FIRST AMENDMENT TO AGREEMENT

Tulare County Agreement Number 25619 is amended on _____, between the **COUNTY OF TULARE**, hereinafter referred to as "**COUNTY**" and **STARVIEW ADOLESCENT CENTER, INC.**, hereinafter referred to as '**CONTRACTOR**" with reference to the following:

A. The COUNTY and CONTRACTOR entered Agreement No. 25619 on July 24, 2012 for the purpose of providing professional Intensive Day Treatment, Medication Support, and Specialty Mental Health Services to County's Mental Health Program; and

B. The COUNTY and CONTRACTOR agree to amend Agreement No. 25619 to update Exhibits "A," and "B," and insert and incorporate Exhibit "A-2."

C. This amendment shall become effective July 24, 2012.

ACCORDINGLY, IT IS AGREED:

I. Effective July 24, 2012 Exhibit A entitled Day Rehabilitation and Day Treatment FY 2012/2013 Scope of Work is hereby substituted in its entirety with the attached Revised Exhibit A, which Exhibit is made a part of this Agreement by reference.

II. Effective July 24, 2012 Exhibit A-2 entitled Therapeutic Behavioral Services FY 2012/2013 Scope of Work is hereby added in its entirety and is made a part of this Agreement by reference.

III. Effective July 24, 2012 Exhibit B entitled Compensation Rates is hereby substituted in its entirety with the attached Revised Exhibit B, which Exhibit is made a part of this Agreement by reference.

IV. Except as provided above, all other terms and conditions of Agreement No. 25619 shall remain in full force and effect.

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THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

COUNTY OF TULARE

By_____
Chairman, Board of Supervisors

ATTEST: JEAN M. ROUSSEAU
County Administrative Officer/Clerk of the Board
Of Supervisors of the County Of Tulare

By_____
Deputy Clerk

STARVIEW ADOLESCENT CENTER, INC.

Date:_____ By_____
Title Executive President

Date:_____ By_____
Title CEO

Corporations Code section 313 requires that contracts with a corporation shall be signed by the (1) chairman of the Board, the president or any vice-president and (2) the secretary, any assistant, the chief financial officer, or any assistant treasurer; unless the contract is also accompanied by a certified copy of the Board of Directors resolution authorizing the execution of the contract.

Approved as to Form
County Counsel

By_____ Dated 2-7-13
Deputy

Exhibit A
STAR VIEW ADOLESCENT CENTER
DAY REHABILITATION AND DAY TREATMENT
FY 2012-2013
Scope of Work

CONTRACTOR AGREES:

A. To provide an environment conducive to the treatment of all mentally disabled minors ages 12-18 years of age except those excluded herein. This shall include, but is not limited to, adequate room, patient bed space, individual storage for patient use, telephone service, access to the patient's rights advocate and to family members and visitors.

B. To have written admission and employment practices and policies in conformance with State and Federal laws and regulations pertaining to equal access to services and nondiscrimination/equal opportunity in Assurances attached to the herein Agreement and made a part thereof.

C. To protect the confidentiality of patients in conformance with but not limited to, State Welfare and Institutions Code § 5328, and 45 Code of Federal Regulations § 205.50.

D. To protect the rights of individuals admitted for service in conformance with, but not limited to, Welfare and Institutions Code § 5325, especially with regard to the administration of psychotropic medication, provision of electro convulsive therapy and use of seclusion.

E. To maintain the continuing appropriateness of such admissions through such processes as are required by law such as, but not limited to, hearings pursuant to Welfare and Institutions Code § 5256, and habeas corpus hearings.

F. Where, in this Agreement, consultation with designated County staff on such matters as admission, treatment or provision of other services is indicated, Contractor's Medical Director or designee shall make reasonable efforts to so consult prior to delivery of services. However, where immediately indicated, such services shall be provided or caused to be provided by the Medical Director or designee without such consultation but notification of admission will be made to the COUNTY within 24 hours, pursuant to California Code of Regulations, Title 9, Chapter II, Section 1820.225. After notification of admission, COUNTY will perform concurrent review for assessment of medical necessity. Review will be in person or by phone at the COUNTY'S discretion.

