PEI FREQUENTLY ASKED QUESTIONS

GENERAL:

1. **How do we handle clients who drop out in the middle of treatment and return to the program later on?**
   In general, this situation would be handled in the same way as clients receiving basic mental health services. EBPs focus on outreach and engaging client's and families' participation in services and completing treatment, therefore the clinician would outreach to the client/family before closing the case. If the client does not return, the case would close and documentation would include reason(s) for termination and the data gathered from the outcome measures would be recorded. If the client returns within the year an assessment addendum or full assessment would be completed with strong justification for allowing the client to initiate treatment again. The decision for returning would also be based on the Provider's expertise, consultation with the EBP/Promising Practice consultant if available, and other subjective clinical factors that would need to be looked at on a case-by-case basis.

2. **Who monitors when sessions are completed?**
   It is the responsibility of the agency to monitor completion of treatment and to ensure that all documentation is complete.

3. **Is there an authorization process if a Provider needs to repeat treatment for the same client?**
   There is no authorization process. Each Provider is trained on which clients are appropriate to receive EBPs. Generally, it is not recommended that clients repeat treatment after completing an EBP; however, there may be circumstances in which it would be clinically appropriate to review the client's and family's needs. This would be on a case-by-case basis with strong justification for repeating treatment as required for ongoing utilization monitoring.

4. **Who monitors the monthly reports?**
   Agencies are always responsible for remaining aware of their service delivery patterns and adjusting service delivery as necessary to remain within their contractual requirements. DMH will be developing reports to help agencies with this process. It is anticipated that Lead District Chief staff and/or Service Area District Chief staff will also have a role in monitoring monthly reports.

5. **Who monitors the agency's compliance with completion of outcome measures?**
   Monitoring outcomes is a joint agency and DMH responsibility. By agencies monitoring their own outcomes, clinicians can receive useful information regarding service delivery.

GENERAL (cont.)

6. **Who is responsible for the analysis of the data collected?**
   For Triple P and TF-CBT, CIMH will handle reporting and agencies will have access to their data for monitoring their outcomes. For all other EBPs, DMH is currently developing procedures for gathering data and reporting.

7. **What will be the responsibility of Service Area staff?**
   Lead District Chief and/or Service Area staff will assist with monitoring PEI programs and other duties as the program unfolds.

8. **Who is responsible for keeping track of who is certified in each EBP?**
   Agencies and DMH will be keeping track of who is certified.

9. **If a potential client for an EBP also has a co-occurring diagnosis of Pervasive Developmental Delay or also has developmental delay issues, can the individual still receive the EBP?**
   The answer depends on what is clinically appropriate given an assessment of the client's presenting problems, functional impairment; and ability to benefit from the chosen EBP.

10. **Can we complete another assessment when a client changes from one EBP/intervention to another EBP/intervention?***
    EBPs are intervention strategies. Changing intervention strategies/EBPs is not sufficient reason, in and of itself, to complete another assessment. For further information please refer to the Assessment sections, pages 2-3 and 2-7 through 2-8, of the Short-Doyle/Medi-Cal Organizational Provider's Manual (hereafter Provider Manual).

11. **When would I complete an assessment addendum?***
    An assessment addendum can be completed when an existing assessment does not accurately reflect the client's current status. A child short format assessment may also be completed in this type of situation. In addition, an assessment addendum can be completed when there is additional pertinent or valuable assessment information received or discovered after the assessment period (the assessment period is 60 days from the date of admission).

12. **How does our agency start providing mental health services in schools?***
    You can contact your Service Area District Chief for the name of the Service Area School-based Coordinator. The School-based Coordinator will guide you on the process of providing mental health services in the schools.

13. **Can Report Writing – No contact (90889) and Review of Records (90885) be claimed as ancillary services?***
    Yes, if these are already in your contract and your agency wishes to use PEI funding for this purpose.

CLAIMING:

1. **Can Medication Support Services be claimed under the PEI Plan?**
   Yes, Medication Support Services may be claimed as an ancillary service for a specific PEI Program while an individual is receiving mental health services under a PEI Program.

2. **If a Provider enrolls a client who has another payer source (such as Medi-Cal or EPSDT); do they claim MHSA funds or the payer source?**
   Upon enrollment, all PEI clients should undergo a standard financial screening to determine their eligibility for benefits and ability to pay for services (UMDAP). Agencies are to assist their clients in establishing any benefits they are eligible for. All other payer sources, e.g., Medi-Cal, Medicare; Healthy Families; AB 3632; etc., should be claimed for eligible services before claiming MHSA funds. The client's funding sources can include private insurance, public programs, and the family's ability to pay. Keep in mind that almost all funding sources will claim to a client's payer source first. For example, if a client has Medi-Cal and you choose a PEI plan, Medi-Cal will be claimed automatically as long as the Medi-Cal box is marked and the match will come from the funding source (in this case, the PEI plan). Medi-Cal should be claimed if all requirements for Medi-Cal claiming are met (i.e. Medical Necessity criteria are met, service is reimbursable).

3. **How do we claim for a child in FSP and an EBP?**
   The EBP will be claimed under FSP Plan since FSP is an all-inclusive service. Outcome measures for the EBP will be required.

4. **How do we claim for a child in Wraparound and an EBP?**
   If the Wraparound Provider delivers the EBP, then the Provider will claim to the appropriate Wraparound Plan. If the child is linked to another Provider to deliver the EBP, then the other Provider will claim the appropriate plan, which may be a PEI Plan. In both cases, outcome measures will be required for the EBP.

