☐ Self injurious behavior
☐ Threat to others
☐ Withdrawal, isolates self
☐ Disregard for rules
☐ Property damage
☐ Verbal aggression
☐ Physical aggression
☐ Other
☐ Has made allegations of abuse in past
Explain:

POSSIBLE AREAS of FOCUS

☐ Increasing coping strategies
☐ Increasing social skills
☐ Increasing daily living skills
☐ Increasing school functioning
☐ Sexual behaviors Explain:
☐ Decreasing opposition/defiance
☐ Decreasing self-injurious behaviors
☐ Decreasing property damage
☐ Decreasing verbal/physical aggression
☐ Community integration
☐ Other:

Print Name Title; Agency	**Fax Number:**

☐ **Expedite Referral**	**Rational:**

***Incomplete TBS referral packets cannot be processed.** Please fax all items together (TBS Referral form, signed copy of clinical assessment, signed copy of treatment plan that includes the intervention of TBS) to Managed Care at (559)455-4633.*

Therapist's Signature _____ **Date** _____

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FRESNO COUNTY MENTAL HEALTH PLAN
THERAPEUTIC BEHAVIORAL SERVICES
Coach Application Checklist

Name: _____ DOB: _____ SSN: _____

Gender: _____ Ethnicity: _____ NPI: _____

Languages Spoken other than English: _____

State of Birth: _____ Country of Birth: _____

Criteria	Yes	No	Description / Date
MINIMUM EDUCATION AND EXPERIENCE (REQUIRED)			
• **Bachelors Degree** in a non MH related field, but with at least **one year of full-time experience** working with children/youth, or			
• Completed **12 semester units** from an accredited college or university from any of the following disciplines- Social Work, Psychology, Rehab Counseling, Education Counseling or Marriage and Family Counseling, or			
• Completed **6 semester units** from an accredited college or university from any of the following disciplines- Social Work, Psychology, Rehab Counseling, Education Counseling or Marriage and Family Counseling, and with **one year of full-time experience** working with clients in human service settings.			
BACKGROUND CHECK (REQUIRED)			
• Licensed, Certified, registered, or waivered by a State Professional Board			
• Currently or recently employed in a position requiring a background check (law enforcement, child care, health care, teaching, residential care, CPS).			
TRAINING (REQUIRED)			
• Confidentiality			
• Child Abuse Reporting			
• Non-violent crisis intervention training (MAB, Pro-Act)			
• CPR			
• Fresno County General Compliance, includes Doc/Billing			
• TBS Video from state			
Others (Optional)			
• Classes taken on Child Development			
• Classes taken on Behavior Modification			
• Previous TBS experience			

Organizational Provider: _____

Organizational Provider Supervising Staff: _____

Office Address: _____

Phone Number: _____ Fax: _____ E-mail: _____

(For Managed Care staff only)

Comments on Coaches Profile: Approve ( ) Deny ( ) Staff Signature _____

Applicant Signature, please print name and sign Date

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COUNTY MENTAL HEALTH PLAN

PROGRESS NOTES

FRESNO COUNTY

CHILD'S NAME: SSN/CLIENT#: COACH:

Date of Service:_____Start Time: _____ End Time:_____Doc Time:_____Travel Time:_____Total Minutes:_____

Start Time:_____End Time:_____

(Actual Time Billed to County for Documentation and Travel: Documentation Time:_____ Travel Time:_____ Billed Minutes:_____)

TULARE COUNTY ONLY: Location of Services: Location of Services DSM 5/ICD 10:

PLAN OF CARE TARGET BEHAVIORS

Authorization Date for Plan of Care

Services available in preferred language:

☐ **YES** ☐ **NO**

INTERVENTIONS WITH CHILD AND CHILD'S RESPONSE

Intervention 1

Intervention 2

Intervention 3

Intervention 4

Intervention 5

Intervention 6

COUNTY MENTAL HEALTH PLAN

PROGRESS NOTES

REPLACEMENT AND COPING SKILLS UTILIZED

Skills Observed 1	Skills Observed 2	Skills Observed 3	Skills Observed 4

INTERVENTIONS WITH CAREGIVER & CAREGIVER'S RESPONSE

Caregiver Intervention 1	Caregiver Intervention 2	Caregiver Intervention 3	Caregiver Intervention 4