G. To perform physical examinations as soon as possible but no later than twenty-four (24) hours after admission.

H. COUNTY shall participate in the planning of CONTRACTOR'S services to COUNTY'S patients. COUNTY staff shall also participate with CONTRACTOR'S staff in malting discharge plans for all COUNTY'S patients. COUNTY staff shall also assist, on request, with

discharge plans of patients residing in County. However, final responsibility for the planning, implementation and termination of patient's services remains with the CONIRACTOR.

I. CONTRACTOR shall, without additional compensation, make further fiscal, program evaluation and progress reports as required by Assistant Agency Director or by the State Department of Mental Health concerning CONTRACTOR'S activities as they affect the contract duties and purposes herein. COUNTY shall provide and explain reporting instruction and formats.

J. CONTRACTOR shall provide COUNTY access to Community Treatment Facility (CTF) and Psychiatric Health Facility (PHF) beds and related mental health treatment for the benefit of COUNTY patients at CONTRACTOR'S, which is operated by Star View Adolescent Center, Inc and Star View's CTF, which is operated by Star View Children and Family Services, Inc.

K. For the benefit of COUNTY Patients, CONTRACTOR will provide PHF and Life Support services for PHF clients, and Intensive Day Treatment, medication support and other mental health services for CTF clients. These services will be billed to the Tulare County Department of Mental Health, Intensive Day Treatment and TBS provided by CONTRACTOR will be subject to authorization for services from the COUNTY.

L. All adolescents must meet medical necessity and be full-scope Medi-Cal eligible unless authorized by COUNTY. Additionally, all adolescents must meet the legal status of Voluntary W & I Code 6552 or Voluntary per Conservator for 300 youth, and either Parent/Roger S or Voluntary per Conservator for youth fully in their parent's custody.

Day Treatment Intensive and Day Rehabilitation Services

CONTRACTOR shall provide specialty mental health services as described in Title 9, CCR, Chapter II, Sections 1810.213 and 1810.212, when authorized by COUNTY Mental Health Plan (MHP) representatives for COUNTY consumers. Such services shall be consistent with all terms and attachments of this Agreement Authorization and Service Requirements.

1. CONTRACTOR shall request an initial mental health payment authorization, as defined in Title 9, CCR Section 1810.229, from the MHP for Day Treatment Intensive and for Day Rehabilitation. The COUNTY will be responsible for ensuring that all children placed with CONTRACTOR have received prior authorization from the COUNTY'S Resources Intensive Services Committee (RISC) for the services listed that are deemed clinically appropriate before placement with the CONTRACTOR. The CONTRACTOR shall ensure that they have all required authorizations before providing services requiring such authorization as described in DMH Notice 02-06 and DMH Letter 03-03. CONTRACTOR shall complete a mental health assessment when requesting day treatment intensive or day rehabilitation services. The mental health assessment shall clearly delineate medical necessity for Day Treatment Intensive or Day Rehabilitation. CONTRACTOR shall submit the

assessment to the COUNTY MHP with the authorization request form for specialty mental health services prior to the delivery of Day Treatment Intensive or Day Rehabilitation.

2. CONTRACTOR shall request MHP payment authorization from the COUNTY in advance of service delivery when Day Treatment Intensive or Day Rehabilitation will be provided for more that five days per week. The CONTRACTOR shall request payment authorization from the COUNTY MHP for continuation of Day Treatment Intensive at least every three months and Day Rehabilitation at least every six months.

3. The MHP shall require the CONTRACTOR to request initial MHP payment authorization for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of mental health services as defined in Title,9, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253.The CONTRACTOR shall request MHP payment authorization for continuation of these services on the same cycle required for continuation of the concurrent Day Treatment Intensive or Day Rehabilitation for the beneficiary. Services provided without authorization shall not be reimbursed. CONTRACTOR will utilize the state standardized Service Authorization Request form (Attachment A).

4. CONTRACTOR providers of Day Treatment Intensive and Day Rehabilitation shall include the following minimum service components:

   - Community meetings, which mean meeting that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu that may, but are not required to be part of the continuous therapeutic milieu, actively involve staff and clients; for day treatment intensive, include a staff person whose scope of practice includes psychotherapy; for day rehabilitation, include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or manage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist; address relevant items including, but not limited to what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up.