5. **How do we claim for a child in FCCS and an EBP?**
   FCCS services are claimed to the FCCS Plan and the EBP is claimed to the PEI Plan. Outcomes measures will be required.

6. **How do Providers use the IS system to claim against the new PEI plans?**
   In the Outpatient Claim – Plans screen, Provider selects the age-appropriate PEI Plan. The available plans are listed below:

New PEI Plans		Effective on services date
2091	PEI_Special_Programs	7/1/2010
2098	PEI_Children	5/11/2010
2101	PEI_TAY	5/11/2010
2092	PEI_Adult	7/1/2010
2093	PEI_Older_Adult	7/1/2010

CLAIMING (cont.)

7. How would we choose the procedure code in the IS for a group where both children and TAY are present?

No group procedure codes are specific to the ages of the clients present. The Plan is chosen for each individual client in the group (for agencies using the LAC-DMH group log, the plan is listed for each client on the group log). For the children in the group you would choose the Child PEI plan and for the TAY age clients in the group you would choose the TAY PEI plan.

8. Our agency will be serving Healthy Families clients. How do we check eligibility?

This will be covered in the Healthy Families training that all new Healthy Families Providers receive from the Healthy Families Unit.

9. Will Providers be able to claim to COS?

COS funding was not included under the PEI transformation.

10. If a child who was opened under a PEI Plan no longer receives mental health services (such as rehab services) but continues to receive medication support with the psychiatrist, can the psychiatrist continue to claim under PEI?

No. The Provider must use a non-PEI Plan.

11. When a client is seen for an EBP and then has a session that has nothing to do with the treatment of the child, are both sessions claimed as the EBP? Or is the funding source split? For example, we are seeing a child and a mother under TF-CBT and are doing trauma work. Then there is a separate session due to issues in the mother's marriage, how would we claim for both of these?

If the session has "nothing to do with the treatment" then it is not a claimable service to any funding source and would be documented on a separate Progress Note with no procedure code. If the session does in fact relate to the treatment of the client (i.e. the mother's marital issues are impacting the client's mental health and the focus is on this impact and how she can minimize it for the client), and fits into the TF-CBT model, then you would write a separate Progress Note with a collateral procedure code and claim it to the PEI Plan.

12. Is psychological testing covered under PEI?

Providers who want to provide psychological testing will need to ask their Lead District Chief to process the PFAR in order to add psychological testing to their PEI Plan. Psychological testing will be claimed as an ancillary service.

13. Can medication support dollars exempted from CGF EPSDT curtailment for FY 10-11 be used for all EPSDT services (i.e. MHS, TCM, etc.)?

Yes, it can be used for all EPSDT services in your contract.

CLAIMING (cont.)

14. If we are currently offering other EBPs can we claim those to PEI?
In order to claim to PEI, EBPs need to have been approved by the Service Area District Chief and included in your contract with DMH.

15. When selecting EBP codes for core services in the IS, why/when would we use the Service Strategy codes?*
You would select Service Strategies along with an EBP when you want to reflect a broader description of the services you are providing that are not fully captured in the EBP. If your opinion is that the Service Strategies are already reflected as part of the EBP, then there is no need to report the same components of the service as Service Strategies.

16. Our EDI provider informed us that the PEI plans for children only apply to children ages 0-15. We are currently seeing children between the ages of 0-17. Is there another plan that we can use to claim these services or can we only provide EBP/PEI services for children 0-15? What if we do not have funding for TAY?*
For PEI services, the plan you claim corresponds to the age the client is at the time of the service. If the client is 15 as of the time of the service, you would select the PEI Children IS Plan. If the client is 16 years old at the time of the service, you select PEI TAY IS plan. Contractors that transformed to either PEI Child or PEI TAY programs were given both IS plans for claiming. Please check with your lead district chief about the allocation of your PEI dollars into the PEI subprograms in your negotiation package and whether any revision is necessary.

ENROLLMENT:

1. Does PEI require a referral and authorization process through the Service Area Impact team that is similar to FSP clients?
No, PEI does not have a centralized referral authorization process. Each PEI Provider determines internally how referrals are generated. Service Area Impact Coordinators and others may refer clients to PEI programs but authorization from a centralized unit is not needed.

2. If a client is transferred within the same Legal Entity between programs that have the same Provider number (i.e. EBP and Outpatient have the same Provider number), does a new episode need to be opened and new Assessment/CCCPs completed?
No, if the EBP will be provided within the existing Provider number, no new episodes, assessments or CCCPs need to be completed. However, you must ensure that the goals/objectives on the CCCP continue to be appropriate and cover the types of services provided under the EBP.

ENROLLMENT (cont).

3. **If a client is transferred within the same legal entity from an outpatient program to a PEI program that have DIFFERENT Provider numbers, does a new episode need to be opened with new Assessment/CCCPs completed?**
   If the client is transferred to a program with a different Provider number, then a new episode must be opened. The new episode is opened at the point in which the client presents at the new program. The new Provider needs to determine if the existing Assessment accurately reflects the status of the client. If so, it is acceptable for a copy of the Assessment to be placed in the new record and used. If not, the new Provider may do a new assessment, child short format assessment, or assessment addendum, depending upon the need. A copy of the existing CCCP may be placed in the new record and used as long as the goals/objectives are appropriate to the EBP. (Quality Assurance Bulletin No. 08-2; July 14, 2008)

4. **Can a child in FSP be receiving EBP interventions?**
   It will depend on the EBP and whether it is clinically appropriate. Other things to consider are duplication of services and overwhelming the family. This will be a Service Area District Chief, or District Chief designee, decision with Child PEI Team consultation.

