COUNTY OF LOS ANGELES

DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Prevention and Early Intervention Implementation Handbook

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PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION DIVISION

Prevention and Early Intervention Implementation Handbook

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Abbreviations

ART	Aggression Replacement Training
AF-CBT	Alternatives for Families: A Cognitive-Behavioral Therapy
ASOC	Adult System of Care
BSFT	Brief Strategic Family Therapy
CAPPS	Center for the Assessment & Prevention of Prodromal States
CBITS	Cognitive Behavioral Intervention for Trauma in School
CDE	Community Defined Evidence Practice
CFOF	Caring for Our Families
CGF	County General Funds
CIBHS	California Institute of Behavioral Health
CiMH	California Institute of Mental Health
CIOB	Chief Information Office Bureau
CORS	Crisis Oriented Recovery Services
CPP	Child-Parent Psychotherapy
CSOC	Children's System of Care
CSS	Community Services and Support
DBT	Dialectical Behavior Therapy or Disruptive Behavior
DECA-I/T	Devereux Early Childhood Assessment for Infants and Toddlers
DERS	Difficulties in Emotional Regulations Scale
DMH	Department of Mental Health (Los Angeles); also referred to as the Department
DO	Directly Operated Clinics (DMH operated clinic)
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DTQI	Depression Treatment Quality Improvement Intervention
EBP	Evidence-Based Practice **The term Evidence-Based Practices (EBP) is being collectively used to include Community-Defined Evidence (CDE) and Promising/Pilot Practices (PP).**
EBP/PP/CDE	Evidence-Based Practice/Promising Practice/Community-Defined Practice
EBT	Evidence-Based Treatment (encompasses EBPs, PP, and CDEs)
ECBI	Eyberg Child Behavioral Inventory
EHR	Electronic Health Record

EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FAD	Family Assessment Device
FAQ	Frequently Asked Question
FCCS	Field Capable Clinical Services
FFP	Federal Financial Participation
FFT	Functional Family Therapy
FSP	Full Service Partnership
FOCUS	Families OverComing Under Stress
FY	Fiscal Year
GAD-7	Generalized Anxiety Disorder-7
GLN	General Learning Network
Group CBT	Group Cognitive Behavioral Therapy for Depression
HIPAA	Health Insurance Portability and Accountability Act
Ind CBT	Individual Cognitive Behavioral
IBHIS	Integrated Behavioral Health Information System
IPT	Interpersonal Psychotherapy for Depression
ICD-10	International Classification of Disease – 10th Version
IS	Information System
IY	Incredible Years
LAC	Los Angeles County
LACDMH	Los Angeles County Department of Mental Health
LE	Legal Entity (contract agency)
LIFE	Loving Intervention Family Enrichment Program
MAP	Managing and Adapting Practice
M/C	Medi-Cal
MCA	Maximum Contract Allocation
MCE	Medi-Cal Expansion
MCHIP	Medicaid and Childrens Health Insurance Program
MDFT	Multidimensional Family Therapy
MHIP	Mental Health Integration Program
MHSA	Mental Health Services Act (Proposition 63)
MHSOAC	McMasters Model of Family Functioning
MMFF	Mental Health Services Oversight and Accountability Committee
MP	Mindful Parenting Groups

MST	Multisystemic Therapy
MTASV	Monitoring and Technical Assistance Site Visit
NOS	Not Otherwise Specified
OA	Older Adults
OASOC	Older Adult System of Care
OMA	Outcome Measures Application
OQ	Outcome Questionnaire
PATHS	Providing Alternative Thinking Strategies
PCL-5	Posttraumatic Stress Disorder Checklist for DSM-5
PDS	Post Traumatic Stress Diagnostic Scale
PE	Prolonged Exposure
PEARLS	Program to Encourage Active Rewarding Lives for Seniors
PEI	Prevention and Early Intervention
PE-PTSD	Prolonged Exposure for Post-Traumatic Stress Disorder
PCIT	Parent-Child Interaction Therapy
PHQ-9	Patient Health Questionnaire
PP	Promising Practice
PPMT	Progress and Practice Monitoring Tool
PST	Problem Solving Therapy
PTSD	Post-Traumatic Stress Disorder
PTSD-RI	Post-Traumatic Stress Disorder – Reaction Index
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Plan
RBPC	Revised Behavior Problem Checklist
RCADS	Revised Child Anxiety and Depression Scales (RCADS)
RCADS-P	Revised Child Anxiety and Depression Scales-Parent Version (RCADS-P)
RPP	Reflective Parenting Program
SA	Service Area
SD	Supervisorial District
SDMH	State Department of Mental Health (former)
SESBI	Sutter-Eyberg Student Behavior Inventory
SF	Strengthening Families
SIPS	Structured Interview for Psychosis – Risk Syndrome

SMI	Serious Mental Illness
SOPS	Scale of Prodromal Symptoms
SPA	Service Planning Area
SPMI	Serious Persistent Mental Illness
SS	Seeking Safety
TASV	Technical Assistance Site Visit
TAY	Transition Age Youth (ages 16-25)
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
ToT	Train-the-Trainer; Training of Trainer
Triple P	Triple P Positive Parenting Program
TSCYC	Trauma Symptom Checklist for Young Children
UCLA TTM	UCLA Ties Transition Model
YOQ	Youth Outcome Questionnaire
YOQ - SR	Youth Outcome Question - Self Report

Section 1

Introduction

1.1 Purpose of the Handbook

After an extensive stakeholder planning process, in August 2009, the County of Los Angeles Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) Plan was approved by the Mental Health Services Act (MHSA) Mental Health Services Oversight and Accountability Committee (MHSOAC). Even as planning was underway for the systematic implementation of the DMH PEI Plan components in the Fall 2009, the County of Los Angeles suffered significant cuts in County General Funds (CGF). This necessitated the fast-paced implementation of the PEI Plan in 2010. Massive training of hundreds of administrators, clinicians and other staff occurred at the onset of PEI programs.

This information in the PEI Implementation Guidelines Handbook is specifically intended for providers who receive funding from DMH for MHSA PEI Medi-Cal Funds. The Handbook was developed as a resource and informational guide for DMH Legal Entity (LE) contract agencies and Directly Operated (DO) clinics delivering MHSA PEI services in the County of Los Angeles. The PEI Plan requires the use of Evidence-Based Practices (EBP), Promising Practices (PP) and Community-Defined Evidence (CDE) practices, which were selected by stakeholders in a countywide process.

A number of DMH PEI policy and implementation guidelines and resources have been published in the past five years. This Handbook gathers all this information in one place, including contact information for additional resources. The overall purpose of PEI Implementation Guidelines Handbook is to:

1. Present an overview of the Los Angeles County Department of Mental Health PEI Programs.
2. Specify the State and DMH requirements for providing direct mental health services billed to the PEI Plan.
3. Identify the PEI target population, evidence-based practice parameters, outcome measures, and training protocols governing PEI programs.
4. Provide information on key program aspects that promote client success, quality services, and successful implementation of the PEI Plan.

5. Ensure that provider administration and staff are aware of available resources to assist them to comply with the PEI program requirements.

1.2 Organization of the Handbook

The Handbook is divided into ten Sections and an Appendix.

Section 1. Introduction explains the purpose and organization of the Handbook, which will be updated on an annual basis and more often if major changes are implemented. The development of the Handbook arose from the PEI MTASVs conducted during 2014-2016 when providers requested clarification of PEI guidelines.

Section 2. Overview of the PEI Plan describes the impact of MHSA and PEI guidelines on mental health services, the Los Angeles County PEI Planning Process, and the transformation process jumpstarting the PEI programs. The recent PEI Regulations that further clarify the PEI programs are also highlighted.

Section 3. PEI Target Population identifies the populations to be served by MHSA PEI funding and eligibility criteria. The definition of the PEI target population is presented. Guidelines are presented on priority populations by age group and focus, caregivers of eligible target populations, exclusionary issues and excluded populations. Three decision trees to assist providers in identifying when a client qualifies for PEI services are included.

Section 4. Billing and Claiming addresses billing and claiming services to the PEI Plan, while adhering to Medi-Cal guidelines. Both the specific PEI claiming guidelines and Medi-Cal claiming requirements are explained. Providers must ensure that at least 65% of a specific EBP service qualifies as a core intervention. A guide specifying the core interventions is included. Even though services may be claimed to Medi-Cal, not all diagnoses are appropriate for the PEI target population, and a chart of billable and non-billable diagnoses is provided. PEI has authorized minimal outreach services, which are allowable only to specific agencies. Billable outreach services are identified, as well as special circumstances where claims to PEI must be viewed carefully.

Section 5. Evidence-Based Practices explains the mandatory use of PEI approved Evidence-Based Practices (EBPs), Promising Practices (PP), or Community-Defined Evidence (CDE) practice for the delivery of PEI funded mental health services. "EBP" is sometimes used to refer to all EBPs, PPs, and CDEs. All services, including community outreach services, must be billed to an approved PEI EBP, PP or CDE. A list of approved PEI practices currently being implemented is included as well as the procedure for adding and dropping EBPs from an agency's approved list of practices. Frequently Asked Questions (FAQs) for almost all the practices are also included.

Section 6. Data Collection and Outcomes describes the mandatory use of outcome measures, the requirements for data collection, and how outcomes are evaluated. Each PEI EBP/PP/CDE requires administration of two separate outcome measures. The EBP outcomes matrix identifies these outcome measures for each practice. The submission process describes how outcomes are to be reported. The FAQs for Outcomes provides additional information to aid in training in outcomes, administering the outcome measures, and reporting data.

Section 7. EBP Training Requirements emphasizes that clinical and program staff providing EBP services are required to be fully trained in each specific EBP being provided. The PEI training policy and guidelines, roles of the developer and trainers, as well as the responsibilities of the agency in ensuring staff are completing training, are further delineated. The PEI Training Protocols spells out in detail the initial training requirements for each PEI approved EBP in order to begin billing to an EBP. DMH maintains a staff registry and monitors staff training. Non-compliance and non-completion of training can result in an order to stop claiming for staff deemed Not Qualified to Claim to a specific EBP.

Section 8. Training Funds explains the invoice process for requesting reimbursement for an agency's training costs spent on having staff trained in an EBP. Since 2010, DMH has allocated one-time training funds for agencies to assist them in purchasing training for staff. Such funds have been dependent on the availability of unspent PEI dollars. "One-Time" refers to the course of funding, namely, unspent PEI funds. Consequently, as the PEI Plan has become more fully implemented, one-time training dollars have been greatly reduced. The Guide to Manual Reimbursement Requests explains in detail the invoicing requirements and the deadlines for submission.

Section 9. Program Monitoring and Technical Assistance Site Visits (MTASVs) describes the procedure by which the Department monitors its LE contract agencies and DO clinics. Monitoring is required by State guidelines, as well as County and DMH policy. MTASVs have been conducted since 2010. Performance-Based Criteria, which are spelled out in an agency's contract and amendment are also utilized in the MTASVs. Lessons learned in the implementation of the PEI Plan and provision of services are presented, often gleaned from providers' own stories.

Section 10. Contacts, References, and Resources identifies important contact information, references and resources. Readers should always check with PEI Administration Division.

Appendices contains the 2007-2008 State guidelines and the 2015 PEI guidelines. The list of PEI providers changes, so readers are advised to check the PEI website to see the latest listing.

1.3 Updates to the Handbook

The PEI Guidelines Handbook is posted on the DMH website at http://dmh.lacounty.gov/wps/portal/dmh/!ut/p/b1/04_Sj9Q1Mra0MDY1NjHQj9CPykssy0xPLMnMz0vMAfGjzOJdDQwM3P3dgo3cjd0cDTxdXYxD_AJMDA18TYEKIpEV-LsbuwAVmPg4O7mZAAWNCekP149CVYJmgrsBAQUgK8AKDHAARwN9P4_83FT93KgcS88sE0UAMhRXYA!!/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2X0UwMDBHT0ZTMkczRkEwSUVEM1ROUDQxOTY0/

The Handbook will be updated on an annual basis or sooner as needed. Hard copies of the Handbook are distributed at the PEI 101 Technical Training workshops.

Section

2

Overview of the PEI Plan

2.1 MHSA PEI Guidelines

Proposition 63, known as the Mental Health Services Act, was passed in November 2004 by the voters of the State of California. The intent of Proposition 63 was to provide ongoing funding to support mental health programs through a range of programs from prevention, early intervention, intensive services, and recovery. Also known as the millionaire's tax, the Act imposed a 1% income tax on individuals with a personal income in excess of $1 million. MHSA called for programs and funding in the areas of Community Services and Supports (CSS), PEI, Workforce Education and Training (WET), Innovations, and Capital and Technology.

The former California State Department of Mental Health (SDMH) had the responsibility for developing guidelines for the Plans authorized by MHSA and the funding of the statewide and county programs. In February 2006, SDMH approved the Los Angeles County DMH's CSS Plan, the first of the MHSA Plans to be released. Implementation of the programs funded under the CSS Plan was initiated in 2007.

Subsequently, on September 25, 2007, SDMH released the PEI guidelines, the second largest component of the MHSA. PEI focuses on evidence-based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue.

Transformational Concepts

The DMH PEI projects and programs align with the transformational concepts in the Guidelines:

1. Community Collaboration
2. Cultural Competence
3. Individual and Family-Driven Programs and Interventions, with Specific Attention to Individuals from Underserved Communities
4. Wellness Focus, which Includes the Concepts of Resilience and Recovery
5. Integrated Service Experience for Individuals and their Families
6. Outcomes-Based Program Design

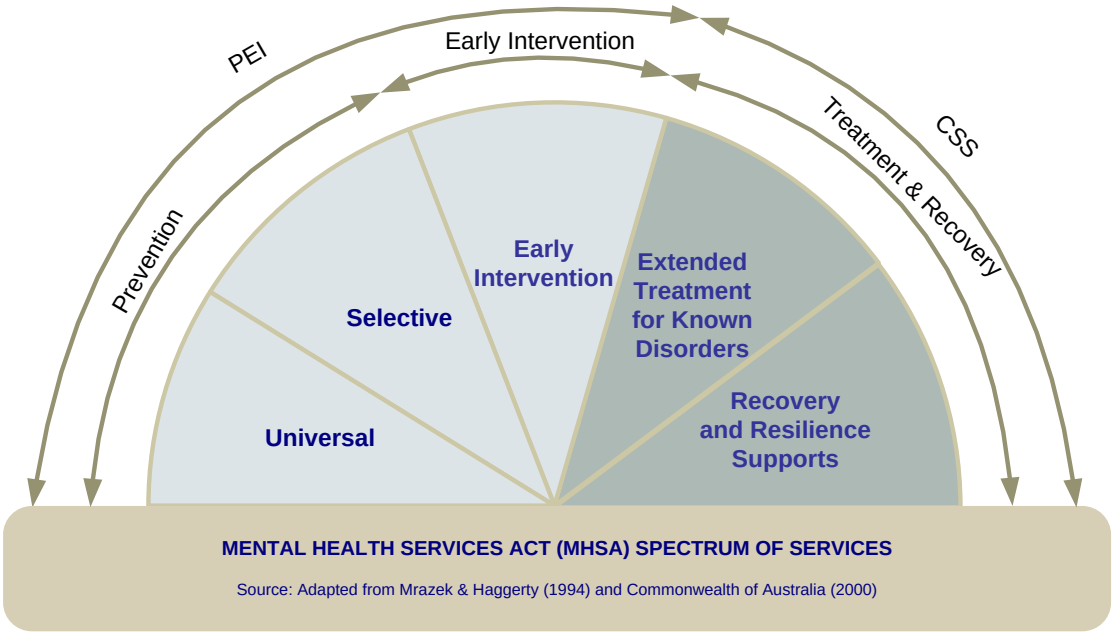
PEI Framework

The Guidelines identified five key community mental health needs critical in developing prevention and early intervention strategies that county PEI Plans must address:

1. *Disparities in Access to Mental Health Services* – PEI efforts will reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services.
2. *Psycho-Social Impact of Trauma* – PEI efforts will reduce the negative psycho-social impact of trauma on all ages.
3. *At-Risk Children, Youth, and Young Adult Populations* – PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
4. *Stigma and Discrimination* - PEI will reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.
5. *Suicide Risk* - PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

PEI Operational Definitions

The guidelines described operational definitions for prevention and early intervention in order to delineate funding parameters for the PEI plan as distinct from other MHSA components. While prevention and mental health occur across the entire spectrum of mental health, the PEI component occurs at the early end of the spectrum.

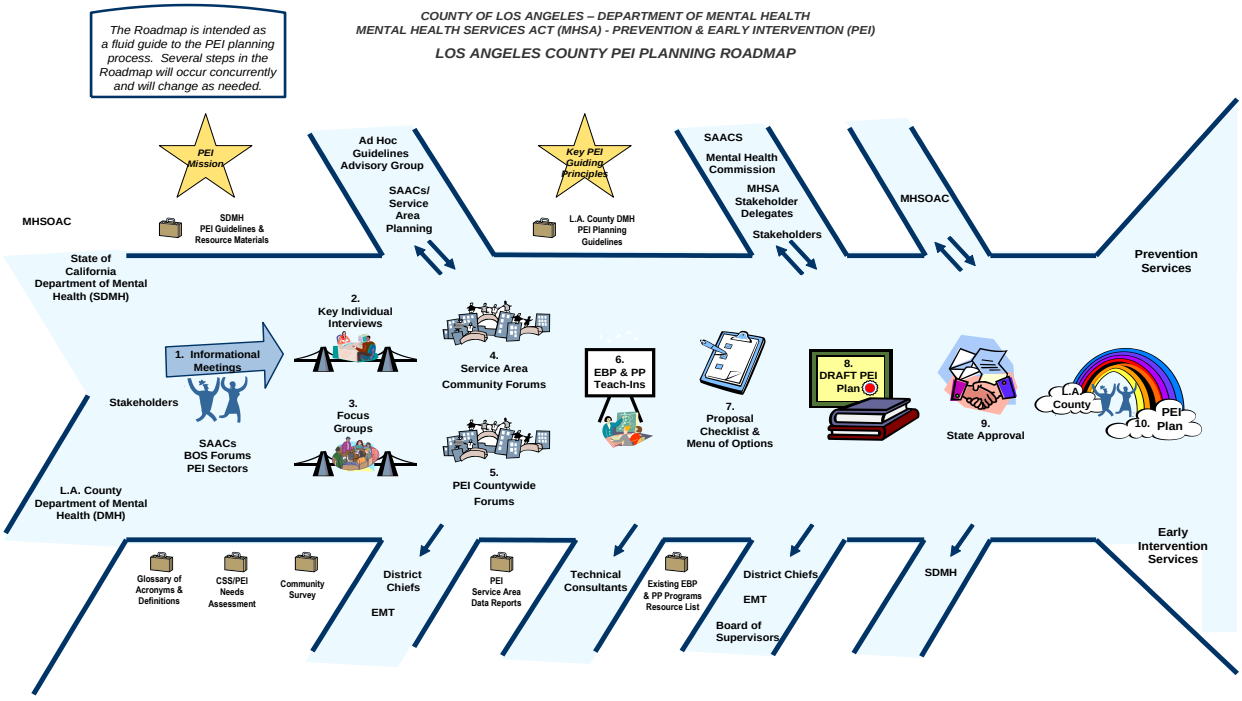


Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. Universal Prevention targets the general public or a whole population group that has not been identified on the basis of individual risks. Selective Prevention targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average.

Early Intervention is directed toward individuals and families for whom a short duration (usually less than one year) of relatively low-intensity intervention is appropriate for these individuals to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

2.2 Los Angeles County PEI Plan

On August 27, 2009, the MHSOAC approved DMH's PEI Plan, which was the result of a community-driven planning process that extended over 20 months, with input from over 10,000 individuals and 655 agency and community-based programs. Another input facet of the planning process was that it was data-driven, i.e., the most recent L.A. County statistics relevant to risk factors were utilized. New as well as expanded programs emphasizing prevention, early intervention, or a combination of both, comprise the PEI Plan. Overall, the PEI projects are composed of EBP/PP/CDEs, and pilot programs delivered at various sites throughout Los Angeles County at the Service Area and countywide level.



Based on community input from stakeholders, including the ad hoc steering committees, DMH developed ten projects that address the needs, priority populations, and special sub-populations identified by the stakeholders.

1. School-Based Services
2. Family Education and Support Services
3. At-Risk Family Services
4. Trauma Recovery Services
5. Primary Care and Behavioral Health
6. Early Care and Support for Transition-Age Youth
7. Juvenile Justice Services
8. Early Care and Support for Older Adults
9. Improving Access for Underserved Populations
10. American Indian Project

In addition, as part of the State's efforts to launch PEI programs as quickly as possible, the MHSOAC approved DMH's PEI Early Start Projects Plan. These programs included programs addressing Suicide Prevention, Stigma and Discrimination, and School Mental Health Violence Prevention.

2.3 Implementation of the PEI Plan

In the Fall 2009, DMH initiated plans for implementation of the PEI Plan approved in August 2009. The strategy for rolling out the different PEI projects involved soliciting bids for services through Requests for Services. The original plan projected at least a two-year timeline to roll out the 51 EBPs, PPs, CDEs, and pilots.

In early 2010, as a result of the worsening economic conditions, DMH was notified that County General Funds (CGF) from the State would be drastically cut, negatively impacting nearly 100 LEs and DOs. Funding cuts would take effect as of July 1, 2010. This meant that many of these providers, particularly those for children and youth, would lose a significant, if not all their funding for mental health services. DMH offered LEs the opportunity of a new funding source, namely MHSA PEI funds. As a condition of transforming to this MHSA PEI funding, providers were required to adhere to the MHSA State and L.A. County DMH PEI guidelines.

The "transformation" from CGF to PEI funding required a paradigm shift. Agencies were required to transform as of July 1, 2010, but could not provide services unless trained in a PEI EBP. Under this time crunch, other significant differences from traditional therapy provided by mental health providers also stood out. Key steps and requirements of PEI providers involved the following:

- Only EBPs, PPs or CDEs approved for the DMH PEI Plan shall be used for client services. In selecting which EBPs to utilize, providers have to identify which practices fit their client population. Only those practices approved by PEI (as listed in the *PEI Evidence-*

Based Practices (EBP), Promising Practices (PP) and Community-Defined Evidence (CDE) practices Resource Guide) could be implemented.

- Clinicians and other staff must be trained in the specific EBP offered by the agency prior to providing any core services. Although DMH has offered free training in several major EBPs over the past several years, in the first year of implementation, there were limited staff training opportunities.
- The PEI population is not the traditional Seriously Mentally Ill population that most mental health agencies served. Instead the PEI target population are individuals with less intense mental health issues who would benefit from short-term services.
- Services are intended to be short-term and time-limited (initially only for one year), in contrast to often open-ended, long-term services. This differed from traditional services that often extended for years, even for children.
- Providers are required to administer outcome measures for every EBP, as well as enter and report the data to DMH. Previously, agencies and clinicians namely evaluated their services, let alone involve clients in reviewing the results using the scores to improve services.
- Every service billed to PEI must be billed to an EBP, including outreach services. There is no billing allowed to "No EBP", "Unknown EBP", or Service Strategy only.

Now entering the sixth year of PEI services, DMH as well as its provider community, have a wealth of experience in implementing and supporting PEI programs. Findings from the DMH Technical Assistance Site Visits conducted in fiscal year 2012-2013 and the current Monitoring and Technical Assistance Site Visits (MTASVs) conducted in fiscal years 2014-2016 are shared with providers during the site visits and provider meetings in an effort to improve, sustain, and expand PEI services.

Section

3

PEI Target Population

The definition of the PEI target population – individuals whose services may be billed to an agency or clinic's PEI funding - draws from 1) the MHSA PEI Guidelines, 2) the PEI Regulations, 3) the Los Angeles County DMH program guidelines, 4) Medi-Cal guidelines, and 5) the specific EBP requirements of the service being provided.

3.1 MHSA PEI State Program Guidelines

The former California State Department of Mental Health (SDMH) released the PEI Guidelines, the second largest component of the MHSA, on September 25, 2007. PEI focuses on evidence-based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

Priority Populations

In addition to the key community mental health needs, the Guidelines listed six priority populations the PEI Plan must address as the focus of prevention and early intervention strategies.