   - A therapeutic milieu, which means a therapeutic program that is structured by the service components described in subsections 5 through 6 below with specific activities being performed by identified staff; takes place for be continuous scheduled hours of operation for !be program (more than four hours for a full-day program and minimum of three hours for a half-day program); includes staff and activities that teach, model and reinforce constructive interactions; includes peer

and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involving clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

- The therapeutic milieu service components described in 5 through 6 below shall be made available during the course of the therapeutic milieu for at least a weekly average of three hours per day for a full-day programs and an average of two hours per day for half-day programs. (For example, a full-day program that operates five days per week would need to provide a total of 15 hours for the week; a full-day program that operates for seven days a week would need to provide a total of 21 hours for the week).

5. **Day Rehabilitation shall include:**

- Process groups, which are facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Day Rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

- Skill building groups, which are groups in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

- Adjunctive therapies which are non-traditional therapies in which both staff and clients participation utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

6. **Day Treatment Intensive shall include:**

- Skill building groups and adjunctive therapies as described in subsection 5, b and c above. Day Treatment Intensive may also include process groups as described in subsection 5 above.

- Psychotherapy, which means the use of psychosocial methods within a professional relationship to assist the client or clients to achieve a better

psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff, practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

- An established protocol for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately qualified staff and include agreed upon procedures for training and addressing crisis situations. The protocol may include referrals fur crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If client will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff shall have the capacity to handle the crisis until the client is linked to the outside crisis services.

- A detailed weekly schedule that is available to clients and, as appropriate, to their families, care givers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written schedule shall specify the program staff: their qualifications, and the scope of their responsibilities. This must be made available to the MHP at their request.

- Staffing ratios that are consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352, and, for day treatment intensive, that includes at least one staff person whose scope of practice includes psychotherapy.

    - Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.
    - The CONTRACTOR is required to have at least one staff person present and available to the group in the therapeutic milieu for all scheduled hours of operation.
    - The CONTRACTOR shall provide the MHP a clear audit trail documenting staff that are providing day treatment intensive or day rehabilitation are also staff with other responsibilities (e.g., as staff of a group home, a school or another mental health treatment program). The CONTRACTOR shall provide the MHP clear documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

- An expectation that the beneficiary shall be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, the CONTRACTOR shall invoice the MHP for reimbursement for Day Treatment Intensive and Day Rehabilitation for an individual beneficiary only if the beneficiary is present for at least 50 percent of the scheduled hours of operations for that day.

- Documentation of Day Treatment Intensive and Day Rehabilitation shall meet documentation standards set forth by the MHP. For Day Treatment Intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to he day treatment intensive program or the person directing the service shall be made available at the request of the MHP.

- At least one contact person (face to face or by an alternative method (e.g., e-mail, telephone, etc.) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of 6 operations and the therapeutic milieu for day treatment intensive and day rehabilitation.

- The CONTRACTOR shall provide the MHP with a written program description for Day Treatment Intensive and Day Rehabilitation. The CONTRACTOR'S staff shall be required to develop and maintain this program description. The written program description shall describe the specific activities of the service and reflect each of the require components of the services described in this section. The MHP shall review the Contractors written program description for compliance prior to the date the provider begins delivering Day Treatment Intensive or Day Rehabilitation.

- The MHP shall retain the authority to set additional higher or more specific standards consistent with state and federal laws and regulations and do not prevent the delivery of medically necessary Day Treatment Intensive and Day Rehabilitation.

- The CONTRACTOR shall follow the timelines described in this section for MHP payment authorization of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253.

State of California - Health and Human Services Agency
SB 785 Service Authorization Request
MH 5125 (rev. 3/09)

Department of Mental Health

Print Form

Service Authorization Request

For out-of-county organizational providers only.

Client's Name:			DOB:	Age:	CIN OR SSN:
(First)	(Middle)	(Last)			

Requesting Agency:	Contact Person:
Starview Adolescent Center	
Contact Phone Number:	**Contact Fax Number:**
Submitted to (MHP):	**Date Submitted:**
Tulare	

○ Initial Authorization for "Client Assessment" only.