5. **Can a child in Wraparound be receiving EBP interventions?**
   It will depend on the EBP and whether it is clinically appropriate. Other things to consider are duplication of services and overwhelming the family. This will be a Service Area District Chief, or District Chief designee, decision with Child PEI Team consultation.

6. **Can a child in FCCS be receiving EBP interventions?**
   It will depend on the EBP and whether it is clinically appropriate. Other things to consider are duplication of services and overwhelming the family. This will be a Service Area District Chief, or District Chief designee, decision with Child PEI Team consultation.

7. **Can a child be receiving two EBPs at the same time?**
   It will depend on the EBP and whether it is clinically appropriate. Other things to consider are duplication of services and overwhelming the family. This will be a Service Area District Chief, or District Chief designee, decision with Child PEI Team consultation.

8. **Will there be any changes in documentation requirements for PEI EBPs?**
   No, all payer source documentation requirements remain the same (adhere to DMH Policy 104.8 and the Organizational Provider's Manual). The EBP developer may have documentation requirements which must be followed but cannot take precedence over documentation requirements of the client's payer source.

ENROLLMENT (cont).

9. **If a potential client for an EBP also has a co-occurring diagnosis of Pervasive Developmental Delay or also has developmental delay problems, can the individual still receive the EBP?**
   The answer depends on what makes clinical sense and whether the client is found to be clinically appropriate to participate in the EBP. Most EBPs can be modified to accommodate individuals with developmental delay. For CBITS, something to consider is the fact that CBITS is delivered in a group thus it is important to consider the group dynamics of whether the individual would be appropriate to participate.

CBITS:

1. **Why is CBITS not appropriate for youth with severe and persistent mental health difficulties?**

   Any youth that has emotional and behavior problems that might disrupt the group process should not be placed in the CBITS group. Severe or persistent mental health difficulties include active homicidal or suicidal ideation, psychosis, or severe physical aggression, for example. The most important factor is whether a youth is able to interact with other group members appropriately so that all may benefit. CBITS is not a crisis intervention.

2. **What if a parent cannot or will not participate in parent education?**
   As in all forms of mental health treatment, the more involved parents are, the greater the likelihood of successful outcomes for the youth. Individual meetings with parents seem to be the best way to access parent participation. Lack of parent participation is not a reason to exclude a child from the CBITS group unless the parent refuses to sign the consent. Parent refusal to participate should be appropriately documented in the clinical record.

3. **What if a teacher cannot or will not participate in parent education?**
   Teachers do not participate in parent education. Program staff while introducing CBITS to the school, should get the support of teachers. Most importantly, the teacher out of whose classroom the student will be taken once a week for therapy should endorse the participation.

4. **Is it one teacher or all teachers involved in a child's life?**
   It depends upon what is meant by involvement. The most important factor is whether the teacher(s) believes that CBITS is helpful and supports youth going to group and being taken out of class. The number of teachers one has to involve depends upon the child. It is possible that the youth is presenting problems for more than one teacher, or more than one teacher may have a special interest in the youth. The teacher whose class the youth will have to miss because of the CBITS group will certainly have to be involved. The involvement with other teachers is on a need-to-know basis and rules of confidentiality apply.

CBITS (cont.)

5. **Can the principal or principal designee participate in place of the teacher?**
   Although principals and other administrators can participate in teacher in-service education on trauma, it is not recommended that they take the place of the teacher. Teachers are the primary point of contact for students and have much to benefit from understanding the many problems that can result from traumatic experiences.

6. **Are the two-parent education sessions held in group format or are they with each parent and a participating child?**
   It is up to the Provider. However, individual sessions with parents appear to be the best way to involve them.

7. **Is the Provider responsible for communicating and making arrangements for space (rooms) with the schools?**
   Yes. All experienced school-based mental health service Providers are well aware of how to negotiate with schools for space. Space is at a premium in most inner city schools. Some school-based clinicians do individual therapy in creative "found" space. CBITS presents a particular challenge because a school may not have the space to allocate for a group once a week for ten weeks.

8. **What is the role of the DMH school-based coordinator?**
   This is a role that has not been defined yet specifically in relation to CBITS. We hope to do that in the next few months. This role may differ from Service Area to Service Area based on the unique needs of the population being served and the Service Area District Chief's way of doing things.

9. **Is there a limit to repeating the group?**
   Many youth screened for CBITS have experienced multiple traumas. It is recommended that the youth and therapist select one trauma that can be worked on successfully. Other traumas may require other forms of treatment. It is hoped that the lessons learned in CBITS would generalize to other traumatic events. Repeating CBITS for any child should be discussed with Provider Supervisors/Managers and possibly with Service Area Program Administrative staff persons. The CBITS Child PEI Team lead can also be consulted.

10. **Can CBITS be delivered in a setting other than a school site?***
    Yes, however it is the provider's responsibility to ensure that even if CBITS is NOT being delivered in a school site that there be clear documentation in the clinical record of ongoing coordination/communication/linkage by provider staff with school personnel regarding the client/family being served.

11. **Since high drop-out rates occur in groups, can one therapist conduct the CBITS group if it dropped to five students?***

CBITS (cont.)

There is no absolute prohibition against one therapist running a group alone, although it is felt this might be taxing for that therapist. The problem is not solely the group count. It is important to remember that for this EBP each participant receives group therapy as well as 3 individual sessions, 1-2 collateral sessions and teacher education. The individual sessions occur in the early stages of the treatment targeting exposure before the group sessions, and the collateral sessions occur toward the end of the treatment.