PLAN FOR CONTINUATION OF SERVICES (Describe Plan for Subsequent Visits)

SERVICES CONTINUE TO BE JUSTIFIED DUE TO:

Justification 1	Justification 2	Justification 3	Justification 4

Coach's Signature _____ **Date:** _____

Print Coach Name & Credentials: _____

Licensed Staff Signature _____ **Date:** _____

Print Supervisor Name: Jana D. Todd, LCSW #16669

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

Preferred language of Caregiver: _____ **DOB:** _____

Language of Client: _____ **SSN:** _____

Services provided in preferred language: YES ☐ NO ☐

PLACEMENT Verification

Current Caregiver Name: _____ Phone: _____

Caregiver Address: Cell:

_____ _____

Type of current placement ☐ Bio Family ☐ Foster Family ☐ Level 12-14 ☐ Other _____

Length of time in current placement:

_____

Why was child moved from former placement?

_____

Other placement information:

_____

OTHER SERVICES THAT ARE BEING PROVIDED

☐ MH Treatment ☐ Supportive Services ☐ Educational Services

Services	Provider	How frequently/When

MEDICATION SERVICES: Drug Allergies:

Medication	Dosage	Prescribing MD/Phone

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

Child's Name:_____ **Date:** _____ **Duration:**_____

ADDITIONAL COMMENTS: include mental health diagnosis, drug exposure, substance use, contact with law enforcement, allegations made against caregivers, if known, physical disorders.

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

Behaviors that put placement at risk or prevent transition to lower level of care. Include severity & frequency of behavior.

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

CURRENT FUNCTIONING: Include Caregiver and Client strengths, skills and adaptive behavior used.

☐ **Additional Information included in Supplemental Page 6** **Section:** ☐

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

☐ Caregiver understands the intensive nature and necessary commitment of time to services.

Services will be provided at: ☐ Home ☐ School ☐ Other:_____

1	Behavior Frequency		Behavioral Goal
2	Behavior Frequency		Behavioral Goal
3	Behavior Frequency		Behavioral Goal

Replacement behaviors to be taught:

Interventions addressing target behaviors:

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

Specific measures used to gauge effectiveness of interventions:	
☐ BAF ☐ BX Chart ☑ Caregiver Report ☐ Other:	

Strategies to involve caregiver in preparation for discontinuing services:

AUTHORIZED SERVICES

Services will be provided for _____ hours per week. **(Excludes Documentation and Travel Time)**

Start date End date

TRANSITION PLAN

When behavioral goals are met, hours will be decreased from _____ to _____

When discharged from services, Child will continue with:

_____

Caregiver will continue to implement:

_____

Please describe the Transition Plan from the inception of services to decrease or discontinue when these services are no longer needed or when the need to continue appears to have reached a plateau in benefit effectiveness:

FRESNO COUNTY

COUNTY MENTAL HEALTH PLAN

Assessment & Plan of Care

Child's Name:_____ **Date:** _____ **Duration:**_____

1. _____ ⇨ _____
   Client Print Name — Client Signature
2. _____ ⇨ _____
   Caregiver Print Name — Caregiver Signature
3. _____ ⇨ _____
   TBS Coach Print Name — TBS Coach Signature
4. _____ ⇨ _____
   TBS Coach Print Name — TBS Coach Signature
5. _____ ⇨ _____
   Print Name/Role — Signature
6. _____ ⇨ _____
   Print Name/Role — Signature
7. _____ ⇨ _____
   Print Name/Role — Signature
8. _____ ⇨ _____
   Print Name/Role — Signature

Clinician Signature/Credential _____ Date _____

Print Name/Credential

Clinician Signature/Credential _____ Date _____

Please Select Licensed Clinician

Assessment & Plan of Care

Child's Name:_____ Date: _____ Duration:_____

Supplemental Page for Additional Information

SECTION A

SECTION B

SECTION C

SECTION D