◉ Initial Authorization (Required documents: "Client Assessment" and "Client Plan")

○ Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

○ Annual Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

(Please note: The MHP may request clarifying information / documentation to process your request for any of the above)

Speciality Mental Health Services Requested	Frequency of Service	Total Units Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Day Treatment Intensive	____ Days/week ○ Half Day ○ Full Day	3 Months			
☐ Day Rehabilitation	____ Days/week ○ Half Day ○ Full Day	6 Months			

Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care:

Service Necessity:

Child/youth requires a day rehabilitation, a structured program of rehabilitation and therapy, to:

1. ☐ Improve personal independence and functioning.
2. ☐ Maintain personal independence and functioning.
3. ☐ Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program program of therapy, which may be:

1. ☐ An alternative to hospitalization.
2. ☐ To avoid placement in a more restrictive environment
3. ☐ To maintain in a community setting.
4. ☐ Other (list): _____

Client Name: , **Record/Identification Number:**

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	____ per ○ Week ○ Month ○ Authorization				
☐ Plan Development	____ per ○ Week ○ Month ○ Authorization				
☐ Individual Therapy	____ per ◉ Week ○ Month ○ Authorization				
☐ Group Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Collateral Services	____ per ○ Week ○ Month ○ Authorization				
☐ Family Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Targeted Case Mgmt	____ per ○ Week ○ Month ○ Authorization				
☐ Medication Support	____ per ○ Week ○ Month ○ Authorization				
☐ Other: _____	____ per ○ Week ○ Month ○ Authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

Client Name: , **Record/Identification Number:**

Diagnosis

List Primary Diagnosis first.

Axis I: P: _____ Axis III: P: _____

_____ _____

_____ Axis IV: P: _____

Axis II: P: _____ _____

_____ Axis V: Current GAF: _____ Past Year GAF (if available) _____

Impairment criteria (Must have one of the following impairments as a result of the DSM diagnosis):

1. ☐ A significant impairment in an important area of life functioning.
2. ☐ A probability of significant deterioration in an important area of life functioning.
3. ☐ A probability of that the client will not progress developmentally as individually appropriate.
4. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Intervention criteria (Must have 5, 6, and 7 or 7 and 8):

5. ☐ The focus of treatment is to address the condition identified in the impairment criteria.
6. ☐ The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate.
7. ☐ The condition would not be responsive to physical health care based treatment.
8. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Authorized by (Printed Name/License): _____ **Date:** _____

Signature: _____ **Authorizer's Phone Number:** _____

Exhibit A-2
STAR VIEW ADOLESCENT CENTER
Therapeutic Behavioral Services
FY 2012-2013
Scope of Work

DESCRIPTION

Therapeutic Behavioral Services (TBS) is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health service as defined in Title 9, CCR, Section 1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

TBS SCREENING REQUIREMENTS

All TBS referrals must be reviewed by COUNTY TBS Coordinator prior to services being rendered. Services provided without approval of the TBS Coordinated shall not be reimbursed.

GENERAL REQUIREMENTS

1. CONTRACTOR shall request MHP payment authorization for TBS in advance of the delivery of services. The requirement for approval in advance of the delivery of TBS applies to direct one-to-one TBS and related service activities, but does not include the initial assessment that determines whether or not TBS criteria are met or to the initial development of TBS client plan. The initial assessment may include observation of the beneficiary in the settings in which TBS is expected to be delivered to note baseline behaviors and make a preliminary assessment of likely interventions. The MHP may reimburse CONTRACT providers for the initial assessment and the initial development of the TBS client plan as a mental health service or as TBS, as determined by the MHP.

2. The MHP shall make decision on CONTRACTOR payment authorization requests for TBS in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

3. Both the initial authorization and subsequent reauthorization decisions shall be made by a Licensed Practitioner of the Healing Arts (LPHA) as required by Title 9, CCR, Section 1830.215. During the term of this Agreement, CONTRACTOR shall have available and shall provide upon request to authorized MHP representatives of the COUNTY, a list of all persons by name, title, professional degree, and experience, who are providing services under this Agreement.

4. CONTRACTOR shall train and maintain appropriate supervision of all persons providing services under this Agreement with particular emphasis on the supervision of para-professionals, interns, students, and clinical volunteers in accordance with CONTRACTOR'S training of all appropriate staff on applicable State manuals and/or training materials and State and County Policies and Procedures as well as any other matters that COUNTY may reasonably require.

5. The MHP shall issue a decision on a CONTRACTOR's payment authorization request for TBS, three working days from the date the additional information is received or 14 calendar days, whichever is less.