TRIPLE P:

1. **Many Providers are asking if a child can be treated in individual therapy at the same time as his/her parents participate in Triple P and how to claim for this individual therapy, and plan. What should we tell them?**
   If a child is already receiving individual therapy and is referred to Triple P, it is appropriate to look at the child's needs and clinically appropriate services so that services are not undermined inadvertently. If a child is referred to an agency for services and the assessment determines that Triple P would be an appropriate service, the recommendation would be to start and complete Triple P prior to providing Individual Therapy. *Note Triple P is primarily a parent/caregiver curriculum and individual therapy is not a core intervention of Triple P.

2. **This EBP does not have some languages available for parent books. How can this be addressed and still meet the developer's requirement that translation needs to be done by the developer?**
   Currently books are available in English and Spanish. Triple P is working on translation in more languages. Agencies should work with their consultants to address language concerns and adaptations.

3. **Can the initial assessment be conducted by a licensed clinician and Triple P implemented by a case manager?**
   Yes.

4. **Will the Service Area staff be informed of who is certified in Triple P for auditing and contract monitoring purposes?**
   Monitoring duties have yet to be assigned; however, yes the information will be shared.

5. **How long is the accreditation and certification process?**
   After a clinician completes the initial training, they are provisionally certified. The clinician will participate in a pre-accreditation day, which is then followed by an accreditation day exam. There is also a post-accreditation day (similar to a booster training.) The time frame that we anticipate for accreditation is approximately 3 months after the initial training. This time frame may vary.

TRIPLE P (cont):

6. **DCFS children occasionally change foster homes. Is this program conducted with the biological parent or the foster parent? Can foster parents participate in Triple P?**
   Triple P can be implemented with biological parents, foster parents, and caregivers. The crucial aspect is "stability of placement." The model is designed to help a child on a long term basis.

7. **How do you handle the program for a child who changes caregivers in Triple P?**
   This question is based on clinical and stability of placement factors. Remember the goal is for long term impact and support. This should be taken on a case-by-case basis and the agency/clinicians should take into consideration what will be most beneficial for the child, as well as fidelity to the model.

8. **Is Triple P Level 3 Medi-Cal claimable?***
   It is not clear to LACDMH that Triple P Level 3 is Medi-Cal claimable. Possible audit exceptions could occur if clinical documentation is not precisely clear and justifiable. Agencies are free to pursue training in Triple P Level 3 as long as they are confident that they will be able to train and monitor staff in appropriately documenting Medi-Cal medical necessity for clients receiving services at this level.

9. **We are receiving training in Group Triple P Level 4 through CiMH. Are these services claimable under PEI?***
   Yes, as long as your staff are trained and certified in Group Triple P Level 4.

10. **If there are siblings in the same family that can benefit from Triple P but their goals and needs are different do we provide the model twice?***
    If both siblings have a disruptive behavior disorder, then typically, the best choice is to open a single case on the child with the more severe behavior problem. The parents would be learning skills to assist both children. If the siblings have different presenting concerns, then a more appropriate treatment would be recommended. However, it is important not to overwhelm families with services. In these types of situations providing treatments sequentially would be more appropriate.

TF-CBT:

1. **Is there a place for a client's somatic response to threats, as well as boundary description in traumatized children?**
   Yes. It is worked through in therapy.

2. **For TF-CBT, how long are the clinicians in training and participating in consultation calls?**
   Approximately one year. There is a two-day initial training and a booster training 6 months after.

TF-CBT (cont):

3. **When are the measurement tools administered? Is there a pre-test measurement?**
   Beginning (pre) and at the end of treatment (post.)

4. **Is DMH PEI rolling out TF-CBT for ages 3-18?**
   Yes.

5. **Q: If clients score in the sub-clinical range in the pre-test for the PTSD-RI are they still eligible to receive TF-CBT?***
   Sub-clinical pre-test scores alone do not preclude a client from receiving TF-CBT. It is possible that clients and/or their families under report on a measure and therefore, as with any intake, clinicians must consider other information gathering practices in addition to the measure, such as the assessment, observations, reports from others, etc., in determining functional impairment and medical necessity of a client.

6. **Can a behavior specialist provide individual rehabilitation as part of the ancillary services for TF-CBT?***
   Yes.

SEEKING SAFETY:

1. **With a minimum of two clinicians, approximately how many clients can be served (caseload)?**
   Dr. Najavits (developer) does not indicate a maximum number of clients to be served per caseload. Caseloads also depend upon whether clients are seen individually or in a group.

2. **What is the staff-to-client ratio?**
   "Staff-to-client" ratio has not been indicated by the developer**.** Ratio will also depend upon whether clients are seen individually or in a group setting.

SEEKING SAFETY (cont):

3. **Can a client do Seeking Safety and also attend AA or other substance abuse treatment?**
   Yes. Clients are able to attend self-help groups. Part of treatment is to get clients connected with resources in their community.

4. **How many topics are recommended for treatment? Is there a maximum or minimum?**
   The more topics/sessions completed the better the outcomes. The developer reported a study consisting of a minimum of 6 sessions yielded positive outcomes.

5. **Is there a maximum number of sessions and who monitors?**
   According to the developer, each topic may be stretched out to 3 sessions (in a residential setting). If all 25 topics are conducted at 3 sessions each, then the maximum would be 75 sessions. In settings such as Outpatient, for example, it may not be necessary to split topics into three sessions. The developer thought that most clients seen in a group, for example, would be done in 5 or 6 months. Countywide and Service Area Administration will work collaboratively to monitor Seeking Safety services. Monitoring details will be clarified at a later time.