1. *Underserved Cultural Populations* – PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

2. *Individuals Experiencing Onset of Serious Psychiatric Illness* – Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

3. *Children/Youth in Stressed Families* – Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

4. *Trauma-Exposed* – Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

5. *Children/Youth at Risk for School Failure* – Due to unaddressed emotional and behavioral problems.

6. *Children/Youth at Risk of or Experiencing Juvenile Justice Involvement* – Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through CSS.

PEI clients must meet the requirements to participate in the PEI services being provided. Clients should be from one of the PEI priority populations outlined above and benefit from prevention and early intervention services to prevent their mental health issues from worsening.

Age Groups

State guidelines also stated that Counties must serve all ages in one or more programs of the PEI Plan. At least 51 percent of the PEI funds shall be used to serve individuals who are 25 years old or younger. Programs that serve parents, caregivers, or family members with the goal of addressing MHSA outcomes for children or youth at risk of or with early onset of a mental illness can be counted as meeting the requirements. In contrast to the CSS Plan, which focuses primarily on adults and older adults with severe, chronic, or ongoing mental health issues, PEI focuses on preventing the onset of and minimizing mental health issues before they become more serious and require long term treatment. The focus on very young children, youth, adolescents, and transition-age youth emphasizes the programmatic decisions for services to these age groups as well as their caretakers.

3.2 PEI Regulations

The PEI Regulations, approved on October 5, 2015, reiterated the guidelines for the PEI Plan implemented by Counties in California, as indicated in Section 3706 below:

Section 3706. General Requirements for Services.

(a) The County shall serve all ages in one or more Programs of the Prevention and Early Intervention Component.
(b) At least 51 percent of the Prevention and Early Intervention Fund shall be used to serve individuals who are 25 years old or younger.
(c) Programs that serve parents, caregivers, or family members with the goal of addressing MHSA outcomes for children or youth at risk of or with early onset of a mental illness can be counted as meeting the requirements in (a) and (b) listed above.

See the Appendix for a copy of the Prevention and Early Intervention Regulations effective October 6, 2015.

3.3 Medi-Cal Guidelines

Providers are expected to follow all Medi-Cal guidelines when providing PEI services to their clients. At the onset of treatment, providers should determine whether the client meets "medical necessity," as this is a requirement in order to bill to Medi-Cal. Components of medical necessity include the following: 1) diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM), 2) impairments that result from a mental disorder/diagnosis, 3) interventions that are directed toward the disorder, and 4) the condition would not be responsive to physical health care based on treatment. Every claimed service must meet the test of medical necessity. The interventions used must be directed toward the identified impairments that are the result of the mental health diagnosis. Services must cease and claiming stopped when it becomes clear that the client does not have an included diagnosis or does not meet all the medical necessity criteria. Providers should refer to the PEI Claiming Guidelines for questions about medical necessity or refer any questions to the DMH practice lead.

However, just because an individual meets medical necessity, does not mean that the individual qualifies for PEI services. The potential client must also meet PEI DMH guidelines as well as the specific PEI practice guidelines.

3.4 DMH Target Population Definition

In order to assist providers in identifying appropriate individuals for PEI services, DMH distributed the Department's definition of the PEI target population in 2012. This definition of the PEI target population has been updated to reflect the expansion of time for services from 12 months to up to 18 months in the PEI Regulations. Although this is a broad, inclusive definition, there are a number of key points contained in the definition:

- These are early intervention services.
- Services are intended to be short-term (18 months or less), and relatively low-intensity.
- Services include EBPs, PPs, and CDEs.

PEI TARGET POPULATION

The Prevention and Early Intervention Plan for Los Angeles County (August 2009) focuses on evidence-based, promising or community defined evidence practices, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Specifically, early intervention services are directed towards individuals and families for whom a short-term (usually less than 18 months), relatively low-intensity intervention is appropriate to measurably improve a mental health situation early in its manifestation. Early intervention services may avoid the need for more extensive mental health treatment, or prevent the mental health problem from becoming worse.

PEI is not a step down of services. In the spectrum it is defined as more of a starting place. If the severity and history of symptoms already qualified the client for FCCS or FSP or Wraparound and they are more chronic concerns they would not be appropriate for PEI. They can be claimed to county general funds. If they have a prior treatment history (brief- less than a year) with PEI funding or prior to 2010 (EPSDT), an agency can definitely look at the clients appropriateness for PEI services. Based on the new regulation, the PEI treatment length can be up to 18 months.

3.5 Evidence Based Treatment Guidelines

Lastly, a determination must be made as to whether a potential client meets the criteria for the specific EBP to be offered. The EBP Matrix in Section 5 provides a brief description of each EBP, the age group served, modality, length of treatment, treatment focus, and other information which must be used in any decision to engage the client in the specific EBP.

Examples of questions to raise in any decision to utlize an EBP include:

- Is the EBP's focus of treatment appropriate given the client's current diagnosis?
- Does the client fit the age range served by the EBP?
- Is the practice developmentally appropriate?
- Does the EBP modality(ies) fit the client's needs, e.g., does the EBP allow indivdual therapy if that is what the client needs?
- Will the client need longer services (EBPs range from 6 weeks to one year)?
- Does the client need more intensive services (most EBPs are provided only once a week) or multiple services (multiple or concurrent EBPs are not generally approved for PEI)?
- Is there a more suitable EBP available that the agency or another agency may offer the client?

Program administrators and clinicians should become familiar with the parameters of the EBPs they are utilizing to ensure that their clients do indeed meet the practice guidelines.

3.6 Who Qualifies for PEI Services

Per State Guidelines and PEI Regulations, for individuals participating in PEI programs, the Early Intervention element:

- Addresses a condition early in its manifestation
- Is of relatively low intensity
- Is of relatively short duration (usually 18 months or less)
- Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- May include individual screening for confirmation of potential mental health services

In general, even though an individual may not qualify for PEI services, most agencies have other County, State, or Federal funding available. If an agency is not able to provide services, referrals to other mental health facilities funded by the Department are available.

Section 4

Billing and Claiming

4.1 PEI Allocations

DMH allocates PEI funds to contracted LEs and DOs to provide PEI services throughout the County of Los Angeles. The allocation of these funds is disbursed based on four PEI Age Group Plans: Child, TAY, Adult, and Older Adult services. DMH submits reports to the State about PEI expenditures based on age group and prevention/early intervention services. The billing and claiming guidelines stated in this section refer to the MHSA PEI Medi-Cal Program. Billing or claiming for these services is entered through former Integrated System (IS) or the Integrated Behavioral Health Information System (IBHIS). The claims are entered via computer.

DMH also allocates training funds to its PEI Providers. However, payment is based on requests for reimbursement, which are submitted via manual invoices. These expenses are not billed to Medi-Cal. A description of these training funds and process for reimbursement are described in Section 8, Training Funds.

4.2 Under/Over Spending and Shifting Funds

Providers are strongly encouraged to maximize spending their entire PEI allocation. Significant underspending of their PEI allocation may signal problems with an agency's PEI program, e.g., insufficient trained staff, lack of understanding of the PEI program, administrative issues, etc. Continued underspending of the PEI allocation may result in a reduction of an agency's continuing PEI allocation.

Providers are likewise warned about exceeding their PEI allocation as the overbilling may result in non-payment. The County's policy on non-retroactive payment of services comes into play for requests for reimbursement after the services have exceeded an agency's PEI allocation. Providers should monitor their PEI billing on a monthly basis in order to avoid under or overspending their allocation. Administrative staff should also be in contact with their Lead District Chief as soon as possible when projects indicate significant under or overspending.

Providers that wish to shift funds from one program to another must complete the Legal Entity (LE) Funded Program/Subprogram Reallocation Request Form. The LE's lead District Chief must approve the shifting of funds. Submission of requests to shift funds does not guarantee approval

by the DMH Financial Services Bureau. All requests to shift funds must be made as soon as it is determined that an agency will exceed its allocation or by March 1 of the fiscal year. A copy of the LE Funded Program/Subprogram Reallocation Request Form is provided on the following page.

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

LEGAL ENTITY (LE) FUNDED PROGRAM/SUBPROGRAM REALLOCATION REQUEST FORM

LE Name _____ LE # _____ FY _____ Last Amendment # _____

In accordance with guidelines set forth in the DMH Policy, *Shifting Guidelines for the Legal Entity Agreement,* the above LE is requesting to shift within subprograms as shown below. The requested shift effective date is _____ .

Shift From:

Funded Program	Subprogram	Beneficiary (e.g. EPSDT)	Original Alloc	Req Shift Amt	Proposed Alloc

as of

Report Name	Report Date	Claim Amt	Cutoff Date	% Utilization	SA(s) affected	Est. # of Clients Affected

Why is this allocation not being spent as intended?

Shift To:

Funded Program	Subprogram	Beneficiary (e.g. EPSDT)	Original Alloc	Req Shift Amt	Proposed Alloc

as of

Report Name	Report Date	Claim Amt	Cutoff Date	% Utilization	SA(s) affected	Est. # of Clients Affected

Why is this shift needed?

DMH use only:	Print Name	Signature	Date	Recommendation
Lead DC				Approve as requested
				Approve with modification
Other				
Affected				modified shift amount _____
DC(s)				modified effective date _____
				Deny

Comments/Analysis:

Deputy Director Approval:

Print Name _____ Signature _____ Date _____

4.3 PEI Claiming Guidelines

All services billed to the PEI Medi-Cal Program must adhere to PEI Claiming Guidelines which were specifically developed for PEI funded programs providing direct mental health services. The DMH Guidelines, titled A Guide to Claiming Prevention and Early Intervention (PEI) & Evidence-Based Practice (EBP) Services, are meant to serve as a guide for DMH's LEs and DOs claiming of mental health services provided through the County's PEI Plan. Please refer to the PEI Claiming Guidelines for information on requirements and procedures for claiming to the PEI funding source, including the use of EBP and Service Strategy Codes, the use of Procedure Codes, the PEI claiming process, and the PEI Clinical Loop. A copy of the Guidelines follows this chapter.

With respect to the information provided in the Claiming Guidelines, DMH does not assume any legal liability or responsibility for the accuracy, completeness, clinical efficacy or value of the implementation of any such information described or referenced. Each LE and DO is fully responsible for ensuring the accuracy, completeness, clinical efficacy or value of their own claims to mental health services and supports that they provide through the PEI Plan.

For general guidelines related to the organization and contents of the clinical record, DMH DO providers and LE contracted providers may refer to DMH Policies No. 104.08 and No. 104.09. These policies are on the DMH Website and may be accessed through the following links:

- DMH Directly-Operated Providers: DMH INTRANET - **http://dmhhqportal1/sites/DMHPAP/default.aspx**
- LE Contracted Providers: DMH INTERNET- **http://lacdmh.lacounty.gov/policy/Contractors/index.htm**

The following are some key points to keep in mind when claiming to PEI Medi-Cal:

- All clients claimed to MHSA PEI must meet the criteria for the eligible PEI target population, as discussed in Section 3 of this handbook.
- Client diagnosis must indicate symptomology that is likely to benefit from brief, short-term treatment. Clients with diagnoses that indicate more severe symptomology are likely not appropriate for PEI, and should be claimed to an alternate funding source. For additional information about PEI diagnoses, please refer to the PEI Billable and Non-Billable Diagnoses in this chapter.
- In order to claim to a PEI Plan, LEs and DOs must provide an approved EPB, PP, or CDE and select the corresponding EBP code. (See Section 5, Evidence-Based Practices, for a list of PEI approved EBPs, PPs, and CDEs.) All services (core and non-core) that are provided under an EBP must be claimed to the EBP code. For more information regarding the use of EBP codes, please refer to the "Claiming to MHSA PEI" section in the PEI Claiming Guidelines. A complete list of the EBP codes is located in the Integrated-Systems Code Manual at the following link: **http://lacdmh.lacounty.gov/hipaa/documents/ CODESMANUAL-IS2Version_000.pdf**

- The majority of services provided must be core to the PEI practice being utilized. Each EBP/CDE/PP differs in terms of the interventions that are core to the practice. Additional information about core interventions, including a complete list of core interventions for each PEI Practice, is available in the PEI Claiming Guidelines.

- Providers should claim to the PEI plan based on the client's age at the time of service. No paperwork needs to be completed solely because the client's age has changed during the EBP services. In addition, there will be no change in outcomes if a client ages up into a new PEI plan. The outcomes collected at intake will be the same outcomes collected at "Update" and "Post" treatment. (See Section 6. Data Collection and Outcomes for information on outcome measures.)

4.4 PEI Billable and Non-Billable Diagnoses

Clinicians must have an "included" diagnosis as the Primary Diagnosis when claiming to Medi-Cal. The Primary Diagnosis is the only diagnosis that is transmitted to the State on claims. Services and/or interventions for Medi-Cal must be directed towards an "included" diagnosis except for initial contacts during the evaluation process or crisis services. The diagnosis which services and/or interventions are directed towards, should be listed as the primary diagnosis in the clinical record and in the IS/IBHIS because this will be the diagnosis associated with a claim.

When an episode is originally opened, it may not be clear what diagnosis is appropriate due to the need to gather additional information or complete the full Assessment. If impairments can be identified and "No Medical Necessity" has not been ascertained, the episode may be opened with a "799.9 Deferred Diagnosis" on Axis I. An episode cannot be closed with a "Deferred Diagnosis." However, it may be closed with "V71.09 No Diagnosis" on Axis I. As soon as a diagnosis is determined, both the clinical record and the IS/IBHIS must be updated with the correct diagnosis. The diagnosis should only be documented on the Initial Assessment and/or Diagnosis information form. Any time a diagnosis is added, changed, or no longer appropriate for a client a "Diagnosis Information" form MH 501 must be completed. If an excluded diagnosis is used to close an episode, only those services provided prior to establishing the excluded diagnosis should be claimed to Medi-Cal.

Diagnoses must be appropriate for the EBP/CDE/PP used and the PEI population. Several diagnoses, although Medi-Cal "included," may not be appropriate for PEI due to the indicated severity of symptomology. Clients with these diagnoses typically require a higher level of care than can be provided by PEI. Additionally, clients with any type of developmental delay are not appropriate for PEI, as they generally are not the target population that benefits from brief, short term intervention.

Inappropriate PEI diagnoses, which are generally not billable to PEI, include but are not limited to the following:

- Autism Spectrum Disorder
- Bipolar I Disorder

- Bipolar II Disorder
- Conduct Disorder
- Major Depressive Disorder, SE, Severe
- Major Depressive Disorder, Recurrent, Mild
- Major Depressive Disorder, Recurrent, Moderate
- Major Depressive Disorder, Recurrent, Severe
- Pervasive Developmental Disorder
- Psychotic Disorder
- Schizoaffective Disorder
- Schizophrenia

While the diagnoses listed above are generally not appropriate for the PEI target population, it is also important to consider whether the diagnosis is appropriate for the particular EBP selected for the client. For example, since CORS is a 6-session practice designed to treat a recent crisis, a diagnosis such as Attention-Deficit/Hyperactivity Disorder may indicate that the client may need treatment longer than 6 sessions in order to improve functioning.

4.5 Core Interventions

Core Interventions are those services intrinsic to the delivery of expected outcomes for each of the PEI programs. To be eligible for PEI services the client must meet the PEI population as specified in the PEI Plan. It is expected that EBP Core Interventions be delivered by staff trained in the EBP for which interventions are being provided. Services not core to the PEI program may be provided on a short-term basis to meet emergent client needs. All service delivery must adhere to the Scope of Practice/Rendering Provider Guidelines in the most recent version of A Guide to Procedure Codes for Claiming Mental Health Services which is available on the County of Los Angeles Department of Mental Health website. Clinicians must select one PEI EBP and the procedure code which corresponds to the service claimed. "No EBP" (00) or "Unknown EBP" (99) should not be selected when claiming to the PEI Plan.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

Core Interventions are those services intrinsic to the delivery of expected outcomes for each of the PEI programs. To be eligible for PEI services the client must meet the PEI population as specified in Los Angeles County's PEI Plan. It is expected that EBP Core Interventions be delivered by staff trained in the EBP for which interventions are being provided. Services not core to the PEI program may be provided on a short-term basis to meet emergent client needs.

All service delivery must adhere to the Scope of Practice/Rendering Provider Guidelines in the most recent version of *A Guide to Procedure Codes for Claiming Mental Health Services* which is available on the County of Los Angeles Department of Mental Health website.

PEI Claiming Guidelines: Please select one PEI EBP and the procedure code which corresponds to the service claimed. Under these PEI Claiming Guidelines, 00 (no EBP) should not be selected when claiming to the PEI Plan.

PEI Program	Core Interventions	Procedure Codes
AF-CBT (Alternatives for Families: A Cognitive Behavioral Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy	90791 90887 90847 90853 H0046, 90832, 90834, 90837
ART (Aggression Replacement Training)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Group Rehabilitation Individual Psychotherapy (To "make up" a missed group session) Individual Rehabilitation Service (To "make up" a missed group session)	90791 90887 90853 H2015 H0046, 90832, 90834, 90837 H2015
BST (Brief Strategic Family Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Individual Rehabilitation Service Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 H2015 T1017
CAPPS (Center of Assessment and Prevention of Prodromal States)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Group Psychotherapy Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 90853 T1017
CBITS (Cognitive Behavioral Intervention for Trauma in Schools)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Individual Psychotherapy Individual Rehabilitation Service (For the purpose of administering the developer - specified For PTSD Screening Tool)	90791 90887 90853 H0046, 90832, 90834, 90837 H2015
CBT (Cognitive Behavioral Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 T1017
CFOF (Caring for Our Families)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Group Rehabilitation Individual Psychotherapy Individual Rehabilitation Targeted Case Management	90791 90887 90847 90853 H2015 H0046, 90832, 90834, 90837 H2015 T1017

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

PEI Program	Core Interventions	Procedure Codes
CORS (Crisis Oriented Recovery Services)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 T1017
CPP (Child Parent Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Crisis Intervention Family Psychotherapy (Joint parent-child) Individual Psychotherapy Individual Rehabilitation Service (Concrete assistance with activities of daily living) Targeted Case Management	90791 90887 H2011 90847 H0046, 90832, 90834, 90837 H2015 T1017
DBT (Dialectical Behavior Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Crisis Intervention Family Psychotherapy Group Psychotherapy Individual Psychotherapy Plan Development Targeted Case Management	90791 90887 H2011 90847 90853 H0046, 90832, 90834, 90837 H0032 T1017
DTQI (Depression Treatment Quality Improvement Intervention)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 T1017
FFT (Functional Family Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy	90791 90887 90847
FOCUS (Families Overcoming Under Stress)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Individual Rehabilitation Service Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 H2015 T1017
GLBTC (GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services)	Under Development	Under Development
Group Cognitive Behavioral Therapy of Major Depression	Assessment/Psychiatric Diagnostic Interview Group Psychotherapy Individual Psychotherapy (To "make up" a missed group session)	90791 90853 H0046, 90832, 90834, 90837
IPT (Interpersonal Psychotherapy for Depression)	Assessment/Psychiatric Diagnostic Interview Family Psychotherapy Individual Psychotherapy Individual Rehabilitation Service	90791 90847 H0046, 90832, 90834, 90837 H2015
IY (Incredible Years)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Group Rehabilitation	90791 90887 90853 H2015
LIFE (Loving Intervention Family Enrichment Program)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Group Rehabilitation (Family and Non-Family) Multi-family Group Psychotherapy Plan Development	90791 90887 90853 H2015 (HE, HQ) 90849 H0032

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

PEI Program	Core Interventions	Procedure Codes
MAP (Managing & Adapting Practice)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Group Rehabilitation Services Individual Psychotherapy Individual Rehabilitation Services Multi-family Group Psychotherapy Plan Development Targeted Case Management	90791 90887 90847 90853 H2015 H0046, 90832, 90834, 90837 H2015 90849 H0032 T1017
MDFT (Multidimensional Family Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Plan Development Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 H0032 T1017
MHIP (Mental Health Integrated Program)	Tier 2 Assessment/Psychiatric Diagnostic Interview Collateral Crisis Intervention Individual Psychotherapy Plan Development Targeted Case Management	 90791 90887 H2011 H0046, 90832, 90834, 90837 H0032 T1017
	Community Partners (CP's) Only CP's providing HWLA collaborative health/mental services	 H2016
MPG (Mindful Parenting Groups)	Assessment/Psychiatric Diagnostic Interview Multi-family Group Psychotherapy	90791 90849
MST (Multisystemic Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Targeted Case Management	90791 90887 90847 T1017
PATHS (Promoting Alternative Thinking Strategies)	Assessment/Psychiatric Diagnostic Interview Group Psychotherapy Group Rehabilitation Plan Development Targeted Case Management	90791 90853 H2015 H0032 T1017
PCIT (Parent-Child Interaction Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy	90791 90887 90847
PE (Prolonged Exposure Therapy for Posttraumatic Stress Disorder)	Assessment/Psychiatric Diagnostic Interview Individual Psychotherapy Individual Rehabilitation Services	90791 H0046, 90832, 90834, 90837 H2015
PEARLS (Program to Encourage Active, Rewarding Lives for Seniors)	Assessment/Psychiatric Diagnostic Interview Individual Psychotherapy Individual Rehabilitation Services Plan Development Targeted Case Management	90791 H0046, 90832, 90834, 90837 H2015 H0032 T1017
PST (Problem Solving Treatment)	Assessment/Psychiatric Diagnostic Interview Individual Psychotherapy Individual Rehabilitation Services Plan Development Targeted Case Management	90791 H0046, 90832, 90834, 90837 H2015 H0032 T1017
Reflective Parenting Program	Assessment/Psychiatric Diagnostic Interview Collateral Multi-family Group Psychotherapy	90791 90887 90849
Seeking Safety	Assessment/Psychiatric Diagnostic Interview Family Psychotherapy Group Psychotherapy Group Rehabilitation Services Individual Psychotherapy Individual Rehabilitation Service	90791 90847 90853 H2015 H0046, 90832, 90834, 90837 H2015

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

PEI Program	Core Interventions	Procedure Codes
SFP (Strengthening Families Program)	Assessment/Psychiatric Diagnostic Interview Collateral Group Rehabilitation Group Psychotherapy Multi-family Group Psychotherapy	90791 90887 H2015 90853 90849
TF-CBT (Trauma Focused Cognitive Behavioral Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy (Referred to as conjoint in TF-CBT model) Individual Psychotherapy	90791 90887 90847 H0046, 90832, 90834, 90837
Triple P Level 4 Standard/Standard Teen (Positive Parenting Program)	Assessment/Psychiatric Diagnostic Interview Collateral	90791 90887
Triple P Level 4 Group (Group Positive Parenting Program)	Assessment/Psychiatric Diagnostic Interview Collateral - Individual or Group (Per Facilitator's Manual for Group Triple P) Multi-family Group Psychotherapy (For group of parents) (This service can only be claimed by staff trained in Level 4 Group Triple P)	90791 90887 90849
Triple P Level 5 Pathways	Assessment/Psychiatric Diagnostic Interview Collateral (For individul or group of parents) Multi-family Group Psychotherapy (For group of parents)	90791 90887 90849
Triple P Level 5 Enhanced	Assessment/Psychiatric Diagnostic Interview Collateral	90791 90887
UCLA TTM (UCLA Ties Transition Model)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Multi-family Group Psychotherapy Plan Development Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 90849 H0032 T1017

* **Psychological Testing has not historically been approved for PEI services. If an agency has an exceptional justification for providing this service, it will need to be brought to the attention of the Service Area/Lead District Chief and Program Deputy.**

This Guide, prepared by DMH, lists and defines the compliant codes that the DMH believes reflects the services it provides throughout its system, whether by directly-operated or contracted organizational providers or individual, group, or organizational network providers. This analysis does not, however, absolve Providers, whether individuals or agencies from their responsibility to be familiar with nationally compliant codes and to inform and dialogue with the DMH should they believe differences exist.

REVISED: 2-18-16 Procedure Codes

4.6 Limited Community Outreach Services

In general, most providers cannot bill for community outreach Services (COS). The COS activities include: access, client engagement, consultation, crisis response, information, referral, linkage, peer support, self-help or screening. In 2012, to assist agencies outreaching communities for PEI program, DMH allowed providers to shift PEI one-time training dollars to PEI COS. Only agencies that already had COS in their DMH contract for other services could initiate the shift based on the guidelines below. The one exception to the use of COS funds is that CAPPS can be billed under COS but only for a limited amount. (See the memo on the next page.)