6. MHP retains the authority to set additional standards necessary to manage the delivery of TBS, including but not limited to establishing maximum hours for individual TBS service components (e.g., assessment, client plan development, and collateral services), provided the MHP standards are consistent with applicable state and federal laws and regulations an do not prevent the delivery of medically necessary TBS.

ASSESSMENT AND PLAN OF CARE

The TBS assessment should be completed within the first 30 days of service by a licensed/waivered staff person. During the first 30 days of service it is suggested that services range between 6-12 hours per week. *If more than suggested hours are required contact with the TBS Coordinator-Managed Care Department, is expected.

The TBS assessment should establish Medical Necessity for TBS by evaluating the child/youth's current behavior (presenting problem/impairment) and documenting the following:

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

1. The following elements are required documentation components in order to substantiate medical necessity for mental health services. TBS assessments can be separate, or part of a more comprehensive assessment.
   - Presenting Problem: Documentation of a client's chief behavioral impairment, history of the presenting problem(s), including current level of functioning, and current family information including relevant family history.
   - Psychological Factors: Documentation of relevant conditions and psychological factors affecting the client's physical health and mental health, including living situation, educations/vocational situation, daily activities, social support, cultural and linguistic factors, and history of trauma.
   - Mental Health History: Documentation of mental health history and previous mental health treatment: providers, therapeutic modality (e.g. medications, psychosocial treatments) and response. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.

- Medical History: Documentation of the complete, relevant medical history and physical health conditions reported by the child/youth or parent/caregiver. Include the name, address and current phone number of current source of medical treatment. (Note: All appropriate Releases of Information forms should be completed prior to communication with other treatment providers.)
- Prenatal: Documentation of the prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
- Medication: Documentation about medications the client has received or is receiving to treat medical conditions, including duration of medical treatment. Documentation of allergies or adverse reactions to medications, etc.
- Substance Exposure/Substance Use: Documentation of past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over-the-counter, and illicit drugs.
- Strengths: Documentation of client strengths that may be utilized in strategies for achieving client treatment plan goals
- Risks: Documentation of special status situations that present a risk to client or others, including past or current trauma.
- Mental Status Examination
- Diagnosis: A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-9 code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.
- Any additional relevant clarifying formulations information.

In addition, a TBS assessment must identify the following:

1. Medi-cal Eligibility
2. Member Eligibility
3. Targeted Behaviors: Identify the child or youth's specific targeted behaviors and/or symptoms that jeopardize continuation of the current residential placement or put the child at risk for psychiatric hospitalization, or the specific targeted behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.
4. Clinical Judgment: Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the 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.
5. Behavior Modification: Identify what observable and measurable changes in behavior and/or symptoms TBS is expected to achieve and how the child's Coordinator or Service Team will know when these services have been successful and can be reduced or terminated.
6. Adaptive Behaviors: Identify skills and positive 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.

The initial TBS Plan of Care should be completed in the first 30 days of service. Subsequent Plans of Care are required at 90 days and 150 days. All Plans of Care will be submitted 5 days prior to service block ending date, to Tulare County HHSA, Managed Care Department-TBS Coordinator.

The Plan of Care can be completed by a licensed/waivered staff person or a non licensed staff person with a co-signature of the above. The TBS Plan of Care is separate from the Consumer Wellness Plan and is specific to the delivery of TBS.

1. The TBS Plan of Care provides a detailed description of the treatment including behavior modification strategies for the child/youth. The TBS Plan of Care must include:
    A. Targeted Behaviors: Clearly identified specific behaviors and/or symptoms that jeopardize the residential placement or transition to a lower of residential placement and that will be the focus of TBS.
    B. Plan Goals: Specific, observable goals tied to the targeted behaviors or symptoms identified in the TBS Assessment.
    C. Benchmarks: The objectives that are met as the child/youth progresses towards achieving client plan goals.
    D. Interventions: Proposed intervention(s) that will significantly diminish the targeted behaviors.
        1. A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
        2. A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
        3. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving the expected results.
    E. Transition Plan: A transition plan that describes in measurable terms how and when TBS will be decreased 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 judgment of the Coordinator or Service Team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills and strategies to provide continuity of care when TBS is discontinued, when appropriate in the individual case.
        1. Transitional Age Youth (TAY): As necessary, a plan for transition to adult services when the beneficiary is no longer eligible for TBS (i.e. beneficiary turns 21 years old) and will need continued services. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued upon the beneficiary reaching 21 years of age.
        2. If the beneficiary is between 18 and 21 years of age, it is expected that case management notes, documenting the process of transitioning the beneficiary into Adult Mental Health Services, will be found in the home chart. Document any special circumstances that should be taken into account.
    F. Signature: A signature (or electronic equivalent) of, at least, one of the following:
        1. A clinician who developed the Plan of Care or is providing the service(s)