6. **What is an adherence check for licensed supervisors in Seeking Safety?**
   Supervisors are expected to maintain a caseload, submit taped audio/video session(s) to the developer, and participate in 1:1 phone consultation with the developer/designee. The adherence check is one requirement for agencies to designate and "certify" a supervisor who can offer agency replacement staff training. The adherence check consumes three hours of consult time.

7. **What is the length of treatment?**
   Length of treatment depends on how many topics are covered, the number of sessions conducted to complete a topic and the frequency of sessions.

8. **Since Seeking Safety does not explore past traumas, how recent must the traumatic event be?***
   Past traumatic events can either be recent or in the distant past, single events or multiple events. It all depends on how trauma is impacting the client in the present time. Please refer to "Principles of Seeking Safety" of the manual (pages 5 to 15) for more information. In addition, since clients may present clinically with an array of symptoms that would be treatable by the Seeking Safety program, practitioners need to perform a good assessment to determine if a client is exhibiting unsafe behaviors (e.g. substance abuse, alcohol, other ri sky behaviors) since Seeking Safety can work for all these issues regardless of trauma history.

9. **Is Seeking Safety considered a crisis intervention?**
   No.

SEEKING SAFETY (cont):

10. **Do participants of Seeking Safety need to have any symptoms of PTSD?***
    Yes. To be clear, clients do not need a diagnosis of PTSD, but would most likely have some symptoms associated with a history of trauma.

11. **Does Seeking Safety have mandatory topics?***
    A: There are no mandatory topics; however, Dr. Najavits (developer) recommends that if you are planning to conduct the full treatment that the topics *Introduction to Treatment/Case Management* and *Safety* be covered first to provide a foundation. Clearly, clinics need to be familiar with all 25 topics in the manual. Some topics will be more relevant for different populations and clinics need to craft a program

that makes sense for the population they are seeing.

AGGRESSION REPLACEMENT TRAINING (ART)

1. **Staff at our agency was trained for Aggression Replacement Training (ART). Although the training is geared toward adolescents, there are sections, such as *Skillstreaming*, that are used for elementary age children that are evidenced-based practices as well. Since we are using these modules within model fidelity for these children, can we put these children in PEI funding for these services?***

   DMH has agreed that the Skill Streaming Module of Aggression Replacement Therapy (ART) can be delivered as a PEI Program (EBP) without implementing the other 2 ART modules (anger control training and training in moral reasoning).

FREQUENTLY ASKED QUESTIONS (FAQ)
MANAGING & ADAPTING PRACTICE (MAP)

TRAINING

1 Q: If you have a trained MAP Agency Supervisor, do you still participate in consultation calls?

1 A: Those taking the 5-day workshop should complete the consultation calls.

2 Q: After the 5-day workshop, will you participate in consultation along with staff from other agencies? Who will coordinate this?

2 A: Consultation for participants in the Direct Service Series training will be coordinated and provided by PracticeWise for 12 calls over approximately a 6 month period. These calls will generally involve participants from multiple agencies.

3 Q: When is the earliest Supervisor training available?

3 A: Supervisor trainings were made available as early as January 2011, but not enough participants were eligible for the training. Therefore, the next training is tentatively scheduled for April 2011.

4 Q: Why is the MAP Direct Service Series training 5 days long?

4 A: The MAP Direct Service curriculum teaches skills from numerous therapeutic approaches to multiple target problems. For example, one might think of the MAP Direct Service training as comparable to attending multiple EBPs for four different target problems.

5 Q: Can the clinicians chosen for MAP training be interns?

5 A: Although PracticeWise does not have a requirement for the credentials or roles of trainees, LACDMH requires that clinicians for MAP should be Masters level clinicians (a Licensed Practitioner of the Healing Arts (LPHA); registered, waivered or licensed clinicians).

6 Q: Our agency has multiple sites in different Service Areas. We were given the minimum amount of slots. Is that for each site or for the entire agency?

6 A: For the entire agency.

7 Q: How soon after the Direct Service training can a supervisor attend the Supervisor Training?

7 A: One must achieve MAP Therapist status before being eligible for the Supervision and Consultation Training. A MAP Therapist has successfully completed the Direct Services Series which includes the 5-day workshop, consultation calls and a portfolio review. The shortest time that one can achieve MAP Therapist status is 6 months, but it often takes a bit longer due to absenteeism, rescheduled consultation calls, portfolio review, etc.

8 Q: My supervisor has not received the 5-day training. Can they do the one day conference, start billing, then do the 5-day training and then complete the supervisor training?

8 A: Yes, if they complete all of the requirements at each step. Their supervisee(s) will not be authorized to bill until (1) the supervisor completes the 2-day workshop portion of the Supervision and Consultation Training, (2) the supervisee(s) completes the required initial components of the Therapist Portfolio (see document: ***Summary of MAP Credential Standards for LAC DMH***), and (3) receive notice of verification from DMH.

9 Q: What happens if a therapist gets provisional training (from the 1-day conference), begins billing, then leaves the agency prior to getting the full 5-day training? Will there be additional 1-day conferences to account for this type of turnover?

9 A: That therapist loses provisional authorization to bill for MAP when he or she leaves the agency. Additional 1-day conferences are not planned at this time.

10 Q: Does a supervisor use one of the Direct Service slots if not already trained in MAP?

10 A: Yes.

11 Q: What if our supervisor has only recently completed the Direct Service Training and has not completed the 6 months of direct service? Do we register them now (as a supervisor) or wait?