The shift of training funds is only valid for the fiscal year in which the shift occurs, as the one-time training dollars allocated to agencies varies each year. Since 2012, the amount of one-time training funds allocated to agencies has been greatly reduced, so that most agencies no longer able to or desire to shift their reduced training funds to COS.

The guidelines for shifting PEI training dollars and claiming COS are as follows:

1. Lead District Chief approval is required in order to shift funds.

2. COS must be authorized in the current year and the agency's current contract.

3. COS is limited to 20% of the agency's total PEI allocation in FY 12-13. In FY 13-14, COS is limited to 15%, and in following fiscal years will be reduced.

4. COS must be targeted and utilized for the PEI target population. It is not intended for the more seriously mentally ill.

5. COS must be billed to a specific PEI approved evidence based practice (EBP), promising practice (PP), or community-defined evidence (CDE) practice. COS cannot be used for general, non-PEI EBP/PP/CDE services.

6. COS may be used only for authorized mental health promotion and community client services.

7. Agencies should ensure they have sufficient funds to cover their training expenses. Invoices requesting reimbursement for training expenses will not be paid if there are insufficient training funds due to funds being shifted to COS.

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

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http://dmh.lacounty.gov

Reply To: (213) 738-4108
Fax: (213) 386-1297

September 5, 2012

TO: Executive Directors, Contract Providers

FROM: Robin Kay, Ph.D.
Chief Deputy Director

SUBJECT: **SHIFTING PEI TRAINING DOLLARS TO PEI COMMUNITY OUTREACH SERVICES**

To assist agencies outreaching communities for Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs, the Department of Mental Health (DMH) is allowing providers to shift PEI training dollars to PEI Community Outreach Services (COS). Agencies that already have COS in their contract may initiate the shift under the guidelines described in this memo. Agencies that do not have COS in their contract must obtain approval from their Lead District Chief in order to add COS.

The guidelines for shifting PEI training dollars to PEI COS are as follows:

1. Lead District Chief approval is required in order to shift funds.
2. COS must be authorized in the current year and the agency's current contract.
3. COS is limited to 20% of the agency's total PEI allocation in Fiscal Year (FY) 2012-13. In FY 2013-14 COS is limited to 15%, and in following fiscal years will be reduced.
4. COS must be targeted and utilized for the PEI target population. It is not intended for the more seriously mentally ill.
5. COS must be billed to a specific PEI approved evidence based practice (EBP), promising practice (PP), or community-defined evidence (CDE) practice. COS cannot be used for general, non-PEI EBP/PP/CDE services.
6. COS may be used only for authorized mental health promotion and community client services.
7. Agencies should ensure they have sufficient funds to cover their training expenses. Invoices requesting reimbursement for training expenses will not be paid if there are insufficient training funds due to funds being shifted to COS.

Please contact your Lead District Chief should you have any questions.

RK:DM:LB

c: Deputy Directors
District Chiefs
Richard Kushi
ACHSA

4.7 Special Circumstances

AGING UP. In circumstances when clients age up from a Child to TAY Age Group, the provider should first make sure that they have both PEI-Child and PEI-TAY available in their contract. As far as claiming to PEI, providers should claim the PEI plan based on the client's age at the time of service. No paperwork needs to be completed solely because the client's age has changed during the delivery of EBP services. In addition, there will be no change in outcomes if a client ages up into a new PEI plan. The outcomes collected at intake will be the same outcomes collected at "Update" and "Post" treatment.

When considering whether to use a PEI practice beyond the age group or population it was normed for or beyond what the developer recommends, clinical judgment, coupled with client choice, should guide decision-making, with the following pieces of information to consider:

- Are the client's presenting symptoms, diagnosis, and treatment goals consistent with what the model is targeted to address?
- Has there been subsequent research extending the use of the model to individuals of different ages?
- In the experience of the provider, is there a significant basis to support the use of the model with an individual outside of the age range of the practice?
- Is it developmentally appropriate?
- Is there a more suitable evidence-based or promising practice available?

Individuals who have had prior mental health services or a previous mental health diagnosis can receive PEI services only if it is clinically appropriate, given an assessment of the client's presenting problems, functional impairment, ability to benefit from brief treatment and the chosen EBP.

TRANSFERRING TO ANOTHER PROVIDER. When clients have been transferred between providers, then a new episode must be opened. The new episode is opened at the point in which the client presents at the new provider. The new provider may complete a new assessment and use the existing treatment plan, as long as the goals and objectives are appropriate to the EBP and meet the PEI target population.

RESIDENTIAL SETTINGS. At this time clients may receive PEI services in residential settings as long as the EBP is clinically appropriate (for a client's symptoms and not overwhelming for the client, family, and/or caregiver). There should not be a duplication of services at the residential setting. Services should not be intensive or a layering of services as it's typically seen in very high need clients.

CONCURRENT EBP/PP/CDEs. A client who is receiving concurrent EBPs should be the exception rather than the rule. The recommendation is always to implement one EBP at a time, if sequential treatment is needed. The clinician should identify along with the client/family, the

primary issues and identify the best fitting service. Upon completing that service (EBP), if necessary, the client may start another EBP to address remaining issues, likely in different foci of treatment. Other considerations in implementing more than one EBP include clinical appropriateness, duplication of services, overwhelming the client/family, and the required outcomes for each EBP.

CONCURRENT BILLING TO DIFFERENT FUNDING SOURCES. A client should not be enrolled in an EBP through PEI and receive concurrent services in other non-PEI funding programs. This constitutes layered services and means that the client requires a higher level of care. PEI should never be chosen as a step-down service from other services, i.e. Wraparound, FCCS, FSP, or County General Funds.

MEDICATION SUPPORT ONLY. If a client was receiving mental health services and terminated treatment under a PEI Plan, but continues to receive medication support with the psychiatrist, then the medication support may continue for a limited time only. Thereafter, the provider must find another funding source (not a PEI Plan) in order to continue claiming medication support for an extended period of time (e.g. longer than 3 months). Providers are not allowed to bill PEI for only medication support beyond the 3-month period.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

A Guide to Claiming Prevention and Early Intervention (PEI) & Evidence-Based Practice (EBP) Services

Updated February 22, 2016

TABLE OF CONTENTS

1. INTRODUCTION

A. Background

The Los Angeles County Department of Mental Health (LAC-DMH) **Guidelines for Claiming Prevention and Early Intervention (PEI) Programs** is a reference tool designed to assist directly-operated and contracted mental health providers when claiming mental health services and supports through the respective Prevention and Early Intervention plans.

The PEI Plan of the Mental Health Services Act (MHSA) was developed through a large countywide stakeholder process and was adopted in 2009. The Los Angeles County PEI Claiming Workgroup formed in 2010 and met for a period of 18 months. Its purpose was to advise the Department regarding claiming for services provided under the PEI Plan. Members of the PEI Claiming Workgroup included the Department's age group leads (Children, Transition Age Youth, Adults, and Older Adults), the Department's Quality Assurance Division, and the Department's MHSA Implementation Team. Its role was to provide guidance and lend expertise toward the development of guidelines for the claiming of the various services and supports provided through the County's PEI Plan. The result is the attached document, which will serve as a recommended guide for the claiming of PEI mental health services and supports for LAC-DMH directly-operated and contracted providers.

B. Purpose

This document is meant to serve as a guide for LAC-DMH's directly-operated and contracted providers for the claiming of mental health services and supports provided through the County's PEI Plan. With respect to the information provided in these guidelines, the LAC-DMH does not assume any legal liability or responsibility for the accuracy, completeness, clinical efficacy or value of the implementation of any such information described or referenced in this document. Each LAC-DMH legal entity and contracted provider is fully responsible for ensuring the accuracy, completeness, clinical efficacy or value of their own claims to mental health services and supports that they provide through the PEI plan.

2. DOCUMENTATION AND CLAIMING

All services provided under contract with Los Angeles County Department of Mental Health (LACDMH) must meet the documentation and claiming requirements set forth in Policy 401.03 and the Organizational Provider's Manual. LACDMH uses Medi-Cal requirements as the basis for these documents. As such, all MHSA PEI services must meet Medi-Cal requirements set forth in Policy 401.03 and the Organizational Provider's Manual.

Below is the link to the Organizational Provider's Manual:
http://file.lacounty.gov/dmh/cms1_159846.pdf

In addition to meeting the Medi-Cal standards, any services using MHSA PEI funding must clearly document how the client meets the target PEI population. The PEI Target Population is as follows:

> According to the Prevention and Early Intervention Plan for Los Angeles County (August 2009), PEI focuses on evidence-based, promising or community defined evidence practices, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Specifically, early intervention services are directed toward individuals and families for whom a short-term (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health situation early in its manifestation. Early intervention services may avoid the need for more extensive mental health treatment, or prevent the mental health problem from becoming worse.

PEI-specific program documentation standards and fidelity guidelines will be discussed in the following sections.

3. CLAIMING TO MHSA PEI

LAC-DMH has implemented many new programs under MHSA PEI which utilize EBPs. When claiming to a MHSA PEI Plan, there are special requirements regarding the use of *EBP Codes.

A. Evidence-Based Practice and Service Strategy Codes

LAC-DMH implemented the use of EBP and SS codes in November 2006. Reporting the use of EBP and SS interventions are a State and Federal requirement, regardless of the funding source.

- EBP codes reflect services that are provided as part of an Evidence-Based Practice when the program using the EBP meets the fidelity and criteria of the EBP model. In addition, in order to use an EBP code for a service, the client must meet the criteria identified by the EBP model and ensure that the treatment approach is appropriate to the mental health needs and treatment plan of the client.

  EBPs include Evidence-Based Practices as well as Community-Defined Evidence Practices (CDE) and Promising/Pilot Practices (PP).

- SS codes are used to describe the intervention strategies reflected by the service provided. Unlike EBP codes, there are no fidelity or criteria measurements in order to use SS codes. Any program, regardless of funding source, may use SS codes if the program/staff person believes the service meets the definition of the SS.

B. Using EBP codes when Claiming to MHSA PEI

When claiming to a MHSA PEI Funding Plan, there are special requirements regarding the use of EBP codes.

1. All services for clients being claimed to a PEI Plan **MUST** have a PEI-approved EBP code selected for the claim:
   a. When claiming services to a PEI plan, an EBP code must **ALWAYS** be selected.
   b. Only one EBP can be identified on a claim.
   c. "No EBP/SS" (Code 00) or "Unknown EBP" (code 99) **may not** be selected for claims under the PEI Plans.
   d. Select one PEI-EBP and no more than two Service Strategies (if Service Strategies are applicable) and the procedure code which corresponds to the service claimed.

2. Unless otherwise specified by the DMH EBP Lead, Rendering Providers do not have to be trained / certified in the EBP in order to claim services under a PEI Plan. However, the following conditions must be met:

   a. The majority of services provided must be intrinsic to the EBP model.

   b. If a Rendering Provider is not trained / certified in the EBP model, he/she shall **coordinate services with someone who is trained in the EBP model.**

   c. EBP codes should be used for both "Core" and "Non-Core" services in accord with the aforementioned instructions.

C. Special Additional Criteria for the use of the MHIP EBP ONLY

1. In addition to the instructions noted above for claims under the PEI Plans, to use the Mental Health Integration Program (MHIP) EBP code (listed as 2K IMPACT - MHIP in the IS), the Rendering Provider of the service should be trained in the use of the MHIP model by either LACDMH or the developer of the model AND be implementing all 5 components of MHIP noted here: 1) The Care Team is collaborating with the client's Primary Care Provider (PCP); 2) The PCP is prescribing all medications including any psychotropic medications; 3) The MHIP team includes a consulting psychiatrist; 4) An EBP intervention and/or behavioral activation is being implemented; and, 5) Applicable screening tools (PHQ-9, GAD-7, or the PCL-C) are being administered on a session-to-session basis.

D. Where to Find the Current List of EBP/SS Codes

The IS Codes Manual contains the most current list of available EBP and SS codes, which may be accessed on-line at **http://LAC-DMH.lacounty.gov/hipaa/index.html**

E. Procedure Codes for PEI-EBP (Appendix A)

1. Procedure codes are determined by the service provided.

2. MHSA PEI Services include both:

   a. "Core" Interventions: those services intrinsic to the delivery of expected outcomes for each of the PEI programs. It is expected that EBP Core Interventions be delivered by staff trained in the EBP for which interventions are being provided.

   b. "Non-Core" Services: those services not core to the PEI program which are provided on a short-term basis to meet the emergent client needs and support the client's participation in the EBP model.

3. PEI "Core" Interventions and "Non-Core" Services utilize the same procedure codes as all other services – DMH Procedure Codes Guides.

4. To be eligible for PEI services, the client must meet the PEI population requirements as specified in Los Angeles County's PEI Plan.

5. PEI Services are identified by the PEI IS Plan and potentially, the EBP selected.

F. MHSA PEI IS Plans:

1. PEI IS Plans are age-specific; whereas, other MHSA Integrated System (IS) Plans such as Full Service Partnership (FSP) and Field Capable Clinical Services (FCCS) are either enrollment programs or designed for any age group.

2. There are four (4) IS PEI Age Group Plans and one PEI Special Program Plan. Select a Plan according to the age of the client.

   a. PEI Children: Ages 0-15, Plan No. 2098

   b. PEI TAY: Ages 16-25, Plan No. 2101

   c. PEI Adult: Ages 26-59, Plan No. 2092

   d. PEI Older Adult: Ages 60 & Older, Plan No. 2093

   e. PEI Special Programs, Plan No. – 2091
      i. Assigned to Agencies providing services to individuals with the Healthy Way Los Angeles (HWLA) insurance benefit and those with *Non-Age Specific Services
      ii. *Does not apply to DMH directly-operated programs

G. Claiming Medication Support Services:

1. If a client is receiving a specific EBP, and the psychiatrist determines that medication intervention is justified, the medication intervention will be billed to the appropriate IS PEI Age Group Plan and to the specific EBP identified.

2. Following completion of the an EBP, those clients who require ongoing medication support should be transferred to an alternate funding source.

IMPORTANT REMINDERS:

- You can deliver an EBP under any funding source; however, you must deliver a LACDMH-approved EBP under a PEI Plan.

- All PEI claims must be associated with an EBP.

- Reporting the use of EBP and SS interventions are a State and Federal requirement, regardless of the funding source.

4. PEI CLAIMABLE SERVICES

ALL current regulations and requirements of Medi-Cal apply to MHSA PEI services. Rules of Medi-Cal do not change because of PEI funding. In Appendix A, the MHSA PEI Programs Guide to Core Interventions, highlights the core services that should be the majority rendered for each EBP.

Due to the requirement that Outcome Measures be administered, collected, and reported for each client that is claimed to PEI the following example illustrates how these services can be utilized as symptoms scales that drive clinical decision making. Administration of symptom scales for clinical purposes, such as assessing and monitoring client's symptoms and treatment progress, and guiding treatment planning are claimable services. The following is an example of how you might document symptom scales in a progress note:

> "Administered the PHQ-9 to the client to monitor treatment progress. Client's current PHQ-9 score of 16 indicates that she is experiencing a moderately severe level of depression. She reported depressed mood, feelings of guilt and failure, hypersomnia, low energy and difficulties concentrating. Upon further inquiry, client denied both hopelessness and suicidal ideation. In reviewing client's PHQ-9 scores across all of her sessions (see PHQ-9 forms dated 10/1/12 – 12/6/12), her depressive symptoms appear to be diminishing **OR** her depressive symptoms do not appear to be improving."

- **KEEP IN MIND**: EBP screening tools are used to monitor treatment progress and respond accordingly:

  a. if scores / symptoms are decreasing, then continue doing what you are doing

  b. if scores / symptoms are increasing or not changing, then troubleshoot (e.g., consult psychiatrist, assess client's treatment adherence, increase supports, etc.)

A. CLAIMING COMMUNITY OUTREACH SERVICES

In general, most providers cannot bill for Community Outreach Services (COS). COS activities include: access, client engagement, consultation, crisis response, information, referral, linkage, peer support, self-help or screening. In 2012, to assist agencies outreaching communities for PEI program, DMH allowed providers to shift PEI one-time training dollars to PEI COS. Only agencies that already had COS in their DMH contract for other services could initiate the shift based on the guidelines below. Agencies that do not have COS in their contract must obtain approval from their Lead District Chief in order to add COS.

The one exception to the use of COS funds is that CAPPS can be billed under COS but only for a limited amount.

The guidelines for shifting PEI training dollars to PEI COS are as follows:

1. Lead District Chief approval is required in order to shift funds.

2. COS must be authorized in the current year and the agency's current contract.

3. COS is limited to 20% of the agency's total PEI allocation in Fiscal Year (FY) 2012-13. In FY 2013-14 COS is limited to 15%, and in following fiscal years will be reduced.

4. COS must be targeted and utilized for the PEI target population. It is not intended for the more seriously mentally ill.

5. COS must be billed to a specific PEI approved evidence based practice (EBP), promising practice (PP), or community-defined evidence (CDE) practice. COS cannot be used for general, non-PEI EBP/PP/CDE services.

6. COS may be used only for authorized mental health promotion and community client services.

7. Agencies should ensure they have sufficient funds to cover their training expenses. Invoices requesting reimbursement for training expenses will not be paid if there are insufficient training funds due to funds being shifted to COS.

B. EXAMPLES OF PEI NON-REIMBURSABLE ACTIVITIES

The following activities are commonly part of PEI services but are <u>not reimbursable</u> by Medi-Cal or PEI. If any one of these activities is completed during a claimable/reimbursable service, LAC-DMH suggests completing two separate Progress Notes – one for the claimable/reimbursable service and one for the non-reimbursable activity (making a notation that it is “not claimable”).

1. Administration of <u>outcome measures</u> for <u>research purposes</u>, such as submitting or analyzing results to measure the EBP treatment efficacy.

2. Inputting of data (e.g., symptom scale scores) into an EBP developer’s ‘treatment progress monitoring website.

3. Consultation with the developer of a treatment practice/protocol.

C. EXAMPLES OF NON-CLAIMABLE SERVICES TO MHSA PEI

1. Psychological Testing has not been historically approved for PEI services. If an agency has an exceptional justification for providing this service, it will need to be

brought to the attention of the Service Area/Lead District Chief and Program Deputy.

2. Providing an Evidence-Based Practice (EBP)* intervention to the non-PEI population.

KEEP IN MIND:

EBPs may be used with any client deemed clinically appropriate for the model; however, only those clients who meet the PEI target population criteria may be claimed to MHSA PEI.

*** The term Evidence-Based Practices (EBP) is being collectively used to include Community-Defined Evidence (CDE) and Promising/Pilot Practices (PP).**

5. DOCUMENTATION OF MEDICAL NECESSITY

In order to receive reimbursement from Medi-Cal, services must meet all Medical Necessity criteria. Documentation of Medical Necessity is found by looking at the client's initial assessment, treatment plan, and progress notes. LAC-DMH calls this sequence of documentation the "Clinical Loop". When claiming to PEI, use of the EBP/PP/CDE being utilized should be clearly documented within this sequence of documentation to justify the PEI match dollars.

The PEI **"Clinical Loop"** has three components and is done on a continual basis. It is not a one-time process. **The three components are**:

1. **Mental Health Assessment:** complete the assessment including documentation of:
    a. Symptoms/Behaviors leading to an **Included Diagnosis that is appropriate for the PEI target population**
    b. Impairments in Life Functioning, Needs, and Strengths with justification for the client's likely ability to benefit from *brief, short-term treatment*.
    c. Documenting history and severity of symptoms and prior mental health treatment.

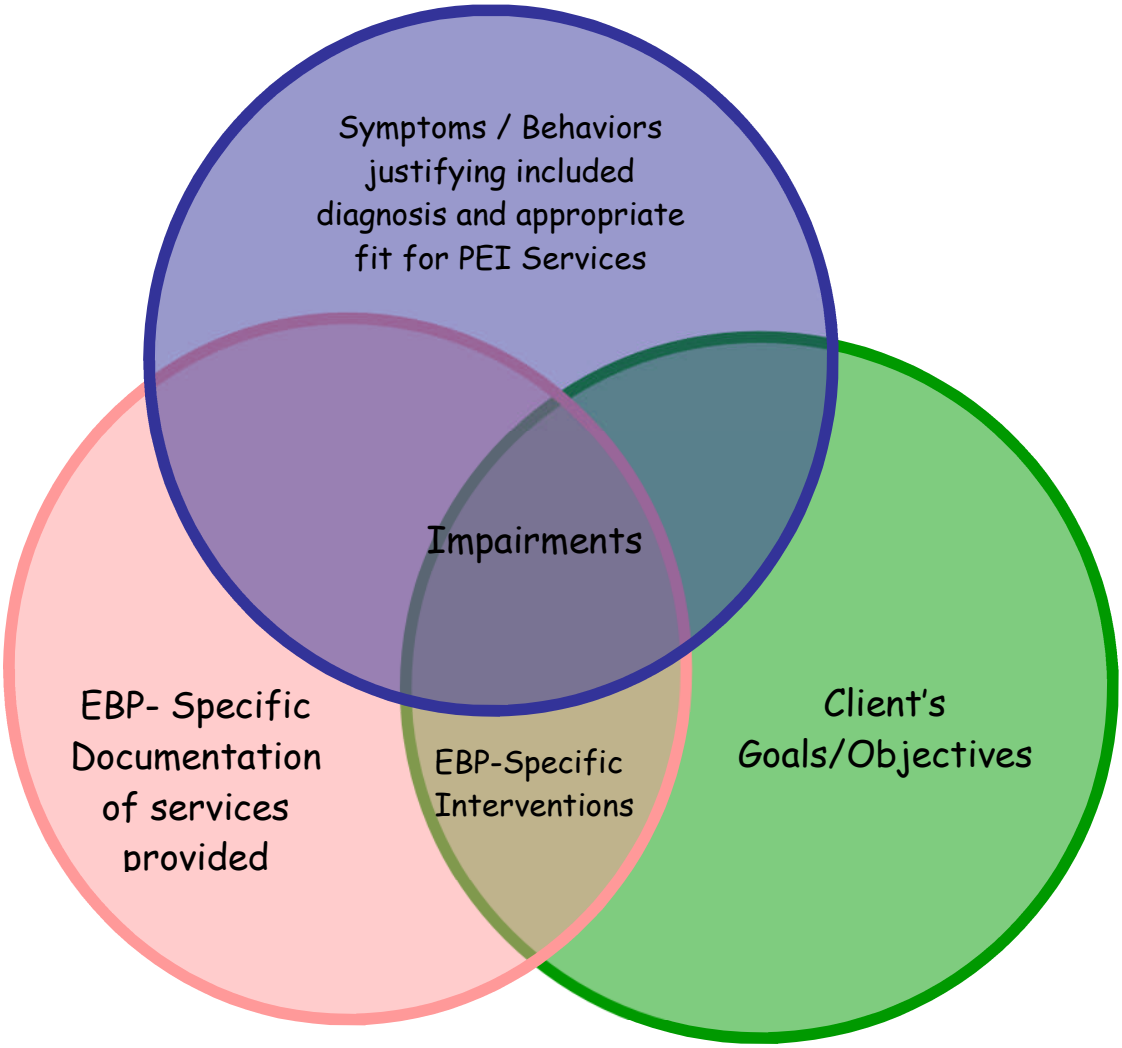
2. **Treatment Plan:** use the information from the Mental Health Assessment to collaborate with the client in formulating their treatment goals, which documents:
    a. Goals/Objectives linked to the identified Symptoms/Behaviors or Impairments and the EBP/PP/CDE being utilized.
    b. EBP-specific Interventions that will assist the client in achieving each goal/objective noted.

3. **Progress Note:** use the goals/objectives and interventions identified in the treatment plan to complete a progress note, which documents goal-based interventions provided to the client that reflect the use of the EBP.
    a. Interventions documented in the progress notes should include specific elements/components of the EBP/PP/CDE being utilized
    b. e.g. A progress note documenting the use of Seeking Safety may include the specific Seeking Safety topic discussed during the session; A progress note documenting TF-CBT may include the specific "PRACTICE" components addressed (i.e. psychoeducation, relaxation, etc.)