2. A clinician representing the MHP providing the service
   Note: if the above person is providing the service is not licensed or waivered, a co-signature from a physician, licensed/waivered psychologist, licensed/waivered social worker, or a licensed or registered marriage and family therapist is required.

G. Evidence of the child/youth's degree of participation and agreement with the Plan of Care as evidenced by the child/youth's or legal guardian's signature. If child/youth or legal guardian is unavailable or refuses to sign the client plan, a written explanation must be present in the progress notes why the signature could not be obtained.

H. Evidence that a copy of the Plan of Care was provided to the child/youth or parent/caregiver upon request.

2. Note: TBS Plan of Care updates should document the following:
   A. Any significant changes in the child or youth's environment sine the initial TBS Plan of Care; and
   B. If TBS interventions tried to-date ...
3. A clear and specific TBS client plan is a key component in ensuring effective delivery of TBS.

A. TBS Progress Notes:
   1. Progress notes should clearly and specifically document the following:
      a) Whether there have been significant changes in the child or youth's environment since the initial development of the TBS Plan of Care.
      b) Whether 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.
      c) Whether progress is being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors.
   2. Documentation is required each day that TBS is delivered.
   3. Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The service may be noted by contact or shift.
   4. Progress Notes must be co-signed by a licensed mental health professional (LMHP) if the TBS coach providing the service is not an LMHP.

CULTURAL COMPETENCY

CONTRACTOR shall use professional skills, behaviors, attitudes, and policies in the delivery of services that work effectively in cross-cultural situations.

PROVIDER GRIEVANCE PROCEDURE

CONRACTOR may appeal a denied, terminated or modified request for services from COUNTY. The written appeal shall be submitted to COUNTY within 30 (thirty) calendar days of the postmark of the notification of the denial, termination or modification. Send appeal to:

Tulare County Health & Human Services Agency
Managed Care Division
5957 S Mooney Blvd
Visalia, CA 93277
ATTN: Grievances'/Appeals

MH 661 Revised 04/30/09	SUPPLEMENTAL THERAPEUTIC BEHAVIORAL SERVICE ASSESSMENT	Page 1 of 2

I. Provider Information		
TBS Rendering Provider		
Name:	Telephone #:	
Single Fixed Point of Responsibility		
Agency: Stat View Adolescent Center		
Name:	Discipline:	Telephone #:

II. Client Identifying Information		
Name:	DOB:	Sex: ☐ Male Female
Ethnicity:		Medi-Cal: Yes ☐ No
Current Living Situation:		
Parent/Caregiver:	Address:	Phone:
CSW/Probation Officer:		Phone:
Regional Center/Case Manager:		Phone:
Other:	Address:	Phone:

III. Child/Adolescent Initial Assessment	
Completed by (name of agency and provider):	Reviewed on (date):
Additional Information/Changes to Initial Assessment:	

IV. TBS Class Eligibility
The child/youth is currently placed in a Rate Classification Level (RCL) facility of 12 or above and/or locked treatment facility for the treatment of mental health needs. Child/youth is being considered by the County for placement in one of the facilities described above. Child/youth has undergone, at least, one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months. Child/youth previously received TBS while a member of the certified class

V. Criteria for TBS Eligibility
To prevent out-of-home placement or a higher level of care To ensure transition to home, foster home, or lower level of care

VI. TBS Assessment
1a. Identify the specific behaviors and/or symptoms that jeopardizes continuation of the current placement or the specific behaviors and/or symptoms that interfere with the child or youth transitioning to a lower level of care:
VI. TBS Assessment (continued)
1b. Describe child or youth's behaviors and/or symptoms in terms of intensity, frequency, and duration in support of TBS,

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Tulare County – Health and Human Services Agency