11 A: One must successfully complete the Direct Services Series (which includes the 5-day workshop, consultation calls and a portfolio review) to be eligible for the Supervisor training. Agencies can pre-register potential supervisors at this time. Pre-registration forms for the Supervision and Consultation Training were due on January 7, 2011 and all agencies have submitted the pre-registrations for their supervisors.

12 Q: Is the MAP one day conference only for untrained clinicians/supervisors or should previously trained MAP therapists and agency supervisors attend one of the days as well?

12 A: It was only for untrained clinicians/supervisors.

13 Q: Does a MAP supervisor need to be licensed as supervisors usually need to be?

13 A: PracticeWise does not require specific credentials for MAP Agency Supervisors, but Agency Supervisors are expected to satisfy local requirements (e.g., LACDMH requirements) and must have **direct clinical authority** over their supervisees while directing the professional development of those supervisees in the MAP system.

The expectation of DMH for clinical programs and licensing requirements at provider agencies is that supervisors be licensed in order to supervise others. This is our expectation for other programs and is consistent with licensing board requirements.

14 Q: How was the number of slots determined for each agency?

14 A: The number of training slots is based on the PEI budgets of each legal entity and the number of available slots. Each agency was given, at minimum, 2 Direct Service training slots and 1 Supervisor training slot.

15 Q: Will more 1-day conferences be offered?

15 A: No additional 1-day conferences are planned at this time.

16 Q: Our agency needs to send at least one supervisor. We have no supervisors who have completed any MAP training. Does a supervisor need to complete the direct service training and the minimum 2 cases, 6 months of consultation, portfolio review, etc. before they can begin being

trained as a MAP supervisor? Or can the supervisor training run concurrently?

16 A: All requirements for MAP Therapist status must be completed *prior* to attending the Supervision and Consultation Training. The Direct Service series and Supervision and Consultation series may not overlap.

17 Q: Are the 5-day trainings scheduled in the same week?

17 A: Generally, the 5-day trainings are from Monday to Friday. However, some trainings may begin on a Tuesday to the following Monday due to a holiday.

18 Q: Are Direct Services series forms due for each therapist and supervisor? What exact forms are due? Where do we fax them?

18 A: Pre-registration forms for both the Direct Service Series and the Supervision and Consultation Series trainings should be submitted. The pre-registration forms for the Direct Service Series training were due on December 9, 2010. The pre-registration forms for the Supervision and Consultation Series training were due on January 7, 2011.

Once the training dates have been determined and the participants identified, invitation letters with registration forms will be sent to the agency training coordinator. Once completed, all forms should be emailed by the due date indicated to Lucy Farias at lfarias@dmh.lacounty.gov. If you are not able to email your forms, you can fax your forms to (213) 252-0236. When faxing forms, please confirm that your fax has been received.

19 Q: For staff who attended the 1-day conference and received provisional training, do we need a supervisor who has already completed the direct service and supervisor training?

19 A: No.

20 Q: If the supervisor trainings start in January, does it mean staff who have recently received the Direct Service Training may attend if not yet completed the 6 months?

20 A: No. All requirements for MAP Therapist status must be completed *prior* to attending the Supervision and Consultation Training. The Direct Service series and Supervision and Consultation series may not overlap.

21 Q: The sheet shows 2 direct service slots and 1 supervisor slot. Does this give us a total of 3 people or only 2?

21 A: It can give you a maximum of 3 people trained. For example, if you already have a MAP Therapist on your staff, then your agency can send that person to the Supervisors training and send an additional 2 staff to the Direct Service training. Whereas, if your agency does not have a MAP Therapist, then the potential supervisor will need to take both the Direct Service training and the Supervisor training, and therefore, only 2 people will be trained at the agency.

22 Q: There seems to be a contradiction on how many we can train after we are a supervisor. DMH stated 6 and Dr. Chorpita stated that this is unlimited. Can you clarify?

22 A: During the Supervision and Consultation Training Series, supervisors must work with at least 6 different supervisees to satisfy the requirements of the MAP Supervisor Portfolio. There is currently no limit on the number of MAP Therapists that may be developed by a MAP Agency Supervisor over time, but all supervisees must be under the direct clinical authority of the Agency Supervisor. Practical caseload size restrictions apply to the number of supervisees that may be trained at any given time by an individual supervisor. During the Agency Supervisor Training period, a maximum caseload of 10 supervisees may be active at one time.

DMH will pay for up to 6 supervisees to get trained by the Agency Supervisor during the Supervisor training period. Providers may privately pay for additional supervisees by purchasing information resources and portfolio reviews directly from PracticeWise.

23 Q: Are there specific worksheets/workbooks that are available online for different interventions (e.g., workbook to teach relaxation, positive thinking, etc.)?

23 A: The Practitioner's Guide is available on the PracticeWise website and access to the website is included in the subscription under the User Agreement.

24 Q: What about staff who train under one agency and then go to work for another agency?

24 A: The receiving agency can use one of their training slots, or the staff person and/or the receiving agency will be responsible for the cost of providing make up sessions, consultation calls and/or subscription fees.

For staff that were privately trained, the receiving agency can either apply one of their training slots to the partially trained staff and allow the person to complete their training under the auspice of the new agency, or the agency can choose to privately pay to finish training for partial completers, contingent on the availability of consultation.