6. PEI CLINICAL LOOP

PEI CLINICAL LOOP

MENTAL HEALTH ASSESSMENT



PROGRESS NOTES **TREATMENT PLAN**

7. OVERVIEW OF DOCUMENTING AND CLAIMING MHSA PEI SERVICES

1. Complete an Initial Assessment.

    a. Determine if client meets medical necessity. If yes, what type of intervention (EBP) would be the most effective for the client?

    b. Determine if client meets PEI target population.

    c. Identify the appropriate EBP to address client's presenting needs/problem (staff must be trained in the model to provide 'core' services)

    d. Administer appropriate screening tool, symptom scale / initial outcome measures

2. Complete the Client Treatment Plan.

3. Maintain fidelity to EBP model by ensuring the majority of services provided to the client are 'core' interventions of the EBP in which the client is receiving services (see **Appendix A:** MHSA PEI Programs Guide to Core Interventions).

4. Complete Progress Note (document intervention, location of service, staff's time and procedure code)

5. Fill in Daily Service Log (required for Directly-Operated Providers), which is available on the DMH website and may be accessed through the following link: **http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/admin_forms**

6. Select the appropriate EBP/SS (e.g., Seeking Safety) from the drop-down menu.

7. Select the age-appropriate PEI IS Plan (based on client's age on date service was provided).

8. HOW TO GET HELP – WEBSITE LINKS

Documentation regulations and procedures for the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs shall adhere to the existing standards found in the *Short-Doyle/Medi-Cal Organizational Provider's Manual* (hereafter *Provider's Manual*).

References used in this document are from the **DMH – Organizational Provider's Manual and the Procedure Codes Manual.**

The full version of the *Organizational Provider's Manual* and the *Procedure Codes Manual* are available on the DMH website and may be accessed through the following link:
http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals

Providers may also refer to the Clinical Records Bulletins, the Quality Assurance Bulletins, and Documentation Trainings (PowerPoint presentations and online modules) which are available on the DMH website and may be accessed through either of the following links:

http://dmh.lacounty.gov/wps/portal/dmh/admin_tools

http://psbqi.dmh.lacounty.gov/QA_Div.html

For Service Strategies definitions, providers may refer to the following Client and Services Information (CSI) Training Supplement link/web address:
http://dmh.lacounty.gov/hipaa/downloads/EBP_and_Strategies_SDMH_CSI.pdf

A current PEI Frequently Asked Questions **(FAQs)** can be found on the PEI Website located at **http://dmh.lacounty.gov/wps/portal/dmh** under "About DMH" then click on "MHSA" and then click on "FAQs"

For clarification, staff may refer to their agency's Quality Assurance (QA) department. If further clarification is required, an agency may refer to their Service Area QA Liaison/QIC Chair(s) ***(Appendix B)***.

APPENDIX

APPENDIX A

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

Core Interventions are those services intrinsic to the delivery of expected outcomes for each of the PEI programs. To be eligible for PEI services the client must meet the PEI population as specified in Los Angeles County's PEI Plan. It is expected that EBP Core Interventions be delivered by staff trained in the EBP for which interventions are being provided. Services not core to the PEI program may be provided on a short-term basis to meet emergent client needs.

All service delivery must adhere to the Scope of Practice/Rendering Provider Guidelines in the most recent version of *A Guide to Procedure Codes for Claiming Mental Health Services* which is available on the County of Los Angeles Department of Mental Health website.

PEI Claiming Guidelines: Please select one PEI EBP and the procedure code which corresponds to the service claimed. Under these PEI Claiming Guidelines, 00 (no EBP) should not be selected when claiming to the PEI Plan.

PEI Program	Core Interventions	Procedure Codes
AF-CBT (Alternatives for Families: A Cognitive Behavioral Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy	90791 90887 90847 90853 H0046, 90832, 90834, 90837
ART (Aggression Replacement Training)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Group Rehabilitation Individual Psychotherapy (To "make up" a missed group session) Individual Rehabilitation Service (To "make up" a missed group session)	90791 90887 90853 H2015 H0046, 90832, 90834, 90837 H2015
BST (Brief Strategic Family Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Individual Rehabilitation Service Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 H2015 T1017
CAPPS (Center of Assessment and Prevention of Prodromal States)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Group Psychotherapy Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 90853 T1017
CBITS (Cognitive Behavioral Intervention for Trauma in Schools)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Individual Psychotherapy Individual Rehabilitation Service (For the purpose of administering the developer - specified For PTSD Screening Tool)	90791 90887 90853 H0046, 90832, 90834, 90837 H2015
CBT (Cognitive Behavioral Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 T1017
CFOF (Caring for Our Families)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Group Rehabilitation Individual Psychotherapy Individual Rehabilitation Targeted Case Management	90791 90887 90847 90853 H2015 H0046, 90832, 90834, 90837 H2015 T1017

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COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

PEI Program	Core Interventions	Procedure Codes
CORS (Crisis Oriented Recovery Services)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 T1017
CPP (Child Parent Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Crisis Intervention Family Psychotherapy (Joint parent-child) Individual Psychotherapy Individual Rehabilitation Service (Concrete assistance with activities of daily living) Targeted Case Management	90791 90887 H2011 90847 H0046, 90832, 90834, 90837 H2015 T1017
DBT (Dialectical Behavior Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Crisis Intervention Family Psychotherapy Group Psychotherapy Individual Psychotherapy Plan Development Targeted Case Management	90791 90887 H2011 90847 90853 H0046, 90832, 90834, 90837 H0032 T1017
DTQI (Depression Treatment Quality Improvement Intervention)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 T1017
FFT (Functional Family Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy	90791 90887 90847
FOCUS (Families Overcoming Under Stress)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Individual Rehabilitation Service Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 H2015 T1017
GLBTC (GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services)	Under Development	Under Development
Group Cognitive Behavioral Therapy of Major Depression	Assessment/Psychiatric Diagnostic Interview Group Psychotherapy Individual Psychotherapy (To "make up" a missed group session)	90791 90853 H0046, 90832, 90834, 90837
IPT (Interpersonal Psychotherapy for Depression)	Assessment/Psychiatric Diagnostic Interview Family Psychotherapy Individual Psychotherapy Individual Rehabilitation Service	90791 90847 H0046, 90832, 90834, 90837 H2015
IY (Incredible Years)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Group Rehabilitation	90791 90887 90853 H2015
LIFE (Loving Intervention Family Enrichment Program)	Assessment/Psychiatric Diagnostic Interview Collateral Group Psychotherapy Group Rehabilitation (Family and Non-Family) Multi-family Group Psychotherapy Plan Development	90791 90887 90853 H2015 (HE, HQ) 90849 H0032

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COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

PEI Program	Core Interventions	Procedure Codes
MAP (Managing & Adapting Practice)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Group Rehabilitation Services Individual Psychotherapy Individual Rehabilitation Services Multi-family Group Psychotherapy Plan Development Targeted Case Management	90791 90887 90847 90853 H2015 H0046, 90832, 90834, 90837 H2015 90849 H0032 T1017
MDFT (Multidimensional Family Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Individual Psychotherapy Plan Development Targeted Case Management	90791 90887 90847 H0046, 90832, 90834, 90837 H0032 T1017
MHIP (Mental Health Integrated Program)	Tier 2 Assessment/Psychiatric Diagnostic Interview Collateral Crisis Intervention Individual Psychotherapy Plan Development Targeted Case Management	 90791 90887 H2011 H0046, 90832, 90834, 90837 H0032 T1017
	Community Partners (CP's) Only CP's providing HWLA collaborative health/mental services	 H2016
MPG (Mindful Parenting Groups)	Assessment/Psychiatric Diagnostic Interview Multi-family Group Psychotherapy	90791 90849
MST (Multisystemic Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Targeted Case Management	90791 90887 90847 T1017
PATHS (Promoting Alternative Thinking Strategies)	Assessment/Psychiatric Diagnostic Interview Group Psychotherapy Group Rehabilitation Plan Development Targeted Case Management	90791 90853 H2015 H0032 T1017
PCIT (Parent-Child Interaction Therapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy	90791 90887 90847
PE (Prolonged Exposure Therapy for Posttraumatic Stress Disorder)	Assessment/Psychiatric Diagnostic Interview Individual Psychotherapy Individual Rehabilitation Services	90791 H0046, 90832, 90834, 90837 H2015
PEARLS (Program to Encourage Active, Rewarding Lives for Seniors)	Assessment/Psychiatric Diagnostic Interview Individual Psychotherapy Individual Rehabilitation Services Plan Development Targeted Case Management	90791 H0046, 90832, 90834, 90837 H2015 H0032 T1017
PST (Problem Solving Treatment)	Assessment/Psychiatric Diagnostic Interview Individual Psychotherapy Individual Rehabilitation Services Plan Development Targeted Case Management	90791 H0046, 90832, 90834, 90837 H2015 H0032 T1017
Reflective Parenting Program	Assessment/Psychiatric Diagnostic Interview Collateral Multi-family Group Psychotherapy	90791 90887 90849
Seeking Safety	Assessment/Psychiatric Diagnostic Interview Family Psychotherapy Group Psychotherapy Group Rehabilitation Services Individual Psychotherapy Individual Rehabilitation Service	90791 90847 90853 H2015 H0046, 90832, 90834, 90837 H2015

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COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MHSA PEI PROGRAMS GUIDE TO CORE INTERVENTIONS

PEI Program	Core Interventions	Procedure Codes
SFP (Strengthening Families Program)	Assessment/Psychiatric Diagnostic Interview Collateral Group Rehabilitation Group Psychotherapy Multi-family Group Psychotherapy	90791 90887 H2015 90853 90849
TF-CBT (Trauma Focused Cognitive Behavioral Psychotherapy)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy (Referred to as conjoint in TF-CBT model) Individual Psychotherapy	90791 90887 90847 H0046, 90832, 90834, 90837
Triple P Level 4 Standard/Standard Teen (Positive Parenting Program)	Assessment/Psychiatric Diagnostic Interview Collateral	90791 90887
Triple P Level 4 Group (Group Positive Parenting Program)	Assessment/Psychiatric Diagnostic Interview Collateral - Individual or Group (Per Facilitator's Manual for Group Triple P) Multi-family Group Psychotherapy (For group of parents) (This service can only be claimed by staff trained in Level 4 Group Triple P)	90791 90887 90849
Triple P Level 5 Pathways	Assessment/Psychiatric Diagnostic Interview Collateral (For individul or group of parents) Multi-family Group Psychotherapy (For group of parents)	90791 90887 90849
Triple P Level 5 Enhanced	Assessment/Psychiatric Diagnostic Interview Collateral	90791 90887
UCLA TTM (UCLA Ties Transition Model)	Assessment/Psychiatric Diagnostic Interview Collateral Family Psychotherapy Group Psychotherapy Individual Psychotherapy Multi-family Group Psychotherapy Plan Development Targeted Case Management	90791 90887 90847 90853 H0046, 90832, 90834, 90837 90849 H0032 T1017

*** Psychological Testing has not historically been approved for PEI services. If an agency has an exceptional justification for providing this service, it will need to be brought to the attention of the Service Area/Lead District Chief and Program Deputy.**

This Guide, prepared by DMH, lists and defines the compliant codes that the DMH believes reflects the services it provides throughout its system, whether by directly-operated or contracted organizational providers or individual, group, or organizational network providers. This analysis does not, however, absolve Providers, whether individuals or agencies from their responsibility to be familiar with nationally compliant codes and to inform and dialogue with the DMH should they believe differences exist.

APPENDIX A

Quality Assurance Contacts by Service Area

*Please first contact the QA Liaison. If the QA Liaison is unavailable, you may contact the QA Lead.

SERVICE AREA		CONTACT INFORMATION
1	*QA Liaison*	Debra Berzon-Leitelt (661) 223-3800, DBerzonleitelt@dmh.lacounty.gov
	QIC Co-Chair	Barbara Paradise (661) 341-3900 x102, Barbara.paradise@pathways.com
	QA Lead	Allen Pouravanes (213) 251-6746, APouravanes@dmh.lacounty.gov
2	*QA Liaisons*	Kimber Salvaggio (Adults) (818) 610-6722, KSalvaggio@dmh.lacounty.gov Michelle Rittel (Children) (213) 739-5526, MRittel@dmh.lacounty.gov
	QIC Co-Chairs (Adult) *(Children)*	N/A Angela Kahn (818) 901-4830 akahn@sfvcmhc.org Alex Medina (818) 739-5611, amedina@childguidance.org
	QA Lead	Allen Pouravanes (213) 251-6746, APouravanes@dmh.lacounty.gov
3	*QA Liaison*	Bertrand Levesque (213) 739-5438, BLevesque@dmh.lacounty.gov
	QIC Co-Chairs	Gassia Ekizian (626) 993-3000 x3047, GEkizian@foothillfamily.org Margaret Faye (626) 395-7100 x2042, margaretfaye@hathaway-sycamores.org
	QA Lead	Robin Washington (213)251-6734, RWashington@dmh.lacounty.gov
4	*QA Liaison*	Kary To (213) 738-3504, KTo@dmh.lacounty.gov
	QIC Co-Chair	Lisa Harvey (213) 623-8446, Lharvey@paralosninos.org
	QA Lead	Allen Pouravanes (213) 251-6746, APouravanes@dmh.lacounty.gov
5	*QA Liaison*	Monika Johnson (310) 482-6609, MoJohnson@dmh.lacounty.gov
	QIC Co-Chair	David Tavlin (310) 985-5250, david.t@stepuponsecond.org
	QA Lead	Robin Washington (213)251-6734, RWashington@dmh.lacounty.gov
6	*QA Liaison*	Aprill Baker (323) 290-5826, AMBaker@dmh.lacounty.gov
	QIC Co-Chair	N/A
	QA Lead	Lori Arnold (213) 251-6848, LDobbs@dmh.lacounty.gov

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Quality Assurance Contacts by Service Area

7	*QA Liaison*	Antonio Banuelos (323) 267-3411, AnBanuelos@dmh.lacounty.gov
	QIC Co-Chair	Caesar Moreno (562) 692-0383 x236 Cmoreno@thewholechild.info
	QIC Co-Chair	Kari Thompson (562)865-364x101, kari.thompson@pathways.com
	QA Lead	Robin Washington (213)251-6734, RWashington@dmh.lacounty.gov
8	*QA Liaisons*	Ann Lee (562) 435-3027, ALee@dmh.lacounty.gov Aelyen Yoon (Harbor/UCLA) (310) 519-6210, AYoon@dmh.lacounty.gov
	QIC Co-Chairs	Michele Munde (310) 221-6336 x114, mmunde@starsinc.com Emily Ramos (562) 599-9280, eramos@dmh.lacounty.gov Misty Aronoff (323)526-4016x213, mistya@almafamilyservices.org
	QA Lead	Lori Arnold (213) 251-6848, LDobbs@dmh.lacounty.gov
Countywide Children's	*QA Liaison*	Debra Mahoney (213) 739-5592, DMahoney@dmh.lacounty.gov
	QIC Co-Chair	Lisa Harvey (213) 623-8446, Lharvey@paralosninos.org
	QA Lead	Lori Arnold (213) 251-6848, LDobbs@dmh.lacounty.gov
Juvenile Justice	*QA Liaison*	Gail Blesi (213) 351-5220, GBlesi@dmh.lacounty.gov
	QIC Co-Chair	N/A
	QA Lead	Robin Washington (213) 251-6734, RWashington@dmh.lacounty.gov
Transition-Age Youth	*QA Liaison*	Natasha Billups (213) 738-2680, NBillups@dmh.lacounty.gov
	QIC Co-Chair	N/A
	QA Lead	Robin Washington (213) 251-6734, RWashington@dmh.lacounty.gov
DHS/DMH Co-located Program	*QA Liaison*	Crystal Cianfrini (213) 639-6306, CCianfriniPerry@dmh.lacounty.gov
	QIC Co-Chair	N/A
	QA Lead	Allen Pouravanes (213) 251-6746, APouravanes@dmh.lacounty.gov
Tele-Mental Health	*QA Liaison*	Diana Radakovic 310) 781-3431 , DRadakovic@dmh.lacounty.gov
	QA Lead	Lori Arnold (213) 251-6848, LDobbs@dmh.lacounty.gov

Section 5

PEI Evidence-Based Practices

5.1 Selection of Practices for the PEI Plan

The State PEI guidelines issued in 2007 and 2008 strongly emphasized the use of evidence-based practices for PEI services. As a consequence, DMH conducted research into which EBPs were most suitable for PEI services in Los Angeles County, taking into consideration, highly urban, mobile, and very diverse communities. A menu of PEI appropriate EBP/PP/CDE practices were identified and published in the Evidence-based Practices, Promising Practices, and Community-Defined Evidence Practices Resource Guide. This guide was designed to inform the deliberations of the Los Angeles County Service Area PEI Steering Committees, as well as the Countywide Populations Steering Committee, as they identified priorities to be addressed in the County MHSA PEI Plan. The guide also contained information to help in the development of the plan once the priorities have been identified. A copy of the Resource Guide is posted on the DMH PEI website at http://file.lacounty.gov/dmh/cms1_159575.pdf.

Stakeholders participating in the PEI Service Area Ad Hoc Planning Committees were asked to select from the menu of practices that were most suitable for the populations in their service areas. The ensuing list of selected practices were then included in the PEI Plan. In fact, all the EBP/PP/CDEs in the PEI Plan were the result of service area selections. The County PEI Plan approved by the State mandated the utilization of the specific EBP/PP/CDEs for all services, with the exception of one pilot program. This emphasis on EBPs/PPs/CDEs included both prevention only and early intervention services.

DMH staff have been designated as PEI Practice Leads for each of the EBP/PP/CDE practices being implemented by PEI Providers. The Practice Leads often have direct contact with the developer and trainers and can assist providers with their implementation concerns. See Section 10 for the list of the PEI Practice Leads.

5.2 Implementation of Authorized PEI EBPs

To enable the fast-paced transformation of the PEI Plan in 2010, DMH contracted with several EBP developers and trainers to provide massive training for clinicians and other program staff. Initially, the training focused on EBPs in the PEI Plan. DMH was able to schedule training in Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Child-Parent Psychotherapy (CPP), Managing and Adapting Practice (MAP), Trauma Focused CBT (TF-CBT), Seeking Safety (SS) and Positive Parenting Program (Triple P). In addition to being able to receive the required training and begin to provide these services, agencies had the option to implement other practices in the PEI Resource Guide that had not previously been in the 2009 PEI Plan. Agencies are responsbile for paying the cost of training for any practices selected that do not offer DMH sponsored training.

As of January 1, 2016, DMH has approved the implementation of 33 practices. Utilization of other practices in the PEI Resource Guide is not allowed without the prior approval of DMH and authorization for billing. Only those EBPs listed in the Information System/ Integrated Behavioral Health Information System (IS/IBHIS) can be billed to the PEI Plan:

1. Aggression Replacement Training (ART)
2. Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)
3. Brief Strategic Family Therapy (BSFT)
4. Caring for Our Families (CFOF)
5. Center for Assessment and Prevention of Prodromal States (CAPPS)
6. Child-Parent Psychotherapy (CPP)
7. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
8. Crisis Oriented Recovery Services (CORS)
9. Depression Treatment Quality Improvement (DTQI)
10. Dialectical Behavior Therapy (DBT) (authorized for DO Clinics only)
11. Families Over Coming Under Stress (FOCUS)
12. Functional Family Therapy (FFT)
13. Group Cognitive Behavioral Therapy for Major Depression (Group CBT)
14. Incredible Years (IY)
15. Individual Cognitive Behavioral Therapy (Ind. CBT)
16. Interpersonal Psychotherapy for Depression (IPT)
17. Loving Intervention Family Enrichment Program (LIFE)
18. Managing and Adapting Practice (MAP)
19. Mental Health Integration Program (MHIP) – *formerly known as IMPACT*
20. Mindful Parenting Groups (MP)
21. Multidimensional Family Therapy (MDFT)
22. Multisystemic Therapy (MST)
23. Parent-Child Interaction Therapy (PCIT)
24. Problem Solving Therapy (PST)
25. Program to Encourage Active Rewarding Lives for Seniors (PEARLS)
26. Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD) (authorized for DO Clinics only)
27. Providing Alternative Thinking Strategies (PATHS)
28. Reflective Parenting Program (RPP)

29. Seeking Safety (SS)
30. Strengthening Families Program (SFP)
31. Trauma Focused CBT (TF-CBT)
32. Triple P Positive Parenting Program (Triple P)
33. UCLA Ties Transition Model (UCLA TTM)

5.3 EBP Matrix

Information about each practice is presented in the EBP Matrix at the end of this Section 5. Additional information may be obtained at the training sessions as well as by contacting the DMH assigned PEI Practice Lead for each individual EBP/PP/CDE. The EBP Matrix presents information on the following items:

- Program Name: The full name and acronym of the practice; the individual EBP codes for billing are listed for each practice.
- Description: A brief description of the purpose, approach, and key components of the practice
- Age Groups Service (Age Limits): Not only are the MHSA age categories (Young Child, Children, TAY, Adult, Older and Older Adult) listed, but very specific age limits are listed. Services should not be provided to anyone outside the identified age limits.
- Rendering Provider Minimum Requirements: Minimum staff needed for a team, as well as clinical and non-clinical staff training and licenses required in order to provide core services are listed.
- Duration of Program (Estimated Frequency and Length of Treatment): The estimated frequency per week, length of session in number of minutes or hours, and treatment length by number of weeks or months are given.
- Modality: The type of modality such as individual, group, conjoint parent-child, etc. are listed.
- Clinical Measures/Tools: Each EBP requires the administration of 2 outcome measures: a general one and another one specific to the focus of the treatment. The type of Youth Outcome Questionnaire (YOQ) or Outcome Questionnaire (OQ) required for each age group as well as the specific outcome measure for the EBP are named.

5.4 EBP Model Fidelity Guidelines

EBP model fidelity assesses a provider's fidelity to the specific EBP and the PEI mandated guidelines. Specifically, DMH will look at training, program design, outcomes, population served, and the quality of services. We look at the role and qualifications of staff when training is assessed. Part of this process is to determine whether staff has completed training, staff trained versus those providing the service, recommended or required supervision, and supervisor participation in training.

Program design includes adherence to the EBP program modality and procedures and treatment goals (Do progress notes fit EBP?). Part of program design is to look at the length of treatment, number of sessions, age group served, cost per client, core vs. non-core ratio, percent of medication support, treatment modality (group vs. individual), manualized treatment – not being modified (accommodating re: language, which affects model), treatment alignment with goal, and adaptations/innovations.

Outcomes include the effectiveness of the EBP and that program components are delivered as prescribed. In the outcomes component we also look at whether the outcome supports the practice. Specifically, we look at compliance rate, completion rate, drop-out rate, and outcomes collected vs. unable to collect.

As we look at population served, we look at whether the participant matches to the PEI guidelines, such the diagnoses, concurrent and/or sequential enrollments, appropriate age group served, and treatment episode, treatment cycle (re-evaluation if another EBP is needed, what is the agency's recheck and discovery process?), assessment, triage process (how agency places clients in EBPs).

For the quality of service, we look at whether program delivery is in line with EBP guidelines and whether the required elements are captured. In quality of service, we look at attendance at booster trainings and learning networks, supervision (model drift), agency monitoring, client satisfaction (how does agency determine client satisfaction?), supervisors trained in EBPs they are supervising, caseload (clinicians and supervisors), anything that is done above the model requirements, supervision role and doing adherence rating, use of adherence scales, supervision offered (i.e. EBP specific), and the maximum number of EBPs trained for clinicians and supervisors.

Providers should not make any adaptions or changes to the model unless the adaption or change has been approved by the developer of the EBPs, CDEs, PPs and by DMH.

EBP FIDELITY MONITORING CHECKLIST

- ☑ Program Design
  - ○ Appropriate Diagnosis for Practice
  - ○ Billing 75% Core vs. Non-Core (Ancillary Services)
  - ○ Client Cost for Services in line with PEI and EBP Guidelines
- ☑ Target Population
  - ○ Appropriate Age Group Served
  - ○ Client appropriate for EBP
- ☑ Staff Trained In EBP
- ☑ Outcome Measures
  - ○ Outcome Measures Administered & Utilized

5.5 Adding and Dropping EBPs

Providers interested in adding a practice not previously offered by their agency, or dropping a practice currently on their menu of EBPs must submit the Provider Request to Add/Drop PEI Practice form. This also includes scenarios in which a provider would like to update information in the Provider PEI Practice List. DMH monitors the EBPs being claimed by agencies, and at the site visits or other reviews, will question why an agency is billing to a practice that has not been approved by DMH. Note that clinicians must be trained in the practice and have completed the initial training before the approval to add the practice is given. The steps to adding a practice are as follows:

1. Agency must obtain the approval of their Lead District Chief to add a PEI practice. Among the factors taken into consideration by the District Chief before giving approval are the range of services offered in the Service Area, whether the proposed EBP is compatible with the target poplation the agency serves, and the financial and programmatic capabilities of the agency.