SUPPLEMENTAL TBS ASSESSMENT

note when and/or where behaviors and symptoms occur:
2a. What other specialty mental health services(s) is client currently receiving? Indicate why child or youth needs TBS in addition to current service(s):
2b. List previous less intensive services that have been tried and/or considered and describe why these less intensive services are not our would not be appropriate:
3. Identify skills and adaptive behaviors that the child or youth is using now to manage the targeted behaviors and/or symptoms and/or is using in other circumstances that could replace the targeted behavior and/or symptoms:
4. 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:
5. (Optional) Provide any additional clinical information supporting the need for TBS:

VII. Diagnosis
Diagnosis is the same as on the Child/Adolescent Initial Assessment Diagnosis is different from the Child/Adolescent Initial Assessment **(Complete MH 501 Diagnosis Information Form by an LPHA)**

VIII. Signatures			
Signature & Discipline		Co-Signature & Discipline (if required)	

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Agency:	Provider #:
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SUPPLEMENTAL TBS ASSESSMENT

CLIENT CARE COORDINATION PLAN

Annual Cycle Month: (Due prior to the 1st day of the Month)

☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be SMART: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology in the Assessment.

Objective #1

Effective Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this plan. Describe proposed intervention and duration (specify if time frame is less than 1 year).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-term Res ☐ CalWorks ☐ TBS ☐ Other: _____

Client Involvement	Family Involvement: ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month. If not met, please specify what was or was not met and adjust objective accordingly.

Initials: Date:

Short-term Goals / Objectives:

Objective #2

Effective Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this plan. Describe proposed intervention and duration (specify if time frame is less than 1 year).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-term Res ☐ CalWorks ☐ TBS ☐ Other: _____

Client Involvement	Family Involvement: ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: Date:

Additional Client Contacts/Relationships: Refer to the "MH525: Contact Information" form.	Interpretation
☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run ☐ Education/AB3632 ☐ Other _____	Prefer a language other than English: ☐ Yes ☐ No This plan was interpreted: ☐ Yes ☐ No Language: _____

*MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services.

Name: _____ IS#: _____

Agency: _____ Provider #: _____

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CLIENT CARE COORDINATION PLAN

- Signator or Co-Signator must be consistent with Scope of Practice.
- Signatures must be obtained when objectives are created (both initial and additional) and at each review period.
- One signature block can be used for multiple objectives created on the same day if the objectives are within the scope of the signator.

Objective Number(s) X & Y	Unlicensed Staff/Title	Used if Staff does not hold one of the licenses or registrations below. Second signature required.
	PhD/PsyD, LCSW, MFT, RN, CNS	Required for all Objectives without MD/DO signature. Includes licensed or registered and waivered PhD/PsyD, licensed or registered/waivered LCSW & MFT, Licensed RN, Certified CNS.
	MD/DO, NP	MD/DO Required for Medicare Clients/Private Insurance. MD/DO or NP required for Medication Support goals.
	Client*	Document reason for lack of signature below. Signature should be obtained as soon as possible with regular updates in Progress Notes until obtained.
	Other*	Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment.

Objective Number(s) ______	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) ______	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) ______	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

*The signature of the individual signing the Consent for Services is required. If unavailable, the signature of the caregiver may be obtained instead.

Name: ______________ IS#: ______________

Agency: ______________ Provider #: ______________

Tulare County – Health and Human Services Agency

CLIENT CARE COORDINATION PLAN

Initial Assessment/Annual Assessment Update Completed on: _____

1 Week	30 Days	60 Days	3 Months	6 Months	Annual
☐ Crisis Residential	☐ Transitional Residential	☐ Long-Term Residential	☐ CalWORKS ☐ Day Treatment Intensive (DTI) ☐ TBS	☐ Day Rehab	☐ Mental Health Services (MHS) ☐ Medication Support (MSS) ☐ Targeted Case Management (TCM)

Objectives must be reviewed, updated, and recorded on the Signature and Coordination Pages prior to the first day of the cycle month. DR and DTI goals do not have to be on the Client Care and Signature pages but must be listed on the Coordination Page.