CLINICAL

1 Q: Is MAP appropriate for children with developmental delays?

1 A: Yes, with some qualifications. With MAP, a key part of service planning and revision involves use of the PracticeWise EBS Database (PWEBS). This database summarizes over 450 studies involving mental health treatments for children. PWEBS currently focuses on treatments that target anxiety, attention problems, autism spectrum, depression, disruptive behavior, eating problems, mania, substance use, suicidality, and traumatic stress. Some of these studies include children with developmental delays, and some of them do not. MAP Therapists are encouraged to probe the relevance of the available research to a given client or family and to use sound judgment in choosing a course of action. MAP also incorporates a measurement plan into its direct service model, so that regardless of the strategies suggested by the literature, a MAP Therapist would be expected to measure and review the practices being used and the progress associated with those practices.

2 Q: Is MAP time limited?

2 A: No. There is no explicit length of time required to deliver MAP services. Therapists are expected to chart the progress being made by clients and families, and termination is typically triggered by goals being met or by evidence that a different type of service would be more appropriate. The PWEBS does provide information about the length of service for treatments that have been found to be effective, and it is recommend that this information be used as a guideline for evaluating if any individual treatment episode is achieving gains at a rate consistent with the "best practices" from the evidence base.

3 Q: Is there a limited age range for clients in MAP?

3 A: See Clinical question #1. The PWEBS Database summarizes literature in participants ranging in age from 0 to 23 years. However, that literature is not uniform across problems, gender, ethnic groups, etc. (e.g., the age range of established treatments for Attention Problems is 2 to13 years) and the PWEBS literature review is not comprehensive for youth above age 18. When therapists are operating outside the age range of the literature, they are typically expected to use best practices by adapting and extending approaches that work for groups of children "most similar" to the client in question (in this case, closest in age). To the extent that there are departures from the literature, therapists should be aware that the uncertainty of achieving a positive outcome is increased, and thus especially conscientious use of outcome monitoring is warranted. (See document: ***Direct Service Workshop Overview***)

4 Q: If we have questions about the model that arise prior to the 5-day training, will we have some access to consultation (on an as-needed basis)?

4 A: There is no clinical consultation procedure preceding the 5-day trainings in place at this time. A project webpage will be made available that provides responses to common questions. The Community Development Team (CDT) "champion" calls and individualized technical assistance will also be available to agencies.

5 Q: I understand that there are 4 additional diagnoses addressed by MAP. Will these be added/included at a later point?

5 A: MAP is a system for approaching treatment planning and delivery and making decisions about care, making it applicable to a wide variety of clinical problems. That said, because it relies on specific tools for delivering practices (PWEBS, the Practitioner Guides), it is best suited to children and families for who the literature and practices have been summarized most fully (which at this time include anxiety, attention problems, autism spectrum, depression, disruptive behavior, eating problems, mania, substance use, suicidality, and traumatic stress).

Currently, services provided under MAP claimed to PEI are limited to the treatment of Anxiety, Depression, Disruptive Behavior, and Trauma-related disorders.

6 Q: How do we find out more information about the Practice Guides?

6 A: The PracticeWise Practitioner Guide is available with each subscription on the PracticeWise website.

CLAIMING

1 Q: Progress notes/billing: What needs to be on progress notes regarding MAP and on billing logs?

1 A: All payer source documentation requirements remain the same (adhere to DMH Policy 104.8 and the Organizational Provider's Manual).

2 Q: MAP includes TCM and Rehab as core interventions; sometimes a BA level staff can assist in these areas. Can they bill as a core intervention?

2 A: BA level staff were not eligible to take the DMH sponsored MAP trainings. However, if BA level staff members have received the 5 day training through

agency sponsored trainings and received a verification notice through DMH, BA level staff can claim for services s/he provided given that the service is within his/her scope of practice .

3 Q: When can staff who receive training/supervision from the MAP Agency Supervisor, start to use MAP?

3 A: Supervisee(s) will not be authorized to bill until (1) the supervisor completes the 2-day workshop portion of the Supervision and Consultation Training, (2) the supervisee(s) completes the required initial components of the Therapist Portfolio (see document: ***Summary of MAP Credential Standards for LAC DMH***), and (3) receive notice of verification from DMH.

4 Q: Is there a gap for billing between completion of one-day training and receipt of certificate?

4 A: Staff are allowed to claim for MAP services upon completion of the one-day conference. Certificates will not be issued for the one-day conference as the sign in sheets will be used as the record of participation.

5 Q: For MAP, we are likely to serve both TAY and child with the same provider. How do we allocate the funds to child or TAY? Will child include up to age 18?

5 A: Each provider has already submitted a transformation budget indicating the amount of funding for MAP under Child PEI and/or TAY PEI. Child PEI funds services from 0-15 years and TAY PEI funds services from 16-21 years (for MAP). Clinicians should consult their agency with questions on the availability of funding for the Child and TAY age groups.

6 Q: When can agencies who have already submitted PracticeWise certificates and internally trained clinician portfolios expect to gain DMH approval to bill MAP to PEI plan? And will that approval be back dated?

6 A: PracticeWise will issue appropriate certificates for MAP upon request from providers. Request forms for certificates are available from the PracticeWise website. The ***Summary of MAP Credentials Standards*** describes the different types of certification that will be issued for the training(s) completed including the Supervisor Credential.

Agencies who already have practitioners trained and certified in MAP should continue to submit the following information for each staff person to Lucy Farias at lfarias@dmh.lacounty.gov:

- Name of staff trained in MAP
- Rendering Provider Number
- Certificate(s) issued by PracticeWise

Upon verification, DMH will send agencies a confirmation of the names of staff and the effective date that the agency can start billing services for MAP.

Note: When submitting certificates via email, please do not forward zip files as the DMH email system will not accept emails with zip files.