2. Staff that will be billing to the practice must be trained (begin the initial minimum training required) prior to submitting the Provider Request Add/Drop form. The PEI Administration Division will not approve adding the EBP without verification that staff has completed the required initial training.

3. Agency must provide a plan that indicates how and when staff will complette the entire required training protocol.

4. Agency must submit the Provider Request to Add/Drop PEI Practice and Attachment forms to PEI Administration Division. The Attachment must be filled out for every practice that the agency is requesting to add. There must be ONE attachment per practice for each Provider Number stated in the Provider Request to Add/Drop form.

5. Agency can only begin billing to the requested EBP once approval is received from PEI Administration Division. Agencies that bill to an EBP not authorized for their agency may be notified to stop billing.

In addition to completing the Provider Request to Add/Drop PEI Practice form, providers must complete the Attachment to the PEI Add/Drop Form: Trained Clinicians. This attachment must be filled out for every practice that the agency is requesting to add. There must be ONE attachment per practice for each Provider Number stated in the Provider Request to Add/Drop form. PEI Administration Division will officially approve the new practice after verifying the information on the attachment. PEI Administration Division must approve the adding or dropping of a practice prior to the provider taking any additional action, including the implementation of a new EBP, PP, and CDE.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Provider Request to Add/Drop PEI Practice

Agency: Click here to enter agency name.

LE Number Click here. Provider Number(s): Click here to enter PN(s).

Contact Name: Click here to enter contact person regarding this form.

Phone Number: Click here. E-mail: Click here to enter e-mail.

Providers requesting to add or drop a Practice must complete this add/drop form (including cases of updating information in the Provider PEI Practice List).

INSTRUCTIONS:

1. Fill out the table below by selecting the Practice and the requested action from the drop-down lists. For Practices to be added, mark the check boxes for the age group(s) to be served, and if outcome measure and/or outcome measure trainings are needed.
2. Complete the Add/Drop form Attachment to identify the clinicians who were trained or currently in-training for the Practice to be added. There must be one Attachment for every Practice to be added for every Provider Number listed above.
3. All completed forms and attachments must be forwarded to the lead District Chief for approval and signature. The District Chief's analyst (staff) will e-mail the approved documents to PEI Administration at mhsapei@dmh.lacounty.gov.

PEI Practice	Action	Age Group to be Served	Outcome Measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure

*DBT and PE-PTSD are currently applicable to DMH directly-operated clinics only.

Approve the Request: ☐ Yes ☐ No

Lead District Chief: Click here to enter district chief.

Signature: ______________________ Date: ______________

Email mhsapei@dmh.lacounty.gov for any questions or if you find trouble completing this form. Version 03/2015

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PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Trained Clinicians

Agency:	Click here to enter agency name.
Provider Number:	Click here to enter PN.
PEI Practice to Add:	Click here to select a Practice.

This attachment must be filled out for every Practice that the agency is requesting to add, there must be ONE Attachment per Practice for each Provider Number stated in the Add/Drop form. *PEI Administration will officially approve the new Practice after verifying the information on this Attachment.*

INSTRUCTIONS:

Table 1 – Clinicians who are currently attending a training

1. Enter the name of the Trainer, and the training start and end dates. If the end date is still undetermined due to the different training protocols, enter the estimated completion date and click the appropriate box.
2. List all clinicians that are currently in the process of completing their training, with their corresponding Rendering Provider Numbers (RPN) and NPI Numbers. Add as many rows as needed. If there is more than one training going on, please email mhsapei@dmh.lacounty.gov to request the appropriate form.

Table 2 – Clinicians who already completed their training protocol

3. List all clinicians who successfully completed the training protocol with their corresponding RPN and NPI Numbers. Enter Yes or No in the last column to state whether the clinicians completed their trainings while in your agency. Add as many rows as needed.

For Tables 1 and 2, list only clinicians that are going to provide this Practice in this Provider Number.

By completing this Attachment, your agency certifies that the listed clinicians are currently in training and/or have completed the entire training protocol to provide and claim for the Practice being added. Clinicians who have not completed the entire training protocol within the specified time will be required to stop providing and claiming under this Practice.
This Attachment is not meant to replace the EBP Training verification form that is submitted every six months for updates on new trainings and/or to report newly hired trained staff.

Table 1 – Clinicians currently in-training

Trainer:	Click here to enter trainer name.
Training Location:	Click here to enter location(s) of training.
Training Start Date:	Click here to select a date.
Training End Date:	Click here to select a date. Is this an estimated date only? ☐Yes ☐No

Last Name	First Name	Rendering Provider Number	NPI Number

Email mhsapei@dmh.lacounty.gov for any questions or if you find trouble completing this form.
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COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Trained Clinicians

Table 2 – Clinicians who completed the entire training protocol

Last Name	First Name	Rendering Provider Number	NPI Number	Did the clinician complete the training protocol while employed at your agency? (Yes or No)

Email mhsapei@dmh.lacounty.gov for any questions or if you find trouble completing this form.
Version 03/2015

PEI EBP Matrix
(updated as of August 2015)

	Program Name	Description	Age Groups Served (Age Limits)	Rendering Provider Minimum Requirements	Duration of Program (Estimated Frequency and Length Of Treatment)	Modality	Clinical Measures/Tools
1	**Aggression Replacement Training (ART)** **EBP Code: 4A**	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	Children (5-12) – Skillstreaming Only Children (12-15) TAY (16-17)	▪ Non-Clinicians - Bachelor's level or higher and in accordance with scope of practice ▪ Clinicians - Master's level or higher (Licensed, Registered, Waivered)	Frequency: for Skillstreaming Only – 1x per week Frequency: 3x per week (1 group in each component per week) Session Length: 60 minutes Treatment Length: 10 weeks	Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)] *Developer Required* Skillstreaming Checklist Aggression Questionnaire How I Think Questionnaire Satisfaction Questionnaire
2	**Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)** **EBP Code: 4B**	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	Children (5-15) TAY (16-17)	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT)	Frequency: 1x or 2x a week Session Length: 60 to 90 minutes Treatment Length: 4 to 8 months	Individual Group Conjoint: Parent-Child Family	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) UCLA PTSD-RI for Children and Adolescents–Parent (Child, 3-18) UCLA PTSD-RI for Children and Adolescents–Child/Adolescent (Child, 6-20)
3	**Brief Strategic Family Therapy (BSFT)** **EBP Code: 2A**	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.	Children (10-15) TAY (16-18)	▪ Counselors - Master's Level or higher, or Bachelor's Level with extensive clinical experience	Frequency: 1x per week, or more frequent if the client is in a state of crisis Session Length: 1 to 1 ½ hours Treatment Length: 5 to 24 weeks	Individual, family, peer (including peer resistance education)	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) RBPC-Parent (Child, 5-18) RBPC-Teacher [if parent is unavailable (Child, 5-18)]
4	**Caring for Our Families (CFOF)** **EBP Code: 3B**	Adapted from the "Family Connections" model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	Children (5-11)	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT)	Frequency: 1x per week Session Length: 60 minutes Treatment Length: 6 months	Individual Group Conjoint: Parent-Child	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16)] SESBI-R [if parent is unavailable (Child, 2-16)]
5	**Center for the Assessment and Prevention of Prodromal States (CAPPS)** **EBP Code: 8C**	CAPPS is a family focused treatment program targeting TAY and their families at high risk for developing psychosis or in danger of experiencing their 1st psychotic break (i.e. prodromal phase). Treatment includes psycho-education, skill building, and problem solving.	TAY (16-25)	▪ Minimum staffing of three: ▪ 2 Clinicians – Master's level or higher (Licensed, Registered, Waivered); ▪ 1 Licensed Supervisor with required training	Frequency: 1x per week Session Length: 60 to 120 minutes Treatment Length: 18 sessions on average	Family	YOQ-2.0 SR (16-17) YOQ-2.01 Parent (16-17) OQ (19+) SIPS Developer Required: PQ-R
6	**Child-Parent Psychotherapy (CPP)** **EBP Code: 2B**	CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.	Young Children (0-6)	▪ 2 Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) ▪ 1 Licensed Supervisor	Frequency: 1x per week Session Length: 60 to 90 minutes Treatment Length: 50 weeks	Conjoint: Parent-Child	YOQ-2.01 Parent (Child, 4-17) TSCYC (Child, 3-6)
7	**Cognitive Behavioral Intervention for Trauma in School (CBITS)** **EBP Code: 2C**	CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff, as part of multi-disciplinary treatment teams. CBITS intends to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure.	Children (10-15)	▪ 2 Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT)	Frequency: 1x per week Session Length: 60 minutes Treatment Length: 10 weeks Plus two - 60 min collateral	Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) UCLA PTSD-RI for Children and Adolescents–Parent (Child, 3-18) UCLA PTSD-RI for Children and Adolescents–Child/Adolescent (Child, 6-20)

PEI EBP Matrix
(updated as of August 2015)

	Program Name	Description	Age Groups Served (Age Limits)	Rendering Provider Minimum Requirements	Duration of Program (Estimated Frequency and Length Of Treatment)	Modality	Clinical Measures/Tools
8	**Crisis Oriented Recovery Services (CORS)** **EBP Code: 4D**	CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.	Children (3-15) TAY (16-25) Adults (26-59) Older Adults (60+)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD/PsyD, LCSW, MFT, MD, DO, RN) and required training ▪ Licensed Supervisor	Frequency: 1x per week Session Length: 60 to 90 minutes Treatment Length: up to 6 consecutive weeks	Individual	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) OQ (19+)
9	**Depression Treatment Quality Improvement (DTQI)** **EBP Code: 2F**	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.	Children (12-15) TAY (16-20)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) and required training ▪ Licensed Supervisor	Frequency: Individual Therapy 1x per week; Group 1x per week Session Length: 60 minutes Treatment Length: 12 to 16 sessions	Individual Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) OQ (19+) PHQ-9 (12+)
10	**Dialectical Behavior Therapy (DBT)** **EBP Code: 8B** *currently available for DMH directly-operated clinics only*	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.	TAY (18-25) Adults (26-59) Older Adults (60+) *currently available for DMH directly-operated clinics only*	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD/PsyD, LCSW, MFT, MD, DO, RN) and required training ▪ Licensed Supervisor and required training	Frequency: Individual Therapy 1x to 2x per week; Group Skills Training 1x per week Session Length: Individual 45 to 90 minutes; Group 90 to 120 minutes Treatment Length: up to 1 year	Individual Skills Group Therapy	YOQ-2.0 SR (Child, 12-18) OQ (19+) DERS (18+)
11	**Families Over Coming Under Stress (FOCUS)** **EBP Code: 4R**	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole, with hopes of building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.	Couples Families Children (5-15) TAY 16-25) Adults (26-59) Older Adults (60+)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD/PsyD, LCSW, MFT, MD, DO, RN) and required training ▪ At least 1 Licensed Supervisor	Frequency: 1x per week Session Length: 60 to 120 minutes Treatment Length: 8 to 10 weeks	Couple or Family	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) OQ (19+) McMaster FAD (12+)
12	**Functional Family Therapy (FFT)** **EBP Code: 11**	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.	Children (10-15) TAY (16-18)	▪ Clinicians - Master's level or higher (Licensed, Registered, Waivered)	Frequency: 1x per week (First 3 sessions in the first 10 days) Session Length: 60 to 120 minutes Treatment Length: 8 to 30 sessions (depending on severity)	Family	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) *Developer Required* Clinical Services System: Counseling Process Questionnaire Client Outcome Measure Therapist Outcome Measure YOQ/YOQ-SR
13	**Group Cognitive Behavioral Therapy for Major Depression (Group CBT)** **EBP Code: 2J**	Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.	TAY (18-25) Adults (26-59) Older Adults (60+)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD/PsyD, LCSW, MFT, MD, DO, RN) and required training ▪ Licensed Supervisor and required training	Frequency: 1x per week Session Length: 90 to 120 minutes Treatment Length: 12 to 16 weeks	Group	YOQ-2.0 SR (Child, 12-18) OQ (19+) PHQ-9 (18+)
14	**Incredible Years (IY)** **EBP Code: 2L**	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.	Children (0-12)	▪ Bachelor's level or higher	Frequency: 1x per week Session Length: 2 hours for basic parent group Treatment Length: 12 to 14 sessions Dina School: 1x per week, 2 hours in length, 20 to 22 weeks (offered in conjunction with weekly parent group sessions)	Individual Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]

PEI EBP Matrix
(updated as of August 2015)

	Program Name	Description	Age Groups Served (Age Limits)	Rendering Provider Minimum Requirements	Duration of Program (Estimated Frequency and Length Of Treatment)	Modality	Clinical Measures/Tools
15	**Individual Cognitive Behavioral Therapy (Ind. CBT)** **EBP Code: 8A**	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.	TAY (16-25) Adults (26-59) Older Adults (60+)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD/PsyD, LCSW, MFT, MD, DO, RN) and required training ▪ Licensed Supervisor and required training	Frequency: 1x per week Session Length: 45 to 50 minutes Treatment Length: 18 to 52 sessions	Individual	YOQ-2.0 SR (12-18) OQ (19+) *Trauma:* UCLA PTSD-RI for Children and Adolescents–Child/Adolescent (Child, 6-20) UCLA PTSD-RI Adult Short Form (21+) *Anxiety:* GAD-7 (18+) *Depression:* PHQ-9 (18+)
16	**Interpersonal Psychotherapy for Depression (IPT)** **EBP Code: 2M**	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.	Children (12-15) TAY (16-25) Adults (26-59) Older Adults (60+)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD/PsyD, LCSW, MFT) and required training	Frequency: 1x per week Session Length: 60 minutes Treatment Length: 8 to 20 sessions, with the intention of tapering off sessions as clinician moves closer to the 20th session	Individual	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) OQ (19+) PHQ-9 (12+)
17	**Loving Intervention Family Enrichment Program (LIFE)** **EBP Code: 3E**	An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	Children (4-15) TAY (16-19) criteria for TAY-aged clients is client should be living in the home	▪ Clinicians - Bachelor's and Master's level Occupational Therapists (Licensed Registered, Waivered, PhD, PsyD) and masters level LCSW and MFT	Frequency:1x per week Session Length: 2 to 3 hours Treatment Length: 22 weeks	Group Conjoint: Parent-Child	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]
18	**Managing and Adapting Practice (MAP)** **EBP Code: 4K**	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.	Children (0-15) TAY (16-21) Disruptive Behavior: 0-21 Depression and Withdrawal: 8-21 Anxiety and Avoidance: 2-19 Traumatic Stress: 2-18	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) ▪ Required training for Clinicians and Supervisors (to train new staff)	Treatment Length Max: ~12 months	Individual	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) OQ (19+) *Disruptive Behavior:* ECBI-Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)] *Depression and Withdrawal:* PHQ-9 (12+) *Anxiety and Avoidance:* RCADS-Parent (Child, 6-18) RCADS-Child (6-18) *Trauma:* UCLA PTSD-RI for Children and Adolescents–Parent (Child, 3-18) UCLA PTSD-RI for Children and Adolescents–Child/Adolescent (Child, 6-20)
19	**Mental Health Integration Program (MHIP) – *formerly known as IMPACT*** **EBP Code: 2K**	MHIP delivers specialty mental health services to Tier 2 PEI participants with mild to moderate mental health symptoms that are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse of symptoms.	TAY (18-25) Adults (26-59) Older Adults (60+)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT, MD, DO, RN) and required training	Frequency: 1x per week Session Length: 60 minutes initial, 30-45 minutes thereafter Recommended Treatment Length: 6-12 sessions	Individual	*Trauma:* PCL-C (18+) *Depression:* PHQ-9 (18+) *Anxiety:* GAD-7 (18+)

PEI EBP Matrix
(updated as of August 2015)

	Program Name	Description	Age Groups Served (Age Limits)	Rendering Provider Minimum Requirements	Duration of Program (Estimated Frequency and Length Of Treatment)	Modality	Clinical Measures/Tools
20	**Mindful Parenting Groups (MP)** **EBP Code: 3P**	MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.	Young Children (birth to 3)	▪ Clinicians - Masters level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) with infant/early childhood experience and required training ▪ 2 co-facilitators per group ▪ Licensed Supervisor	Frequency: 1x per week Session Length: 90 minutes Treatment Length: 12 sessions	Group	DECA-I/T (1month - 36months)
21	**Multidimensional Family Therapy (MDFT)** **EBP Code: 2P**	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.	Children (12-15) TAY (16-18)	Each MDFT Team: ▪ 2-3 Clinicians – Master's level or higher (Licensed, Registered, Waivered) ▪ 1 Non-Clinician - Bachelor's level or higher and in accordance with scope of practice	Frequency: 3 to 5x per week Session Length: 60 to 90 minutes Treatment Length: 12 to 24 weeks	Family	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) RBPC Parent (Child, 5-18) RBPC Teacher [if parent is unavailable (Child, 5-18)]
22	**Multisystemic Therapy (MST)** **EBP Code: 10**	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).	Children (12-15) TAY (16-17)	Each MST Team consists of 2-4 Clinicians and a Supervisor: ▪ Clinicians - Master's level or higher (Licensed, Registered, Waivered) ▪ Non-Licensed - Bachelor's level or higher and in accordance with scope of practice	Frequency: 1+x per week Session Length: 60+ minutes Treatment Length: 16 to 24 weeks	Family	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) *Developer Required* Therapist Outcome Measure Supervisor Adherence Measure
23	**Parent-Child Interaction Therapy (PCIT)** **EBP Code: 2R**	PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	Young Children (2-7)	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) and required training and on-going supervision ▪ Licensed Supervisor	Frequency: 1x per week, plus homework Session Length: 60 minutes Treatment Length: on average 16 to 24 sessions	Conjoint Parent/care giver and Parent/care giver with Child	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]
24	**Problem Solving Therapy (PST)** **EBP Code: 4S** *Older adult providers only*	PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	Older Adults (60+) *Older adult providers only*	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT, RN) ▪ Licensed Clinical Supervisor Training protocol: Clinicians certified in IMPACT/MHIP, PST-PC, or trained in PEARLS, or PST are qualified to implement this intervention model	Frequency: 1x per week; should be guided by the urgency of the situation and the capacity of the client to have sufficient time and opportunity to implement each step of PST. Session Length: 60 minutes; and should probably be guided by the client's capacity to actively engage in the various steps of PST. Treatment Length: 6 to 10 sessions	Individual	OQ (19+) PHQ-9 (18+)
25	**Program to Encourage Active Rewarding Lives for Seniors (PEARLS)** **EBP Code: 2S**	PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	Older Adults (60+)	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT, RN) and required training may serve as PEARLS Counselor ▪ Licensed Clinical Supervisor	Frequency: Sessions 1, 2, 3 weekly Sessions 4 and 5 bi-monthly Sessions 6, 7, 8 monthly Session Length: 60 minutes Treatment Length: 6 to 8 sessions over the course of 19 week	Individual	OQ (19+) PHQ-9 (18+)

PEI EBP Matrix
(updated as of August 2015)

	Program Name	Description	Age Groups Served (Age Limits)	Rendering Provider Minimum Requirements	Duration of Program (Estimated Frequency and Length Of Treatment)	Modality	Clinical Measures/Tools
26	**Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)** **EBP Code: 2T** *currently available for DMH directly-operated clinics only*	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.	TAY (18-25) Adults (26-59) Older Adults (60+) *currently available for DMH directly-operated clinics only*	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT, MD, DO, RN) and required training ▪ Licensed Supervisor	Frequency: 1x to 2x per week Session Length: 90 minutes Treatment Length: 10 to 18 sessions	Individual	YOQ-2.0 SR (Child, 12-18) OQ (19+) PDS (18-65)
27	**Providing Alternative Thinking Strategies (PATHS)** **EBP Code: 2Z**	PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.	Children (5-12)	▪ Non-clinician – Bachelor's level or higher and in accordance with scope of practice	Frequency: 1x per week Session Length: 60 minutes Treatment Length: 12 months max	Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]
28	**Reflective Parenting Program (RPP)** **EBP Code: 3L**	RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents /caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	Children (0-12)	▪ Licensed and pre-licensed mental health clinicians	Frequency: 1x per week Session Length: 90 minutes Treatment Length: 10 sessions	Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]
29	**Seeking Safety (SS)** **EBP Code: 4N**	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.	Children (13-15) TAY (16-25) Adults (25-59) Older Adults (60+)	▪ Clinicians - Master's level or higher (Licensed, Registered, Waivered) ▪ Non-Clinicians, in accordance with scope of practice	Frequency Average: 1x per week Session Length Average: 50 to 90 minutes Treatment Length Average: 5 to 6 months	Individual or Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) OQ-45 (19+) UCLA PTSD-RI for Children and Adolescents–Parent (Child, 3-18) UCLA PTSD-RI for Children and Adolescents–Child/Adolescent (Child, 6-20) UCLA PTSD-RI Adult Short Form (21+)
30	**Strengthening Families Program (SFP)** **EBP Code: 2V**	SFP is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.	Children (3-15) TAY (16)	▪ Low-risk program (SFP10-14) is staffed by school personnel ▪ High-risk program (SFP3-5, 6-11 or 12-16) staffed by community agencies familiar with working with high risk children ▪ Not necessarily mental health workers; can be service agencies ▪ Not necessarily licensed personnel	Frequency: 1x per week is preferred, 2x per month is ok (but no less than that) Session Length: 2 hours Treatment Length: 7 sessions Four 2-hour optional booster in which parents and youth meet separately for instruction during the first hour and together for family activities in the second hour.	1. Parent Group 2. Youth Group 3. Family Activity Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) RBPC-Parent (Child, 5-18) RBPC-Teacher [if parent is unavailable (Child, 5-18)]
31	**Trauma Focused CBT (TF-CBT)** **EBP Code: 2W**	An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.), for children and TAY receiving these services.	Children (3-15) TAY (16-18)	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) ▪ Licensed Supervisor	Frequency: 1x per week Session Length: 60 to 90 minutes Treatment Length: 12 to 16 sessions	Individual and Conjoint	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) UCLA PTSD-RI for Children and Adolescents–Parent (Child, 3-18) UCLA PTSD-RI for Children and Adolescents–Child/Adolescent (Child, 6-20)

PEI EBP Matrix
(updated as of August 2015)

	Program Name	Description	Age Groups Served (Age Limits)	Rendering Provider Minimum Requirements	Duration of Program (Estimated Frequency and Length Of Treatment)	Modality	Clinical Measures/Tools
32	**Triple P Positive Parenting Program (Triple P)** **EBP Code: 2Y**	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.	Children (0-15) TAY (16-18)	▪ Clinicians - Bachelor's level, Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) ▪ Licensed Supervisor	Level 4 Standard (Individual) Frequency: 1x per week Session Length: 60 minutes Treatment Length: 10 sessions Level 4 Group Frequency: 1x per week Session Length: 120 minutes Treatment Length: 5 sessions and Modality: Individual (phone calls) Frequency: 1x per week Session Length: 15 to 30 minutes Treatment Length: 3 sessions	Individual and/or Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]
33	**UCLA Ties Transition Model (UCLA TTM)** **EBP Code: 3M**	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).	Children (0-8)	▪ Clinicians - Master's level (Licensed, Registered, Waivered, PhD, PsyD, LCSW, MFT) ▪ Licensed Supervisor	Frequency: Depends on the needs of the child and family. Young children can be seen once a month and in one group session. Older children and parents can be seen weekly with monthly concurrent support group sessions. Session Length: 3 hour Treatment Length: 3 sessions Additional supports up to 18 months.	Individual Conjoint Parent Child Group	YOQ-2.01 Parent (Child, 4-17) YOQ-2.0 SR (Child, 12-18) ECBI Parent (Child, 2-16) SESBI-R [if parent is unavailable (Child, 2-16)]

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION DIVISION

FREQUENTLY ASKED QUESTIONS

ABOUT

PEI EVIDENCE BASED PRACTICES

REVISED FEBRUARY 1, 2016

FREQUENTLY ASKED QUESTIONS ABOUT PEI EVIDENCE BASED PRACTICES

TABLE OF CONTENTS

For Outcome-related FAQs,
please refer to PEI Outcomes FAQs at
http://dmhoma.pbworks.com/w/page/40360716/PEI%20Outcomes%20FAQ
or contact PEIOutcomes@dmh.lacounty.gov

AGGRESSION REPLACEMENT TRAINING (ART)

1. What are the components of ART®?

The components of ART® are based on social learning and cognitive behavior theories:

1. Skillstreaming
    - The behavioral component
    - *Teaches what to do*
2. Anger Control Training
    - The emotional component
    - *Teaches how to recognize and control anger*
3. Moral Reasoning Training
    - The cognitive component
    - *Teaches why to use pro-social skills*

2. What is the age range for ART®?

ART® (all 3 components) is for clients ages 12-17. Clients who are ages 5-12 are to be provided with **only** the Skillstreaming component of ART®.