Cycle Months:	☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
	☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

Single Fixed Point of Responsibility (SFPR) Contact Information	
SFPR:	**Phone Number:**
Provider/Agency:	**Fax Number:**

Provider Name / Number	Contact Person / Team	Type of Service	Start Date (Mo,Day,Yr)	End Date (Mo,Day,Yr)	Discharge or Transfer Date (Mo,Day,Yr)	SFPR's** Approval (Date & Initial)	Verbal Approval (Date & Initial)

* Services listed should include **MHS, TCM, Med Support, TBS, Day Treatment Intensive,** or **Day Rehab.**
** For DT and DR note the Authorization Unit's approval date.

Name: _____ **ISI#:** _____

Agency: _____ **Provider #:** _____

Tulare County – Health and Human Services Agency

EXHIBIT B
COMPENSATION RATES
STAR VIEW ADOLESCENT CENTER
FY 2012-2013

DESCRIPTION

CONTRACTOR shall provide COUNTY access to Community Treatment Facility (CTF) and Psychiatric Health Facility (PHF) beds and related mental health treatment for the benefit of COUNTY patients at CONTRACTOR'S, which is operated by Star View Adolescent Center, Inc and Star View's CTF, which is operated by Star View Children and Family Services, Inc.

For the benefit of COUNTY Patients, CONTRACTOR will provide PHF and Life Support services for PHF clients, and Intensive Day Treatment, medication support and other mental health services for CTF clients. These services will be billed to the Tulare County Department of Mental Health, Intensive Day Treatment provided by CONTRACTOR will be subject to authorization for services from the COUNTY.

For the benefit of COUNTY patients, CONTRACTOR will provide CTF residential services including room and board, clothing, personal needs, recreation, transportation, education and social services. These services will be billed to the COUNTY. The rate includes the RCL 14 group home rate and CTF supplemental amount.

All adolescents must meet medical necessity and be full-scope Medi-Cal eligible unless otherwise agreed upon by CONTRACTOR. Additionally, all adolescents must meet the legal status of Voluntary/W & I Code 6552 or Voluntary per Conservator for 300 youth, and either parent/Roger S or Voluntary per Conservator for youth fully in their parent's custody.

COMPENSATION

The daily rate is all inclusive for services as defined as psychiatric inpatient services in Title 9, Chapter 11, Section 1810.430 (d) (5), and that rate does not include non-hospital based physician or psychological services rendered to a beneficiary covered under the contract. The day of discharge is non reimbursable.

The daily rates for the term of this Agreement, unless otherwise amended and agreed to by both parties in writing are:

1. Psychiatric Health Facility (PHF): $627.17/day
2. Community Treatment Facility (CTF)
    - Day Treatment Intensive: $202.43/ day
    - Medication Support: $4.82/minute
    - Mental Health Services: $2.61/minute
    - Case Management Services: $2.02/minute
    - Crisis Intervention Services: $3.88/minute
    - **Therapeutic Behavior Services: $2.61/minute**

A. The rates to the County Department of Mental Health for PHF Life Support and CTF mental health supplement are:

1. PHF Life Support: $95.00 / day
2. CTF mental health supplement: $95.00 / day
3. CTF Supplement: $82.19 ($2,500.00 / month)- [this can be claimed to SDMH for offset of CTF costs- approximately $32.00 / day reimbursement from SDMH]

B. These daily rates times the number of days utilized by clients in the program will determine the reimbursement to CONTRACTOR. This contract will not exceed total reimbursement to **TWO HUNDRED AND EIGHTY THOUSAND DOLLARS ($280,000.00) for FY 2012-2013.**

PAYMENT

CONTRACTOR shall submit invoices monthly to:

Tulare County Health & Human Services Agency
Attention: Children's Managed Care Division
5957 S. Mooney Blvd.
Visalia, CA 93277

Each itemized invoice shall include the name of the individual beneficiary, type of service and supporting documentation for all mental health services provided along with the person(s) providing services, time and date of service, COUNTY MHP billing code, and duration of service. Each monthly invoice shall be submitted within thirty days of the end of the month for which Mental Health Services were rendered. COUNTY MHP shall have the right to deny payment if the invoice is not submitted along with supporting documentation, as required by COUNTY MHP, then, payment shall be withheld until COUNTY MHP is in receipt of a complete and correct invoice and such invoice has been reviewed and approved by COUNTY MHP. All monthly invoices shall be subject to adjustments based upon the COUNTY MHP data systems reports. The annual cost report shall not be used for the year-end settlement of the cost of services provided under this fixed rate Agreement.