7 Q: Can consultation be billed as 99361?

7 A: Providers who are unclear regarding appropriate procedure codes for claiming services may reference the current version of *A Guide to Procedure Codes for Claiming Mental Health Services*. Providers may also contact their Service Area QIC liaison for clarification.

8 Q: What activities are reimbursable?

8 A: As noted above, providers who are unclear regarding appropriate procedure codes for claiming services may reference the current version of *A Guide to Procedure Codes for Claiming Mental Health Services*. Providers may also contact their Service Area QIC liaison for clarification.

9 Q: Will we learn about "how to write progress notes" during the 5-day training?

9 A: No.

10 Q: When an MHSA client receives Medication Support, can that be billed under MHSA PEI or does that billing go to Medi-Cal (EPSDT)? It's my understanding Med Support should be billed under Medi-Cal as MHSA PEI programs do not allow for Med Support billing.

10 A: Med support would be claimed as an ancillary service while the client is receiving a PEI EBP. So, if the client is receiving services under an EBP for PEI, then during that time all claims are billed to PEI. Once a client stops with any PEI

service, services like med support would then be billed to another funding source.

OUTCOMES

1 Q: Will there be a spreadsheet created to collect data from MAP outcome measures?

1 A: Yes, CiMH will provide preformatted Excel databases.

2 Q: At this point we do not have access to Eyberg and PHQ-9. How do we get access? How do we get the PHQ9? (it comes up Pfizer)

2 A: LAC DMH is in the process of ordering the Eyberg Child Behavior Inventory (ECBI). Once the Department has the ECBI, the Department will distribute the ECBI to all agencies providing services with EBPs, including MAP, for which the ECBI has been identified as the outcome measure.

The Patient Health Questionnaire – 9 (PHQ-9) is in the public domain. Agencies may find copies of this instrument at the following link: www.phqscreeners.com.

3 Q: How do we handle outcome measures for children outside the age range of the measurement (ex. PHQ-9 has age limitations)?

3 A: The Department has created and distributed a table delineating the outcome measures for each EBP. Whenever possible, DMH selected outcome measures that would cover the greatest ranges for PEI EBPs. In the rare circumstances in which the age of the client falls outside the age parameters of the outcome measure (as noted in the PEI EBP Outcome Measures table attached), the Department does not expect providers to collect outcome data and/or use the measure for individuals for whom the instrument was not developed.

4 Q: Will data transfer to CiMH be on a secure line (i.e. HIPPA and PHI protected/compliant) to ensure privacy? How will this be developed and implemented?

4 A: Yes. Agencies have two options for sending program performance data to CiMH. Data is entered into pre-formatted databases (Excel files) provided by CiMH. These files may be sent electronically or by regular certified mail. Electronic data may be sent by YouSendIt. YouSendIt is a secure (HIPPA compliant) web

vendor that supports encrypted and password protected electronic data transfer. For more information go to www.yousendit.com. Data can also be sent by certified mail, in which case a password protected CD is mailed directly to the CiMH evaluator. Both options are explained in detail during the MAP Program Performance Evaluation training webinars.

OTHER

1 Q: Is there clear distinction between consultation and supervision? What are the consultant's qualifications?

1 A: PracticeWise does not specify minimum qualifications for supervisors or consultants to provide oversight of MAP direct services. Local standards would apply.
However, for supervision or consultation services to qualify as part of the experience needed to complete a MAP Therapist Portfolio, those supervision or consultation services must be provided by a MAP Agency Supervisor (or a PracticeWise MAP Training Professional).

The MAP Agency Supervisor portfolio provides the following definitions from PracticeWise for these services:

Individual Supervision
Supervisory events in which a single practitioner participates as the supervisee and that address components of the MAP system as applicable or applied in direct service to specific clients or client groups.

Group Supervision
Supervisory events in which multiple practitioners participate as supervisees and that address components of the MAP system as applicable or applied in direct service to specific clients or client groups.

Consultation
Direct service events involving co-therapy including a supervisor and supervisee, supervisor direct observation of a supervisee with concurrent or immediate post-event feedback, or supervisee direct observation of a supervisor performing direct service with immediate post-event reflection.

These definitions are not relevant to the definitions of these services for claiming purposes. Standard LAC DMH definitions apply.

2 Q: Can an agency use both Seeking Safety and MAP on the same client or only one EBP for each client?

2 A: Seeking Safety is one of the effective treatments included in the PWEBS database. Given that the service provider is certified to provide Seeking Safety and it is appropriate for a specific client, Seeking Safety could be provided under the MAP umbrella as long as the additional components of MAP (e.g., dashboards, clinical reasoning model) are delivered. There must be compelling clinical reasons to provide more than one EBP at a time.

3 Q: I got the impression MAP is the catch all program for kids that don't fit into the other available EBPs. Did I understand that correctly?

3 A: The MAP System is designed to point toward the most promising treatment approaches for a youth in question based on the latest available evidence. At times, this means that MAP will point to existing EBPs as the treatment of choice. In addition, MAP provides a set of guidelines for thoughtfully extending services beyond the direct evidence base using the "best evidence" available. In this regard, MAP can also be a "catch all" program for kids for whom existing EBPs are unavailable.

4 Q: Is LAC DMH paying for this training for 2 direct/1supervisor the 6 months consultation?

4 A: Yes.

5 Q: Please clarify – the 2010 group + custom order form (for dashboards, guides, etc.) – is this for information only and DMH will pay or are agencies responsible to send payment?

5 A: The order forms issued in December 2010 provide the information necessary to set up the services for the first year of MAP. LACDMH will pay for the first year of these services and agencies will be responsible to pay in future years.