3. What is the focus of treatment for ART®?

The focus of treatment for ART® includes children and youth with disruptive behavior disorders who are at risk of or involved with the juvenile justice system.

4. What is the treatment modality?

The treatment modality for ART® is group format. Individual sessions may be used to make up missed group sessions.

5. What are the minimum and maximum clients allowed per group?

The developer recommends 8 to 10 participants per group; not to exceed 12.

6. How many group facilitators are needed?

Model adherent ART® groups are conducted by 2 facilitators (co-facilitators).

7. How often should ART® sessions be conducted?

Model adherent ART® sessions are conducted in 3 group sessions (using each of the 3 components: Skillstreaming, Anger Control and Moral Reasoning) per week. When providing the Skillstreaming component of ART® only, for clients ages 5-12, sessions (in Skillstreaming only) are conducted 1 time per week.

8. What is the length of treatment?

The length of treatment for model adherent ART® is 10 weeks. When providing the Skillstreaming component of ART® only, for clients age 5-12, the length of treatment is also 10 weeks.

9. What are the "Core Interventions" for ART®?

The "Core Interventions" include:

i. Assessment
ii. Collateral
iii. Group Psychotherapy
iv. Group Rehabilitation
v. Individual Psychotherapy (to "make up" a missed group session)
vi. Individual Rehabilitation Service (to "make up" a missed group session)

10. Do you have to be a licensed clinician to implement ART® under the PEI Plan?

No. Please see Question #11. Please see current version of the County of Los Angeles – DMH, "A Guide to Procedure Codes" for specific Rendering Provider eligibility.

11. What is the minimum amount of education required to be trained in and apply this evidenced based treatment, in order to stay within an appropriate "scope of practice?"

The services listed under Core Interventions for each evidenced based treatment will determine the rendering provider's scope of practice. For example, if one of the core services is Assessment, an AMHD must complete the Assessment. If the core service is Individual Rehabilitation (Rehab), anyone within their scope of practice can provide Rehab services.

As it relates to non-licensed staff (Medical Case Worker, Substance Abuse Counselor, and Community Worker) providing individual/group rehabilitation will be based on the supervisor's discretion. This means that the supervisor has assessed the staff's knowledge, experience, and reviewed staff's documentation and decided that the staff is capable of providing and documenting Rehab services (with or without co-signature).

12. Is there a "train the trainer" model for ART®? Yes. The "train the trainer" model for ART® includes:

i. Completion of the ART® training protocol
ii. Co-facilitate a minimum of 72 groups within a 12-month period, with at least 12 groups in each component
iii. Rating of competency on each item of the Trainer Competency Rating Scale on at least one submitted videotaped session that occurred within 12 months
iv. 2-day Agency Trainer training
v. Participation in 15 consultation calls
vi. Conduct and complete ART required training protocol with 2-6 trainees
vii. Videotaped submission of excerpts of conducted trainings
viii. Demonstration of trainer proficiency by videotape review of trainees

13. What are the required Outcome Questionnaires for ART®?

DMH PEI Outcome Measures Application Requirements: The outcome measures should be administered pre- and post-treatment. Additionally, if the ART® treatment extends beyond 6

months, an update for each measure is required every 6 months. The required outcome measures are the following:

- Youth Outcome Questionnaire (YOQ)
- Youth Outcome Questionnaire-Self Report (YOQ-SR)
- Eyberg Student Behavior Inventory (ECBI) or Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R), if parent is unavailable to complete the ECBI

Note: Even though the SESBI-R is required only when the ECBI cannot be obtained, both the ECBI and SESBI-R must be acknowledged in the PEI OMA. This is achieved by entering either the scores or an 'Unable to Collect Reason Code' for each measure.

CiMH/Developer Requirement: The SkillStreaming Checklist is required to be administered pre and post Social Skills Training component of ART®. The developer highly recommends the Aggression and How I Think Questionnaires to be administered pre and post the Anger Control Training and Training in Moral Reasoning components of ART®, respectively.

14. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs, YOQ-SR)?

Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation can be completed by a person enrolled in a graduate degree program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waivered staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

15. What staff qualifications are required to administer, score/interpret, and input data for the ECBI and SESBI-R?

Administration can be completed by a trained professional with a minimum of a bachelor's degree in psychology or related field. Scoring and interpretation can be completed by a person enrolled in a graduate degree program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waivered staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

CENTER FOR THE ASSESSMENT & PREVENTION OF PRODROMAL STATES (CAPPS)

1. What is CAPPS?

CAPPS stands for the "Center for Assessment and Prevention of Prodromal States". It is named after the agency and not the practice. CAPPS is a family focused therapy for youth at ultra-high risk for psychosis and their families. It is a manualized 18-session family focused treatment program. The actual name for this practice is called Family-Focused Therapy for Prodromal Youth (FFT-PY). However, in order to avoid any confusion with our existing Functional Family Therapy (FFT) EBP, DMH decided to call this EBP "CAPPS".

2. What is the population to be served under Los Angeles County's PEI Plan?

Our PEI plan serves individuals and their families for whom a short duration (usually less than one year) and relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation. This early intervention avoids the need for more extensive mental health treatment or services, and prevent a mental health problem from getting worse.

3. What are the age range limits for implementing CAPPS under the PEI Plan at this time?

CAPPS is currently being implemented for transition age youth and young adults, ages 16 – 25, and their families.

4. What is the length of treatment?

This is a structured manualized approach that is designed to consist of 18 sessions over 6 months. The length of treatment will depend on how many topics are covered, the number of sessions needed by the family to complete a topic, and the frequency of sessions.

5. How often should CAPPS sessions be conducted?

CAPPS family focused therapy sessions are conducted in 12 weekly sessions for the first 3 months, then 6 bi-weekly sessions over the next 3 months for a total of 18 sessions over a 6 months period to adhere to the fidelity of the model.

6. Are there a maximum number of sessions?

On average, each topic is covered in 1- 2 sessions. Therefore, if all 18 topics are completed, the number of sessions may range from 18 to 36.

7. Does CAPPS have mandatory topics?

Yes. This is a structured model with recommended sequencing of the specific topics. There are 18 specific topics that are to be covered depending on the family's needs. The sessions will consist of 3 treatment modules with topics addressing Educational Sessions, Communication Enhancement Training, and Problem Solving Skills Training.

8. How many topics are recommended for treatment? Is there a maximum or minimum?

This model recommends the coverage of all 18 topic areas. There is some flexibility in terms of the order in which the later topics are covered based on the needs of the family

9. What is the CAPPS therapy model staffing required?
This model requires a minimum of two clinicians and one clinical supervisor to implement the CAPPS practice.

10. Is CAPPS considered a crisis intervention?
No.

11. Since family sessions are a core service, what should the content of the family sessions be?
This model is based on the Family Focused Treatment Approach. The model is developed for 18 treatment sessions to be delivered within a 6 month period. These sessions will consist of 3 treatment modules that focus on Educational Sessions, Communication Enhancement Training, and Problem Solving Skills Training.

12. Is there a "train the trainer" for CAPPS practice?
Yes. Once the clinical supervisor has satisfactorily met the requirements listed for Therapist Competency and Adherence Scale (TCAS) and inter-rater reliability competency with the developer for supervisors, they are able to train new staff to the CAPPS practice for their assigned agency only.

13. Does the Department expect that agencies providing CAPPS treatment will have their staff complete the CAPPS Competency and Adherence Scale and Supervisory Trainings?
Yes, this training is required as part of the certification process. Additionally, this training also ensures fidelity to the practice model and sustainability of the practice.

14. Are Outcome Measures required and how often do they need to be completed?
Outcome measures are required to be administered at the beginning and at the end of treatment. The general measures include the Youth Outcome Questionnaires and the specific outcome measures are the Structured Interview for Prodromal Syndromes (SIPS) and Scale of Prodromal Symptoms (SOPS).

15. Does the CAPPS Supervisor have to be a Clinical Supervisor?
Yes. At minimum, each agency is required to designate a CAPPS Clinical Supervisor. This Supervisor is required to be a licensed mental health clinician that is trained in the CAPPS practice.

16. What are the "Core Interventions" for CAPPS?
Assessment/Psychiatric Diagnostic Interview
Family Psychotherapy
Collateral

17. What are "None Core Interventions" for CAPPS?
Individual Therapy
Group Psychotherapy
Targeted Case Management/Outreach and Engagement

Medication Support

18. Do you have to be a mental health clinician to deliver the CAPPS treatment services?
Yes.

19. What is the minimum amount of education required to be trained in and to provide CAPPS therapy services to clients in order to stay within an appropriate "scope of practice"?
This clinical treatment model provides therapy that is based on family therapy and cognitive behavioral therapy treatment approaches. All therapy must be conducted by clinicians that are at least at the master's level or higher and are licensed or license eligible.

There is a case management function that may be done by a Bachelors level case manager that includes outreach and engagement of clients.

COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

1. **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.

2. **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.

3. **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.

4. **What is the role of the DMH school-based coordinator?**
   This role may differ from Service Area to Service Area based on the unique needs of the population being served. Please consult with your service area lead District Chief or contract lead to discuss the role that your specific DMH school-based coordinator will play.

5. **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.

6. **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.

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

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.

CHILD-PARENT PSYCHOTHERAPY (CPP)

1. What is the age range for the CPP model (what ages are included)?
Clients starting treatment can range from 0 months to 5 years, 11months. Treatment must begin on or before the 6th birthday. Once in treatment, CPP is validated for children ages 0 to 6 years.

2. Must my client have experienced trauma to qualify for CPP?
Yes, for the purposes of claiming to the DMH PEI Child Plan the child must have experienced trauma. You may use CPP to serve other populations with a different funding source.

3. How is "trauma" defined for babies/toddlers and what do I look for as far as symptoms in this young population?
If your agency is implementing Child Parent Psychotherapy, it is important that your agency has the ability to provide clinicians with supervision, consultation, and training in early childhood trauma. Please see Scope of Practice (below).

4. Must my client have a diagnosis of PTSD for the CPP model?
No, PTSD does not have to be the diagnosis in order to use the CPP model, but please use your clinical judgment to decide if CPP is an appropriate model for your client. As is always the case, in order to claim to Medi-Cal, your client must meet criteria for a Medi-Cal eligible diagnosis and the service provided must be claimable to Medi-Cal. Trauma screening is considered an important element of the CPP model. The CPP model strongly encourages screening for trauma prior to beginning treatment. Your agency is at liberty to select the screening tools of your choice. The developers recommend The Life Stressor Checklist-Revised (which screens for the caregivers trauma) and the Traumatic Events Screening Inventory – Parent Report Revised (parent report of the child's trauma). Both of these measures are free, were distributed at the CPP training, and are available on the CPP drop box link for trainees. It is recommended that as Trauma is the focus of treatment for providing CPP under PEI funding that your agency be mindful for how to route clients who are the best match for a treatment modality that focuses on trauma to CPP.

5. What are the outcome measures for CPP?
The outcomes are YOQ-Parent Report (ages 4+) and Trauma Symptom Checklist for Young Children (ages 3+).

6. What outcomes do I collect if my client is too young for the outcome measures? Do I collect outcomes for children under three years of age?
Please be consistent with normed age range for the outcome measures. You are not required to report outcomes for children under the age of 3.

7. What are the screening measures for CPP?
The CPP model strongly encourages screening for trauma prior to beginning treatment.

Your agency is at liberty to select the screening tools of your choice. The developers recommend *The Life Stressor Checklist-Revised* (which screens for the caregivers trauma) and the *Traumatic Events Screening Inventory – Parent Report Revised* (parent report of the child's trauma). Both of these measures are free, were distributed at the CPP training, and are available on the CPP drop box link for trainees.

8. The CPP model requires talking with the caregiver about the child's trauma and the caregiver's trauma. To do this, we have to meet with the caregiver alone prior to meeting with the child. Can we open the case without seeing the child?
No, you cannot open the case prior to seeing the client.

9. If I cannot open the case, can I claim for service prior to opening the case?
Yes, you can have a collateral session prior to having face-to-face contact with the client; HOWEVER, you must have face-to-face contact with the client within the same calendar month. Please refer to *Bulletin 09-07 Opening Date for Case Episodes* dated November 13, 2009 for guidelines.

10. As part of the CPP training, we need to complete process/narrative notes. Can we claim for that time?
No, the process/narrative note is not a service to the client; it cannot be claimed to Medi-Cal as a service to the client. The intention of the process/narrative note is to benefit the clinician's learning.

11. What kinds of trainings/resources might we seek out to build our clinicians' capacity to serve children ages 0-5?
Endorsement guidelines for Infant-Family and Early Childhood Mental Health Specialists for professionals serving children ages 0-5 in California have been developed. The guidelines can be found at http://cacenter-ecmh.org/professional-development/

Locally, you may also join the Los Angeles Infancy, Childhood, and Relationship Enrichment (ICARE) Network by e-mailing ICARE@dmh.lacounty.gov. The ICARE Network hosts quarterly meetings and sends e-mails regarding upcoming trainings and resources for working with children ages birth to five.
In addition, each Service Area has a DMH Birth to Five Coordinator. You may contact your lead district chief to find out who the DMH Birth to Five Coordinator is in your Service Area. Some Service Areas also offer regular Service Area Birth to Five Collaborative(s) that have presenters and resources for working with the 0-5 population in your Service Area of the county.

Seeking consultation and training in this specialty population is also recommended. Additionally, The National Child Traumatic Stress Network (www.nctsn.org) has many resources available regarding childhood trauma in young children, which includes articles, screening tools, and free online courses with CEs. The Harvard Center for the Developing Child also has articles and videos on the impact of trauma on young children and early childhood brain development in English, Spanish, and Portuguese.
(http://developingchild.harvard.edu/)

CRISIS ORIENTED RECOVERY SERVICES (CORS)

1. What is the goal of CORS?

To provide immediate crisis intervention and increase adaptive coping strategies which the individual can utilize to manage stress and return to their previous or higher level of functioning. Specifically, CORS is designed for individuals who have experienced a recent event that has disrupted the person's usual equilibrium and created a vulnerable state.

2. Which model is CORS based on?

CORS is a Promising Practice based on the model developed at Didi Hirsch Community Mental Health's Benjamin Rush Center for short-term (up to six calendar weeks, or six sessions, whichever comes first) crisis intervention. Its origins are based on principles found in psychoanalysis, sociology, and life stress research. Any client receiving services in DMH who may have experienced a recent trauma, crisis or "hazardous event" may benefit from CORS.

3. For whom is CORS appropriate?

CORS is designed to serve children (ages 3+), transition-age-youth (TAY), adults, and older adults (OA) who have experienced a hazardous event within the previous three months. For children and families, the model allows for a 6 month timeline between the "hazardous event" and the request for help.

CORS is a Practice effective for clients presenting with Dysthymia, Anxiety disorders, and Adjustment disorders. However, other diagnoses, such as Acute Stress Disorder, Depressive Disorder Unspecified, PTSD, and even Major Depression are common and have been successfully treated with CORS. It is the presence of a stressful event and an inability to cope with the event that defines good candidates for this practice.

4. When is CORS contraindicated?

The model is not suited for individuals who are in a chronic state of crisis, individuals who are chronically using substances, or those who are persistently mentally ill and not able to identify a specific crisis. This Practice may be more effective for clients who voluntarily seek treatment, rather than those who are involuntarily participants. Additionally, court mandated treatment usually requires a long-term commitment (an average of 6 months to one year), and CORS is a short-term practice.

5. What is considered a "hazardous event"?

A "hazardous event" is an external life event that disrupts a person's usual functional equilibrium and creates or elicits a vulnerable state. The event occurs within three (3) months of the initial call or visit to the clinic for TAY, Adult, and OA and within six (6) months for children and families.

A "hazardous event" is defined as an external stressor, ***new*** to the individual(s), and has overwhelmed his/her previously successful coping strategies.

The external event signifies a loss or threat of loss, creating disequilibrium in a steady state. The possible losses include the loss of self-esteem, loss of role mastery, loss of nurturance, or loss of physical integrity (safety).

6. What is the definition of a "crisis" in this Practice?

A crisis is defined as "a state provoked when a person faces an obstacle (hazard) to important life goals. The obstacle is temporarily insurmountable through customary coping behaviors. A period of disorganization follows during which many attempts at solution are made. Eventually, some kind of adaptation is achieved which may be adaptive or maladaptive".

7. What are the key questions for clinicians in this practice?

Based on the practice's guidelines, clinicians should determine and document the following: "Why now?", "How long has the hazardous event been going on?", "What is different this time which motivated the client to contact them?", "What coping mechanisms were used previously that are not now working?" "Who was the last contact for the person prior to asking for help?"

One of the key points in CORS is to facilitate the client's understanding of and document the "meaning attached to the crisis" for the person or family. The meaning always involves a loss or threat of loss.

8. What are some tools a clinician can use to determine if a client can benefit from CORS?

The clinician can utilize a timeline to determine the specific details of the "hazardous event."

9. Does the clinician have to cover all three (3) phases of CORS

Yes. The developer requires the clinician complete all three phrases:

1) Assessment Phase: (Session 1): The clinician assesses the client, develops a timeline of events, explores the meaning of the hazardous event, assesses for homicidal/suicidal ideation, and develops a reformulation of the crisis; including a cognitive understanding of the loss or losses involved.
2) Treatment Phase: (Sessions 2-5): In the treatment phase, the clinician assists the client to develop an affective understanding of the problem and establish new coping skills (Session 2-5). The clinician helps the client become aware of feelings regarding their loss or feared loss, which s/he may not have accessed during the crisis. The clinician works with the client to recognize maladaptive coping behaviors and develop adaptive coping strategies to manage the crisis. The work involves both insight on the part of the client regarding their feelings and associated responses, and behavioral change.
3) Termination Phase: (Session 6): The clinician summarizes the crisis, discusses possible future hazards and engages in anticipatory planning should another crisis arise, and addresses feelings related to termination. Evaluation for ongoing treatment in a different modality would also be done at this phase, however the department expects that many if not most cases will be closed.

10. What type of treatment is generally offered through CORS?

CORS consists of weekly individual therapy sessions for TAY, adult, and OA and weekly family therapy sessions for children.

11. According to the practice, individual sessions can either be 60 or 90 minutes long. What is the Department's requirement?

There is no Department mandate limiting the time frame of individual sessions. Clinicians can provide a 60-minute or 90-minute session on a weekly basis.

12. What are the core interventions for CORS?

The procedure codes for CORS core services are:

- Assessment (Procedure Code 90801 and 90802)
- Individual Psychotherapy
- Family Psychotherapy (for Children only)
- Group Psychotherapy (for Community at large)*
- Targeted Case Management**

*The use of Group Psychotherapy might be suitable for group members who have each experienced the same "hazardous event"; for example, a hurricane, fire, or other natural disaster. However, Group Psychotherapy is not usually indicated with this model as it applies primarily to people with individual hazards that have a particular meaning to them.

**The use of targeted case management may be appropriate if providing these services will reduce the effects of the hazardous event, i.e. the client is unexpectedly homeless or unemployed, and needs to be linked to services.

13. Who can provide CORS?

CORS must be delivered by a trained therapist. Staff that may provide CORS include: licensed, registered, or waivered MD/DO, Ph.D/Psy.D., LCSW, MFT, Psychiatric/Mental Health Clinical Nurse Specialist, a Psychiatric/Mental Health Nurse Practitioner, and student professionals in these disciplines with a co-signature.

14. Does the Department require a clinician to maintain a certain number of CORS clients on their caseload?

No.

15. What role can paraprofessionals play with this Practice?

The primary clinician can work with paraprofessional staff to ensure the client is provided linkage, case management, and care coordination.

16. What role may a psychiatrist play within this Practice, and how are associated psychiatric services claimed?

It is recommended by the practice that unless the client is already on medication, when possible, CORS be delivered without the initiation of medication support. This recommendation is based on CORS being time-limited (up to six calendar weeks, or six sessions, whichever comes first) in comparison to the various length of time it may take to schedule a psychiatric evaluation appointment followed by an additional time period for the prescribed medication to reach a therapeutic level. When possible, the practice

recommends medication support be provided after COS is implemented in its entirety, if/when clinically necessary.

However, as part of the comprehensive assessment, the clinician may decide to refer the client for a psychiatric evaluation. For instance, a client presenting with symptoms of anhedonia, sleeplessness, loss of appetite, psychomotor retardation, and suicidal rumination, perhaps caused by a hazard, may respond well and quickly by the supplementation with psychotropic medication to the CORS practice.

If the CORS treatment team determines medication support is necessary, medication support can be provided in conjunction with the CORS therapy sessions. The clinician and psychiatrist can determine if continuing the medication support beyond the completion of six weeks of CORS psychotherapy is clinically indicated. The level of service that best addresses the consumer's continuing mental health needs should be documented.

17. What is the length of treatment for CORS?

CORS is limited to a maximum of six (6) consecutive calendar weeks, or six (6) sessions, whichever comes first. CORS is intended to address a crisis situation rather than an ongoing illness. A crisis is considered a time-limited event. Some crisis situations may resolve in a shorter period of time.

18. Does the practice state a minimum number of weeks of treatment?

No, there is no limit. However, a client has successfully completed CORS if the crisis the client originally came in for has resolved.

19. Can CORS ever be extended past six weeks?

Yes. According to the practice, the treating clinician can make the clinical decision to extend the practice for TWO weeks (i.e., 8 weeks total treatment duration) if the client experiences a second, distinct new crisis during the course of treatment.

Another possible reason for extending the treatment duration would be if the client expresses suicidal thoughts. In this case, the practice may be extended to stabilize the client and link the client to needed, ongoing mental health treatment and services outside of PEI.

20. What should the clinician do if the client misses two or more sessions? Since CORS is time-limited to six calendar weeks, the practice does not recommend continuing CORS if the client misses two or more weeks. If the client misses one week of treatment, the clinician may complete two sessions in one week to make up for the missed week; however, the total time of treatment should not exceed 6 calendar weeks. Across all age groups, services claimed to a PEI billing plan must have a PEI-approved EBP code selected in the IS. The clinician will select the appropriate EBP code on the drop-down menu once s/he determines which EBP/PP/CDE best addresses the client's needs. For example, if at the initial assessment the clinician concludes the client is appropriate for CORS; s/he will select the corresponding code for "PEI CORS" (4D) in the IS.

If at the initial visit the clinician determines the client does not meet the PEI target population and, instead, refers the client to one of the MHSA CSS or non-MHSA programs, s/he will claim the services to the appropriate IS billing plan. No corresponding EBP code will need to be selected.

21. Does the initial intake session count toward the six session limit?

No. The week when the clinician completes the initial intake session is not included in the six allowable weeks of this practice. However, the six week session limit does begin during the week of the initial intake session, and clinicians are therefore encouraged to make efforts to schedule the first CORS session during that first week as well, whenever possible, to ensure that up to six sessions are available to the client if needed. Another option to ensure six sessions are held is to have multiple sessions held within one of the subsequent calendar weeks of the six week time frame.

22. Can a client from one of the non-MHSA or MHSA Client Supportive Services (CSS) plans (Wellness, Field Capable Clinical Services, or Full Service Partnership) receive this Practice?

Yes. Any client for whom CORS practice is clinically indicated, can receive this CORS treatment. This is true of other PEI practices as well. The service is claimed to the MHSA plan/Level of Care in which the client receives their primary services—and NOT to PEI. For example, a CSS Wellness client can participate in CORS if the client experienced a hazardous event in the previous three (3) months which caused a crisis affecting their previous equilibrium. However, the client will continue to be billed under the "MHSA_Fam_Focused_Wellness Svc" billing plan, not under the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "PEI-CORS" (4D), but no outcome measures are required when the EBP is administered to a client enrolled in a different plan (i.e., not PEI).

23. What happens if the client successfully completes CORS?

The client will be discharged and their case will be appropriately closed. **What happens if the client continues to experience disruption in their level of functioning?**

The treating clinician should consider the following questions:

1) Why is the client's maladaptive response to the hazardous event still lingering? Has he/she not found an adequate alternative coping mechanism? Do we need to pull in some supportive persons in the client's life to assist?
2) Have we appropriately identified the hazard and the meaning of the hazard for the client, so they can understand their situation and find an alternative coping response?
3) Is the person experiencing unresolved grief which is now chronic?
4) Was CORS the most appropriate treatment to provide to this client based on the situation? If not, is there an intervention which would address the client's needs more effectively?

The treating clinician can link the client to continued care, via another non-MHSA or MHSA CSS level of service, such as FCCS or Wellness.

Some clients may be appropriately served in another PEI EBP for continued care.

24. When should the clinician discuss the possibility of on-going treatment with the client?

The developer recommends discussing referrals for on-going treatment during the 5th or 6th weekly session.

25. Can a client receive CORS along with another PEI EBP?

The goal of CORS is to help the client move forward quickly in coping with a crisis; using a brief and focused intervention and their own resources. Therefore, the Department expects that the use of multiple practices for PEI clients is occurring infrequently.

26. What is the required training protocol?

The CORS training protocol consists of a one-day, six-hour training. Some CORS trainers may provide additional on-site consultation support as needed to fully integrate the model into Practice.

27. Is there a certification process?

No. However, the model should only be practiced by clinicians who have received the full 6 hours of training in CORS.

28. Is "train the trainer" available for CORS?

Not at this time.

29. Is there a Booster Training available for CORS?

Yes. There is a CORS Booster training offered to all clinicians who have attended the initial six-hour training. The function of the Booster training is to provide a refresher of the basic tenants of the CORS model and to serve as a forum for clinicians to work active cases through the CORS model via consultation and group discussion, facilitated by the trainer. This Booster became available to all CORS-trained clinicians on a monthly basis since March 2015.

30. Does CORS require a CORS-trained supervisor as part of the practice?

A specific supervisor training in CORS is not available at this time. The Department does require a licensed supervisor to be available to assist the CORS clinician as needed. At a minimum, the department requires this supervisor be trained in the CORS model, and where possible, participate in an ongoing consultation group provided by DMH.

31. What outcome measure should be used with this Practice?

Clinicians will administer the Youth Outcome Questionnaire (YOQ) to parents of youth (ages 4-17) and Youth Outcome Questionnaire-Self report (YOQ-SR) for Children and younger TAY (ages 12-18).

Clinicians will administer the Outcome Questionnaire (OQ) (ages 19+) for older TAY, Adults, and Older Adults.

There is no treatment specific outcome measure for this Practice for children under the

age of 18, TAY, Adults, or Older Adults at this time.

32. When should the outcome measure be completed?

Outcome measures are to be completed within a 21 day window around the due date for that measure.

"Pre-measures" may be completed 1) on the date of the first PEI Practice Treatment Session, 2) up to 7 days before the date of the first PEI Practice Treatment Session, or 3) up to 14 days after the date of the first PEI Practice Treatment Session.

"Post-measures" may be completed 1) on the date of the last PEI Practice Treatment Session, 2) up to 7 days before the date of the last PEI Practice Treatment Session, or 3) up to 14 days after the date of last PEI Practice Treatment Session.

Updates may be done on any date between the Pre and Post Questionnaires.

33. Can the clinician claim for administering the outcome measure?

No, administering an outcome measure is not claimable to Medi-Cal.

FAMILIES OVERCOMING UNDER STRESS (FOCUS)

1. What is Families Overcoming Under Stress (FOCUS)?

FOCUS is a promising practice (PP), which is a family-centered, resiliency training program designed to bridge communication and support in families contending with trauma, stress or loss. Initial implementation at the Department of Mental Health's (DMH) Directly Operated programs was dedicated to assisting service members and their families in successfully navigating through the stressors and troubles associated with military deployment(s). However, it has subsequently been adapted to provide resiliency training to civilian families who have suffered from the effects of traumatic events.

FOCUS teaches families core skills that will better equip them to deal with stresses and changes associated with wartime deployment, injury, illness, death and a range of other traumatic experiences. FOCUS assists families on increasing communication and family cohesiveness. By expressing and exploring different family members' perspectives of a traumatic event, the family is able to address associated problems and monitor the progress of future goals.

2. Who is appropriate for FOCUS?

FOCUS is intended for families with at least one child aged 5 and over, Transitional Age Youth (TAY) (ages 18 to 25), and Adults (ages 26 to 59) in our Directly Operated programs and school-based providers. This PP is appropriate for both military and civilian families who have experienced deployment(s), traumatic or loss event(s) resulting in a disruption of family functioning, personal adaptation, and related psychological difficulties.

3. Does the client need to have a specific diagnosis to receive FOCUS?

No. FOCUS is intended for military and civilian families who are having difficulties adjusting to and dealing with the stressors associated with deployment(s) and a range of traumatic event(s). The Department encourages clinicians to use their clinical judgment to determine if FOCUS is an appropriate model for the family being served. Furthermore, FOCUS is generally not the best practice for clients actively using alcohol or drugs, actively psychotic, actively manic, or at high risk for suicide or homicide. Clients presenting with any of the above issues should be referred to a higher level of care.

4. What does the treatment consist of?

FOCUS utilizes couple and family shared narratives about deployment(s) and/or traumatic event(s) to increase communication, resiliency, and to provide better support for one another. This is accomplished while family members express and explore their understanding of reactions to the deployment(s) and/or traumatic event(s). Families also work on identifying and building upon their existing strengths and positive coping strategies to work more effectively as a team.

5. What is the length of treatment?

FOCUS is an 8-session program designed to have each session used as a stand-alone intervention. This makes FOCUS flexible so military families can benefit from the intervention regardless of missed sessions or truncated time tables associated with pre-deployment, deployment and post-deployment issues.

6. What are the eight sessions?

FOCUS is divided into the following eight sessions:

Session 1: Introducing Parents to FOCUS
Session 2: Constructing Parent's Narrative Timelines
Session 3: Introducing Children to FOCUS Session 4:
Constructing Children's Narrative Map
Session 5: Preparing Parents for the Family Session
Session 6: Developing a Family Narrative
Session 7: Building Family Resiliency Skills
Session 8: Preparing for the Future

7. What are the core interventions of FOCUS?

The core interventions for FOCUS are:

-Assessment (Procedure Codes 90801 and 90802)
-Family Psychotherapy (Procedure Code 90847)
-Collateral (Procedure Code 90887)
-Individual Psychotherapy (Procedure Codes H0046, 90804, 90806, 90808)

Other interventions which may be appropriate during the course of the 8 sessions may include:

-Targeted Case Management (Procedure Code T1017)

The use of targeted case management may be appropriate if providing these services will assist in the reduction of the effects of the deployment(s) and/or traumatic event(s) on the family.

8. Can FOCUS be used in individual treatment?

Although some individuals may benefit from resiliency training, FOCUS was designed to assist the family as a unit. FOCUS can also be used for couples as well as single parent families who have a child between the ages of 5-18.

9. What happens if the family misses a session?

Ideally, all 8 FOCUS sessions should be completed without any interruptions. However, each session was designed as a separate intervention. Consequently, families who miss sessions due to pre-deployment, deployment, and post-deployment issues are allowed to interrupt treatment whenever necessary. Sessions may also be combined, offered multiple times per week or conducted with a co-therapist to allow maximum flexibility.

10. Who can provide this PP?

At this time the developer only allows clinicians (Masters level and higher, registered/waived and higher level clinicians) to be the primary leads in treatment. Paraprofessional staff can provide support with check-ins and case management.

11. What role can a psychiatrist and medication play with this practice?

Generally in this model, clients are not seen for a medication evaluation by a psychiatrist. On the other hand, there may be certain circumstances where a clinician may determine referring a client for a medication evaluation is appropriate. In these cases, not providing such services may be more harmful to the client's well-being and may prevent the client from returning to their previous level of functioning, especially when additional symptoms are resulting in severe impairments.

12. Can a client from one of the Mental Health Services Act's (MHSA) Client Supportive Services (CSS) Programs (Wellness, Field Capable Clinical Services, or Full Service Partnerships) or non-MHSA programs receive FOCUS?

Yes. Any client receiving services in one of our MHSA CSS or non-MHSA programs can receive this and any EBP. The service will be claimed to the current MHSA plan in which the client primarily receives his/her services, NOT to PEI.

13. Can the client receive FOCUS along with other EBPs?

Clients can receive 2 practices simultaneously only when clinically indicated. However, the use of multiple practices for PEI clients should happen very infrequently.

14. What is the required training and certification protocol?

The required training protocol has 4 parts. First, it begins with a six-hour, web-based program which is designed to provide an overview of FOCUS services, background information related to the impact of deployment on families, and to prepare the Resiliency Trainees for the live training component. Second, a three-day, in-person training or "Basic Course" is required which provides detailed instruction regarding how to conduct the full range of FOCUS services. Third, after the in-person training, weekly supervision by a FOCUS staff is required for at least 10 families. Fourth, the final step is a one-day, "Advanced Course" to be completed after the trainee has successfully provided FOCUS to 10 families.

15. Is "train the trainer" available for FOCUS?

No. The Department does not currently provide "train the trainer" as an option.

16. What are the outcome measures for FOCUS?

There are two outcome measures which are required for FOCUS:
-McMaster Family Assessment Device (FAD)

-Outcome Questionnaire (OQ)

17. Can the clinician claim for completing the outcome measure?

No. Administering an outcome measure is not a claimable service. There are two

exceptions: (1) if the primary clinician closes the case as a result of referring the client to another agency, and at discharge, completes the outcome measure; or (2) if the outcome measure is completed during a billable session, and not over the phone or at home by the client.

FUNCTIONAL FAMILY THERAPY (FFT)

1. What are the 3 Phases of treatment during FFT?

The 3 Phases of treatment during FFT include:

1. Engagement and Motivation Phase
    a. During the engagement and motivation phase of treatment the practitioner focuses on developing an alliance with the family, reduce negativity/blame and resistance, improve communication, minimize hopelessness, develop a family focus, increase motivation for change and reduce dropout potential.
2. Behavior Change
    a. During the behavior change phase of treatment the practitioner focuses on development and implementation of individualized change plans, change presenting high risk behavior and build relational skills (e.g. communication, parenting, etc.).
3. Generalization Phase
    a. During the generalization phase of treatment the practitioner focuses on maintaining/generalizing change, preventing relapses and providing community resources necessary to support change.

2. What is the age range for FFT?

FFT is to be provided to families where the identified client is between the ages of 10-18.

3. What is the focus of treatment for FFT?

FFT is intended for families where youth, ages 10-18, are experiencing severe behavior and/or conduct disorders.

4. What is the treatment modality?

FFT is provided in family group settings.

5. Where can FFT be provided?

FFT is primarily provided in the family home, but may also be provided in the community and in an office setting for the comfort of the family.

6. How many family facilitators are needed?

FFT family sessions are conducted by only 1 FFT practitioner.

7. What is the average length of treatment?

The average length of treatment is 12 sessions over a 3-4 month period.

8. How often should FFT sessions be conducted?

FFT sessions are conducted as often as need by the family; generally the first 3 sessions of engagement and motivation are conducted in the first 10 days of treatment, then sessions are typically conducted weekly. Session length is approximately 60-120 minutes.

9. What are the "Core Interventions" for FFT?

The "Core Interventions" include:

i. Assessment
ii. Collateral
iii. Family Psychotherapy

10. Do you have to be licensed clinician to implement FFT under the PEI Plan? Yes. Please see current version of the County of Los Angeles – DMH, "A Guide to Procedure Codes" for specific Rendering Provider eligibility.

11. Is there a "train the trainer" model for FFT?

No. Please see question below for internal agency training.

12. What is the training protocol for new agency staff/when there is staff turnover?

The training protocol for new agency staff/when there is staff turnover includes (Replacement Training Series):

i. Initial Clinical Training (2.5 days)
ii. Follow-Up Training #1 (2 days)
iii. Follow-Up Training #2 (2 days)
iv. Follow-Up Training #3 (2 days)

13. What are the required Outcome Questionnaires for FFT?

DMH PEI Outcome Measures Application Requirement: The outcome measures should be administered pre- and post-treatment. Additionally, if the FFT treatment extends beyond 6 months, an update for each measure is required every 6 months. The required outcome measures are the following:

- Youth Outcome Questionnaire (YOQ)
- Youth Outcome Questionnaire-Self Report (YOQ-SR)

CiMH/Developer Requirement: Each clinician is required to enter information into the Clinical Services System (CSS). The CSS is available online through the developer's website. The CSS includes:

i. Progress Notes (for each session)
ii. Counseling Process Questionnaire (administered every other session)
iii. Client Outcome Measure (administered post therapy)
iv. Therapist Outcome Measure (administered post therapy)
v. YOQ (administered pre and post therapy)
vi. YOQ-SR (administered pre and post therapy)
vii. OQ (administered pre and post therapy)

14. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs and YOQ-SR)? Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation can be completed by a person enrolled in a graduate degree

program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waivered staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

GROUP COGNITIVE BEHAVIORAL THERAPY FOR MAJOR DEPRESSION (Group CBT)

1. Who is appropriate for Group CBT?

The developer intended this Evidence Based Practice (EBP) to be used with individuals experiencing a depressive disorder.

2. What is the age range for Group CBT?

The Department has decided to use Group CBT for Transitional Age Youth (TAY, age 18-25), Adults (age 26-59), and Older Adults (OA, age 60+).

3. Are the diagnoses of Major Depressive Disorder required for Group CBT?

No, clients do not require a diagnosis of Major Depressive Disorder. However, the model is intended to treat symptoms of depression. The Department encourages clinicians to use their clinical judgment to determine if Group CBT is an appropriate model for the client.

Consistent with DMH policy, the client must meet criteria for an included eligible diagnosis in order to claim services to Medi-Cal.

4. Can Group CBT be offered to all clients presenting with depressive symptoms?

Group CBT is more successful with the PEI population versus the serious and persistent mentally ill (SPMI) population. Group CBT is generally not the best practice for clients currently abusing or addicted to alcohol or drugs, currently psychotic, those diagnosed with a mental health disorder other than a mood disorder (such as PTSD), or clients with personality characteristics which may alter the group dynamic.

5. Who can provide Group CBT?

The Department only allows trained psychotherapists to be the primary lead/clinician for the group. Trained psychotherapists include licensed, registered, or waivered MD/DO, Ph.D/Psy.D., LCSW, MFT, Psychiatric/Mental Health Clinical Nurse Specialist, Psychiatric/Mental Health Nurse Practitioner, and student professionals in these disciplines with a co-signature. Paraprofessional staff can provide support with check-ins, homework, and case management. Paraprofessional staff can co-facilitate the CBT Group; however the primary clinician must take lead and, in this situation, the group can only be claimed as group rehab (H2015), not group psychotherapy (90853).

6. What is the length of treatment?

Group psychotherapy is offered one time per week for 12-16 weeks, depending on when the group completes all four sessions of the three modules. Ideally the client should commit to 12 weeks. The weeks do not have to be consecutive; thus the total time allowed is up to 16 weeks. The clinician should ensure that all 12 topics are discussed in the 12-16 week timeframe.

This model supports an orientation session at the beginning of treatment and a relapse prevention session at the end of treatment. These two sessions can be added so long as the entire course of treatment stays within the 16-week limit.

This practice may be extended up to 20 weeks if the Health module is added so long as the clinical appropriateness of extending the practice is clearly documented.

7. According to the developer, group sessions can be either 1.5-hours or 2-hours. What is the Department's requirement?

There is no Department mandate limiting the time frame of groups. Clinicians can provide a 1.5-hour or 2-hour group on a weekly basis.

8. According to the developer, the groups can be open or closed. Does the Department mandate one or the other?

The Department does not mandate that groups be open or closed; however an open group is recommended to allow new clients to enroll every 4 weeks upon the completion of a module. It is also recommended that the clinician orient new members to the group at start of each module. Clients are required to attend Session 1 of the module during which the client enters into the group.

Clinicians should be mindful that the open group format might influence the group's dynamics. Group structure should be based on your clinic and client needs; however an open group allows clients access to services more quickly as compared with a waiting list.

9. Does the Department require a certain number of participants in each group session?

There is no Department mandate regarding the number of participants; however there needs to be at least two clients in order to claim the procedure code for group psychotherapy.

The recommended ratio for Group CBT is 8-10 participants to two clinicians per group.

10. Can the clinicians incorporate other topics and treatment modalities besides CBT in the groups?

Group CBT therapy is limited to the treatment protocols contained within the Group CBT for Major Depression manuals. This EBP does encourage a "tailor approach" by allowing the group facilitator to use clients' life examples and illustrations to make CBT concepts applicable to the clients' lives.

11. Is homework required between each group session?

Yes. Clinicians should review the client's homework, weekly, in the group session.

12. What procedure codes should be used for Group CBT?

The procedure codes for Group CBT are:

- Assessment (Procedure Code 90791)
- Group Psychotherapy (Procedure Code 90853)

- Group Rehabilitation (Procedure Code H2015)* (HE, HQ**)

*For paraprofessional co-facilitates the group with the clinician
**For Contract Providers submitting electronic claims to the Department

Other services, including case consultation, medication support, collateral sessions, or crisis intervention, may be offered to address emergent client needs and individual therapy may be utilized if a client misses a group session; however the client should be referred to a higher level of care if they require ongoing services.

13. When can you use Individual Psychotherapy (Procedure Code H0046, 90832, 90834, or 90837)?

Individual psychotherapy should only be used to "make-up" a missed group psychotherapy session. Ongoing participation in individual psychotherapy is not part of the Group CBT model and could discourage group participation and negatively impact the benefits the client might otherwise gain from Group CBT. Individual psychotherapy with the same clinician to address the issues also discussed in group is discouraged by the Department while the client is participating in Group CBT.

14. What about case management?

Case management can be utilized to keep clients engaged in treatment or to connect them to other non-core services or community resources. For example, a client who is homeless will be more engaged in treatment if housing assistance is also provided. For those clients who may need long-term or more intensive treatment, the clinician can identify appropriate referrals. In these situations, the Group CBT clinician retains clinical responsibility over the case until it is successfully transitioned into the appropriate setting.

15. Can the clinician claim for group preparation on Community Outreach Services (COS)?

No. The Department does not permit use of COS to claim for group preparation.

16. Can a client from one of the Mental Health Services Act (MHSA) Community Services and Support (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnership) or non-MHSA programs receive this EBP?

Yes. Any client receiving services in one of our non-MHSA or MHSA-CSS programs can receive this EBP as well as other EBP interventions. In such instances, the service will be claimed to the MHSA plan/Level of Care in which the client receives their primary services—and NOT to PEI. For example, a CSS

Wellness client can participate in Group CBT if the client meets the criteria for this practice. However, the services for this client will continue to be billed to the "MHSA_Fam_Focused_Wellness Svc" plan, not the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "Group CBT" (2J). PEI outcome measures are not required when the client is receiving EBP services in a different plan (i.e., not PEI).

17. Can a client receive Group CBT along with another PEI EBP?

The goal of PEI services is to help the client move forward quickly in coping with their mental health challenges. Therefore, the Department expects that the use of multiple practices for PEI clients would occur infrequently. The clinician would need to consider duplication of services, overwhelming the client with services/expectations, and, most importantly, the clinical necessity of adding another practice to meet the client's needs.

18. What happens if the client successfully completes Group CBT?

The client will be discharged and their case will be appropriately closed. They may return, if needed, should they benefit from another course of Group CBT or alternative interventions.

19. What is the required training protocol?

The Department requires the clinician to attend the two-day, Initial Adult Group CBT training. Upon completion of the two-day training, trainees participate in consultation calls with the trainer for the duration of their first 12-16 week group (depending on the clinician's level of training and demonstrated competence in Group CBT). The trainees will audio record their group sessions and download the recordings to the trainers secure website for their review. A minimum of a pass score on one recording for each of the three modules is required to complete the training. Clinicians must also attend the one-day Booster Training after completing the other components of the training protocol.

20. Does Group CBT require a trained supervisor as part of the Adult CBT Team at a clinic?

According to the EBP, formal supervision by a licensed clinician is required. The Department encourages each program to select a "champion" who will be trained in Group CBT and can provide implementation and clinical support for the EBP. The "champion" should have prior training in CBT, such as the course offered at Harbor UCLA.

21. Are clinicians who completed the entire Ind CBT training protocol approved to implement Group CBT?

Yes. Clinicians who have completed the entire Individual CBT training protocol are approved to implement the Munoz model for Group CBT.

22. Is "train the trainer" available for Group CBT?

The developer does not currently permit "train the trainer".

23. Can interns get trained in and offer Group CBT?

Yes, interns can be trained in Group CBT. Interns who complete all components of the training will receive provisional authorization to claim Group CBT services. Interns will require supervision by a licensed clinician to claim Group CBT services to the PEI Plan.

24. How do I participate in the weekly phone consultation?

Staff must complete the initial two-day training and the trainer must provide the individual access to the website to download the audio recordings of the group sessions. Staff

must log into the Group CBT Website, www.adoptebp.com, to register. The website and the recordings uploaded to this site are used for the weekly phone consultation and to communicate and share information regarding CBT implementation and compliance. This website and the use of recordings should only be used during the training period. Clinicians should stop using the website and recording sessions once they have become certified in this EBP.

25. Are Group CBT manuals available?

There is a limited supply of Group CBT Manuals distributed as requested to our directly operated clinics. There is also a PDF version which can be emailed for print at the requesting clinician's agency. Please email ASOCEBP@dmh.lacounty.gov for the attached PDF.

26. What are the required outcome measures for Group CBT?

There are two outcome measures for Group CBT:

- Personal Health Questionnaire Depression Scale-9 for ages 18+
- Outcomes Questionnaire (OQ 45.2)-19 and older
- Outcomes Questionnaire (YOQ-SR 2.0)- 12 to 18

27. Can the clinician claim for administering the outcome measure? No.

Administering an outcome measure is not claimable to Medi-Cal.

INDIVIDUAL COGNITIVE BEHAVIORAL THERAPY (Ind CBT)

1. Who is appropriate for Individual CBT?

Ind CBT is intended as an early intervention for individuals who are experiencing or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma which impact various domains of daily living.

2. What is the age range for Ind CBT?

Currently the Department supports utilization of Ind CBT for Transitional Age Youth (TAY, age 16-25), Adults (age 26-59), and Older Adults (OA, age 60+) at our Directly Operated clinics and Contracted Agencies serving clients under MHSA PEI or CSS plans (including FSP, FCCS, and Wellness).

3. Are there specified diagnoses required for Ind CBT?

No, clients do not require specific diagnoses to participate in Ind CBT. The model is intended to prevent or treat early onset of symptoms of depression, anxiety, and effects of trauma that may impact functioning in various domains of daily life. The Department of Mental Health (DMH) encourages clinicians to use their clinical judgment to determine if Ind CBT is an appropriate model for the client. Consistent with DMH policy, the client must meet criteria for an included eligible diagnosis in order to claim services to Medi-Cal.

4. Who can provide CBT?

Ind CBT may be provided by licensed, registered, or waivered MD/DO, Ph.D/Psy.D., LCSW, MFT, Psychiatric/Mental Health Clinical Nurse Specialist, Psychiatric/Mental Health Nurse Practitioner, and student professionals in these disciplines with a co-signature provided they have had (or are currently
receiving) specialized training in CBT.

5. What is the length of treatment?

Treatment length for Ind CBT ranges from 18 to 52 weekly sessions depending on client's clinical needs and treatment response. Clinical tasks, to be completed during a course of Ind CBT include: developing diagnoses, treatment planning from a case conceptualization perspective, and the provision of CBT intervention protocol.

6. What is the length of treatment sessions?

Ind CBT is provided during a 45 to 50-minute weekly session.

7. Can the clinician incorporate other topics and treatment modalities besides CBT?

Adherence to the treatment protocol is required for Ind CBT. For this intervention, treatment is limited to the use of CBT interventions and methods of conceptualization. Ind CBT allows for "tailoring" of CBT conceptualizations and interventions to address individual treatment goals.

8. Is homework required between each session?

Yes, homework is an important part of ensuring treatment generalization to the client's daily life. Homework is tailored to client's treatment goals and reviewed weekly during the therapy session.

9. What procedure codes should be used for Ind CBT?

The procedure codes for Individual CBT are:

- Assessment (Procedure Code 90791)
- Collateral (Procedure Code 90887)
- Crisis Intervention (Procedure Code H2011)
- Family Psychotherapy (Procedure Code 90847)
- Group Psychotherapy (Procedure Code 90853)
- Individual Psychotherapy (Procedure Code H0046, 90832, 90834, 90837)
- Plan Development (Procedure Code H0032)
- Targeted Case Management (Procedure Code T1017)

Other services; including case consultation or medication support may be offered to address emergent client needs. The client should be referred to a higher level of care if they require more intensive ongoing services.

10. What about case management?

Case management can be utilized to keep clients engaged in treatment or to connect them to other ancillary services or community resources. For example, a client who is homeless will be more engaged in treatment if housing assistance is also provided. For those clients who may need long-term or more intensive treatment, the clinician can identify appropriate referrals. In these situations, the CBT clinician retains clinical responsibility over the case until it is successfully transitioned into the appropriate higher level of care.

11. Can the clinician claim for preparation on Community Outreach Services (COS)?

No, DMH does not permit use of COS to claim billing for preparation of service delivery.

12. What is the EBP code associated with Ind CBT for PEI billing?

The clinician will identify the EBP as "Individual CBT" (8A) on the IS drop down menu when providing Ind CBT to a PEI client.

13. Can a client receive Ind CBT along with another PEI Practice?

The goal of PEI services is to help the client move forward quickly in coping with their mental health challenges. Therefore, DMH expects that the use of multiple practices for PEI clients would occur infrequently. The clinician would need to consider duplication of services, overwhelming the client with services/expectations, and, most importantly, the clinical necessity of adding another practice to meet the client's needs.

14. What is the required training protocol for Ind CBT?

DMH offers the following two options for the Ind CBT training protocol:

Option 1

a. 3-day Initial Ind CBT training
b. 16 weekly 55 minutes consultation calls. Clinician can miss up to 2 calls.
c. Submission of 1 audiotape and 1 case conceptualization on 3 current CBT clients reviewed by CBT trainer or designated consultant. Trainee must receive a satisfactory rating score of 36+ on Cognitive Therapy Rating Scale (CTRS) on 2 audio recordings and a satisfactory rating score of 20+ on Case Review Rating Scale (CRRS) on 2 case conceptualizations.
d. 1-day CBT Booster training.

Option 2

a. 9-month Harbor UCLA CBT class
b. Submit 1 audiotape and case conceptualization on 1 current CBT client reviewed by CBT trainer or designated consultant. Trainee must receive a satisfactory rating score of 36+ on Cognitive Therapy Rating Scale (CTRS) and a satisfactory rating score of 20+ on Case Review Rating Scale (CRRS).
c. Additional information found in Question 15.

15. I am a clinician who completed the 9-month Harbor UCLA Ind CBT training in the past. Can I provide Ind CBT for PEI, FSP, FCCS, or Wellness?

To provide Ind CBT for PEI, FSP, FCCS, or Wellness, clinicians who have completed the 9-month Harbor UCLA Ind CBT training course may apply to and complete the Ind CBT Verification process. Applicants for the Verification process must meet the following criteria:

i) Applicant must have completed a terminal graduate degree in the mental health field and be licensed or license eligible (receiving supervision from a licensed clinical supervisor)
ii) Applicant must have completed the minimum number of sessions during the 9-month CBT class and have a certificate of completion form 9-month CBT course.
iii) Applicants will be required to complete the verification application on a secure website (www.academyofct.org/losangeles) managed by The Academy of Cognitive Therapy.

Once an applicant has successfully passed through the CBT verification process, he/she can begin providing Ind CBT for PEI, FSP, FCCS, or Wellness.

16. I took CBT training in the past. Can I provide Ind CBT to PEI, FSP, FCCS, or Wellness clients age 16 and older?

In some instances, clinicians who have received specialized training in CBT treatment interventions and conceptualization may be verified to provide this Ind CBT within DMH. This training may have been received earlier at the graduated level or by attending advance CBT training. These situations will be approved on an individual basis by the Ind CBT Practice Lead. Once approved, the clinician will need to submit an audio recording and case conceptualization for rating to the Academy of Cognitive Therapy and receive a passing score of a 36 or higher on the CTRS and a 20 or higher on the CRRS.

17. What devices are approved for recordings?

Clinicians at DMH-operated clinics may ONLY use Phillips Records for audio recordings. Clinicians at county-contracted agencies are to adhere to recording devices and protocols as determined by their respective agencies.

The recordings are to be uploaded only to the secure website provided to the clinician during the training program in a DS2, WPA, MP3, or MP4 format.

18. How do clinicians participate in the weekly phone consultation and upload recordings and case conceptualizations?

Clinicians sign up for the consultation call during their initial 3-day training. The call is offered on a local or toll-free number each week and clinicians are provided an access code specific to the toll-free number. Clinicians will also receive the secure website address associated with their cohort upon completing the initial training. Submission of audio recordings and case write ups/diagrams can ONLY be accepted through the secure DMH approved website.

19. When can a clinician start billing Ind CBT?

Clinicians are able to initiate claiming Ind CBT to the PEI or CSS billing plan (including FSP, FCCS, and Wellness Programs) upon completing the initial 3-day training and throughout the entire training program and continue billing upon successful completion of the training program.

Clinicians must complete the remaining part of the training protocol (consultation calls, uploading of audio recordings/case conceptualizations to meet adherence, and booster training) within six (6) months of initiating the Ind CBT training protocol. Exceptions to length of training process will be made on an individual case by case basis; with a target date of completing the outstanding parts of the training program within one year of initiating the process to continue billing Ind CBT.

20. Does Ind CBT require a trained supervisor as part of the Individual CBT Team at a clinic?

No it does not. If possible, it is recommended to have one clinical supervisor trained in CBT available for ongoing support and supervision of trained staff.

21. Is "train the trainer" a possibility with Ind CBT?

For sustainability purposes, the Department will be implementing a Clinical Champion (CC) Training protocol.

Staff that have completed either Option 1 or Option 2 under the required Training Protocol, are eligible to apply to become an Ind CBT Clinical Champion. The Clinical Champion Training Protocol is as follows:

1. Ind CBT CC must apply for certification through the Academy of Cognitive Therapy ACT), paid by DMH

2. Initial 1-day training for Ind CBT CC (5 hr/day, 50 staff/training)
3. Consultation Calls: 1 time/week, 55 minute long, 1 consultant to 5 Ind CBT CC per call, 12 calls total. Calls to start 1-2 weeks after 1-day training.
4. During the 12 weeks, Ind CBT CC will provide individual supervision to a staff clinician in house providing CBT to at least 1 client at 16 and older.
5. Audio Recordings: each Ind CBT CC will submit 1 audio recording of a supervisory session with the staff clinician in house providing CBT to be rated by the CBT trainer or designated consultant. Ind CBT CC must receive a minimum score of 40 or higher on the CTRS.
6. During the 12 weeks, each Ind CBT CC will review and rate 2 case write-ups/diagrams (CCD) by a clinician providing CBT and rate the recording using the CTRS. An Ind CBT CC will pass if their CTRS score falls within a 5 point range of the assigned CBT trainer or designated consultant's CTRS.
7. During the 12 weeks, each Ind CBT CC will review and rate 2 case write-ups/diagrams (CCD) by a clinician providing CBT and rate the CCD using the CRRS. An Ind CBT CC will pass if their CRRS score falls within a 4 point range of the assigned CBT trainer or designated consultant's CRRS.
8. Personal Supervisory Model based on CBT Principles: Ind CBT CC will submit a personal supervisory model write-up for review. Must receive a minimum score of 20 on Supervisory Scale.

22. What can a Clinical Champion (CC) provide after completing the training?

Those who successfully complete the CC training protocol will only provide under Required Training Protocol Option 1 (as described in Question 14, bullet "b" and "c." Bullet "a" and "d" will still need to be provided by a DMH approved CBT trainer/institute.

23. Can students and interns get trained in CBT?

Yes, students and interns can be trained in Ind CBT. Those who complete all components of the training and are supervised by a licensed clinician will receive provisional authorization to claim Individual CBT services to the PEI Plan.

24. What are the required manuals for the Ind CBT training protocol and the Ind CBT Clinical Champion training protocol?

For Initial Training Process:

1. Clinician's Guide to Mind Over Mood – Greenberger & Padesky
2. Overcoming Resistance in Cognitive Therapy – Leahy
3. Mind Over Mood: Change How you Feel By Changing the Way You Think- Greenberger & Padesky

For Clinical Champion Process:

1. Teaching and Supervising Cognitive Behavioral Therapy- Donna M. Sudak, R. Trent Codd, Marci G. Fox, Leslie Sokol

25. Is certification required for this EBP?

No. Certification is NOT required.

A CTRS score of 36-39 and a CRRS score of 20+ achieves a level of competency in CBT meeting the DMH requirement to provide this EBP in LA County.

A CTS score of 40+ and a CRRS score of 20+ achieves a level of certification in CBT **IF** received by a national organization accredited to provide certification, such as the Academy of Cognitive Therapy (ACT).

Staff are welcome and encouraged but not required to become certified as a CBT trained therapist through a national organization such as ACT or the Beck Institute.

Only staff applying for the clinical champion training program will be required to become certified to participate.

26. Should a clinician decide to become certified, what is the process?
Clinicians who successfully complete the DMH Ind CBT training program are qualified for the fast track application process set up by ACT to become certified as a CBT therapist. Clinicians expressing interest in moving forward with the certification process will be provided information on how to proceed upon completing the Ind CBT training program.

27. What are the required outcome measures for Ind CBT provided to a PEI client?
Clinicians will administer the General Measure and symptom specific measures congruent with the client's presenting problem in treatment. The outcome measures for Ind CBT are as follows:

General Measure:
- Outcomes Questionnaire (OQ 45.2) – 19 and older

General Measure:
- Outcomes Questionnaire (YOQ-SR 2.0) – 16 to 18 years of age

Focus of Treatment Specific Measure (for Depression)
- Patient Health Questionnaire Depression Scale-9 (PHQ-9)- 16-65+

Focus of Treatment Specific Measure (for Anxiety)
- Generalized Anxiety Disorder 7-item Scale (GAD-7) 18-65+

Focus of Treatment Specific Measure (for Trauma)
- University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA PTSD-RI) for Child & Adolescent (6-20 years)
- Posttraumatic Stress Disorder Checklist-5 (PCL-5)- 21+

28. What is the outcome measure for a 16-17 year old receiving CBT to address anxiety?
According to PEI Outcomes, the 16-17 year olds being treated with anxiety do not need to receive a measure since it has not been set by DMH. Clinicians are welcome to provide the RCADs as a clinical tool; however, it does not need to be inputted into the PEI OMA at this time.

29. Can the clinician claim for administering the outcome measure?
No, administering an outcome measure is not claimable to Medi-Cal.

MANAGING AND ADAPTING PRACTICE (MAP)

Training-Related Topics

1. What are the requirements to be trained as a MAP Supervisor?

To qualify to become a MAP Supervisor, the individual must be 2-years post-licensure, have direct clinical control over the cases seen by their trainees, and must be in the role of supervisor.

2. What is the timeline for training expiration and a therapist's ability to bill?

Therapists may begin to bill after completing the first 8 hours of training. Therapists must complete all training protocol within 12 months or they will not be able to continue billing PEI for MAP services. However, the training for MAP never expires and clinicians may still submit portfolios for review if more than 12 months have passed.

- Certified Therapists have 3 years before needing to renew.
- Certified Supervisors have 2 years before needing to renew.
- Staff must maintain valid certificates in order to utilize and bill PEI for MAP. Agencies must maintain active subscriptions (PWEBS, Dashboards, and Practitioner Guides) in order for their staff to provide MAP at that agency.

3. What is the suggested format for Agency Supervisor-Based Training?

Below are suggestions from Providers:

- 3 days for the big concepts; after 6-8 weeks, a booster day; then break-out into 2-hour supervision format: a 6-month long process, one cohort at a time.
- 8 hours one day per week for 5 weeks. First 2 days are impactful, intense information to absorb.
- After 8 hours initial training, individual supervision every other week; available for drop-in consultations.
- Consider overlapping trainings so if someone misses a day, they can pick it up as the next wave come around.
- Spacing out training is optimal for better learning and retention of material.
- Consecutive 5-day trainings feel more laborious. Recommend to spread out trainings.
- DMH has a PEI Training Registry of who has been trained/certified. After the first 8 hours of training, use form: Request for Authorization to Bill MAP. Complete in .doc format, not .pdf! Send to PEI Administration Training Coordinator Rebecca Hall: rehall@dmh.lacounty.gov and cc: MAP Practice Lead Mike Alba: malba@dmh.lacounty.gov.

4. How do you notify DMH of clinicians' current training status?

An EBP Training Verification Form must be completed and submitted to PEI Administration. Please contact PEI Administration at MHSAPEI@dmh.lacounty.gov for assistance with this form.

5. Will agencies be able to certify their own clinicians in MAP?
No. PracticeWise will always retain certification process.

6. If we have MSW interns (still in school), can we train them?
Yes. Bachelor's level staff and above can be trained and certified in MAP. However, it is the agency's obligation to ensure that these individuals complete the full practice protocol before leaving the agency.

7. How often do you need to be recertified in MAP?

- Recertification for therapists is required every 3 years.
- Recertification for supervisors is required every 2 years.
- Subscriptions to P-Web, Practice Guides, and PPMT Dashboard need to be renewed on a yearly basis.
- Recommended to not let certification lapse, even if you are not supervising, training, or seeing MAP clients.
- Active or inactive status options are available and have different costs for re-certification. "Inactive" status means that you are not currently seeing clients.
- 2 different portfolios:
  - Promotional review portfolio – For initial certification
  - Performance review portfolio – For certification renewal
- "Performance Review" has less client work and requirements than "promotional review."
- Make sure PracticeWise has your updated information (email, phone, street address).

8. Are there DMH-sponsored MAP trainings being offered?
No, not currently; however, PracticeWise will hold training for you if you have clinicians starting employment at your agency, or clinicians who have not yet been trained. Contact PracticeWise at support@practicewise.com for information about purchasing a training. For direct service clinicians, the minimum cohort is 24. For supervisors, the minimum trainee cohort size is 12.

9. Are there DMH-sponsored MAP Supervisor trainings being offered?
No, not at this time. Contract PracticeWise at support@practicewise.com and consider the cost-benefit: The cost of training a supervisor pays off after one cohort of clinicians. With renewal costs of $250 every two years, and the cost of training replacement/new staff (with a general turn-over rate of 6 clinicians every 1-2 years), it may be worth certifying a supervisor.

10. Is the MAP Agency Supervisor credential transferrable?
Agency Supervisor credential is transferrable but can be maintained for only one agency at a time.

11. Do new MAP Supervisors at small agencies have to train 6 clinicians?
For small agencies that have difficulty finding 6 clinicians for a new supervisor to train, PracticeWise allows for a new supervisor to provide "skill enhancement" to currently certified staff as part of the training process for new supervisors.

12. Can one agency's trained supervisor train another agency's staff?
No. An agency supervisor is certified at only one agency at any time.

13. We just hired a clinician trained at another agency in MAP, but his certification ends this month. He has not provided MAP in 2 years. How can he begin providing MAP again at our agency?
A clinician trained by PracticeWise can provided MAP anywhere in LA. If trained by an agency supervisor, then complete an agency transfer packet with PracticeWise, and it is recommended that the supervisor reviews dashboard-building to confirm skills compared to your agency's standard.

- For a certificated clinician close to certificate expiration date, the clinician should review the Therapist's "Performance Review" Portfolio, which fully describes what is required.
- For a clinician new to an agency who does not have a case, look at the criteria in the "Performance Review" Portfolio as there is some flexibility as to how to complete. Contact PracticeWise to work with you to maintain a standard of quality.

PWEBS-Related Topics

14. How do you determine which PWEBS results to use- One with few search criteria and many results or more search criteria but fewer results?

- Practice Elements at the top of search results are referenced by more studies and may be of more relevance.
- Number of articles in PWEBS is limited by what PracticeWise has been able to code. PWEBS is a dynamic database which grows over time but is not exhaustive.
- Note on Culture-based Search results: Culture-based searches often return very few search results.
- In building a treatment plan, identify evidence that is important to you. E.g. age for developmental appropriateness; ethnicity if there is a compelling reason. What cultural adaptations do you need to make? Consider other cultural components not necessarily linked to ethnicity. Perform multiple searches with alternate criteria to see if the same elements are returned. Ethnicity will return few search results due to limited research of specific populations.
- When using PEWEBs to create PPMTs remember client goals: helping reduce symptoms; helping client get better. Search results indicate what has been shown to be effective but may not work for every client.
- PWEB search helps therapist's conceptualization of therapeutic plan.

15. How many practice elements should be returned by a "good" PWEBs search?
There is no set number.

16. Is it possible to incorporate other EBP elements not returned by PWEBS search with MAP?
Yes. Remember, PWEBS is not exhaustive. If a clinician is trained in a different practice and is allowed by agency, it is possible to utilize other practice elements as part of MAP.

17. How strict are the age ranges for MAP?

MAP is adaptable. Current age ranges are determined by what PracticeWise has been able to enter into PWEBS, but MAP allows for additional elements to be utilized. For example, PWEBS trauma treatment currently goes down to age 3. But, if you have a 2-year old, and you have EBP trauma training for children younger than 3, then you can use elements from that EBP on your dashboard. PWEBS provides suggestions (practice elements) for treatment based on the available literature. The dashboard tracks delivery of practice elements and is used to monitor effectiveness of your intervention. Keep in mind that MAP is not an EBP and is a system used to organize and monitor treatment delivery.

Current ages for each MAP focus:
Depression 8-23
Anxiety 2-19
Disruptive 0-21
Trauma 2-18

18. Are TAY Youth covered in PWEBs?

The review underlying the PWEBS is only systematic through age 18 years, but it does include studies with participants over 18 years if youth under 18 are adequately represented in the study. This means that you may find results for youth above 18, but it will not be a thorough representation of the evidence base for those age groups.

QA-Related Topics

19. Is it possible to utilize mood rating as a PPMT/SMART goal?

- Advice is given against using mood rating as a goal; instead, you can monitor/count the number of times the intervention is used by a client to reduce symptoms.
- Level of "anxiety" and "depression" may be too vague."
- One agency's QA recommends that specific behaviors be counted/measured instead of mood rating, e.g. "amount crying."
- Other agencies track mood rating on a weekly basis for some clients.
- Focus on integrating CCCP and PPMT to close the "clinical loop" of Initial Assessment, CCCP goals, and PPMT.
- Recommended to use strength based language and "positive behaviors" as goals.
- It is possible to use outcome measures for help in constructing goals. Use client responses to choose goals for reducing symptoms endorsed by client.

20. How do you integrate clinical need with the demands of QA?

There is no one right way. Create a system that works best for your agency based on size and resources.

21. How do we monitor fidelity to the MAP model? How do we ensure QA, effective supervision, and effective clinical practice while maintaining fidelity to the model?

Agencies are encouraged to create fidelity monitoring tools for use in supervision.

Electronic Health Record and Outcomes-Related Topics

22. How are agencies using Electronic Health Record Systems?
Each agency is using a different EHR system.

23. Are outcome measures for MAP entered in the OMA?
On February 9, 2015, PEI OMA was ready to accept outcomes data for MAP, Triple P, and TF-CBT. Treatment cycles that were inactive/closed, or had fatal errors (i.e., malformed client IDs, incorrect D.O.B., etc.) were not integrated. CIMH Historical section in PEI OMA provides information on what was previously submitted to CIMH (i.e., demographic and outcomes data), and whether the record was integrated or not and reason(s) why it was not.

For more information, see link below:
http://dmhoma.pbworks.com/w/page/55241527/CiMH

24. How do you appropriately maintain copies of outcome measures?
Please contract PEIOutcomes@dmh.lacounty.gov.

25. How can the supervisor ensure that data is correct on the PPMT if someone else is monitoring/collecting the outcome measure data? It seems hard for the responsibilities of MAP to be dispersed. Why can't we write the names of assessments/measures (i.e. ECBI, PHQ-) in case notes if it's such an integral part of treatment?
It is the therapist's responsibility to administer, collect and monitor PPMT data and client progress. A MAP supervisor has the responsibility to ensure that the therapist is competent in capturing accurate data on the PPMT through chart review and supervision.

26. I have not yet been trained in the outcome measures. If I do not have them completed within the first 30 days of treatment, should I administer them at all?
MAP does not have the first 30 days of treatment policy when it comes to pretreatment data. Our interest in the completion of outcome measures has to do with assessing the functioning of the client, within the valid administration guidelines of each measure, for two purposes: (1) providing clinically useful information to guide treatment; and, (2) document treatment-related improvements in functioning.
From an outcomes perspective, the measures should be completed at pre-treatment, pre-MAP intervention. The farther one gets into treatment, the administration of measures no longer represents a pre-treatment assessment.
There is no absolute cut-off point. If the measures are not collected pre-treatment, they're not useful from an outcomes perspective. However, if the client was not seen within those 30 days, and the clinician feels as if the administration would still be pre-treatment, and be an accurate reflection of functioning before the MAP intervention, then it would be worthwhile. In terms of guiding clinical intervention, early and regular measurement is most useful, but even if pre-treatment assessment is missed, the "better late than never" rule applies.

Agency Staff-Related Topics

27. If staff transfer from other agencies will they need to redo the training process? Specifically, what must new clinicians mid-way through their training do when they transfer?

- Supervisor needs 12 total hours training in order to submit your portfolio.

- The 52 hours of supervision does not all have to be with the same person.
- Supervisor attests to the validity of performance portfolio, and that an adequate amount of training was given.
- Only current supervisor's documentation with be accepted by PracticeWise.
- New clinicians already trained need to submit a "Transfer Packet".
- New clinicians can begin billing based on submission date of "Transfer Packet.

28. Is PracticeWise Staff Transfer Process PEI reimbursable as a training expense?
Contact Olivia Sanchez at osanchez@dmh.lacounty.gov to find out if the transfer is reimbursable.

29. If therapist trained through PracticeWise at another agency, do we need to do a transfer packet?
No. There are 2 types of certificates: Countywide and the agency-specific certificate. If PracticeWise conducted the training then the certificate issued is countywide as long as you have valid subscriptions to PWEBS and practice guides. If staff was trained by an agency supervisor, then you must complete transfer packet with PracticeWise. You can start billing DMH once the transfer packet has been submitted.

30. Does a supervisor need to complete a transfer packet if they switch agencies?
Only one agency per certificate; supervisors only supervise and provide trainings at one agency.

31. Can you share some experiences from veterans who have gone through the Supervisors' Recertification process?

- It was very simple and straightforward.
- Submit new Practice Elements.
- You don't have to have an active case – choose someone who you trained, and passed.
- The therapist is your case. You only need one, be sure they did the Eval.
- It took about 20 minutes.
- Minimum of sessions? Not an issue – chose a staff member who passed, demonstrating the skills.
- PracticeWise is looking for skill improvement. If in doubt, you can always call PracticeWise, it's factored into the fee you pay them, and they're prepared for that.
- Submit portfolio WITH payment.
- Evaluations: they're looking to see that they were done, not content. It's important for the supervisor to understand the relationship with the people you've trained.
- They want to see progression in elements; e.g. from skill to habitual, and add 1-2 new elements to change things up.

32. Can you share some experiences from veterans who have gone through the Therapists' Recertification process?

- Therapists have failed because practice element listed on portfolio did not have practice *guides*.
- Only requires 4 pages to submit. Double check that all required documents are submitted for that portfolio (promotion or performance) review.
- Level 1 fail: you omitted basic information on page 1 of the form or their ID wasn't matched, pages are missing, documents not attached – may resubmit at no cost.

    - One report of neither supervisor nor therapists passed b/c "40 hours didactic + [hrs] consultation = [total]" – because it didn't ask, she hadn't written "40 hours didactic +"
- Level 2 fail: One person submitted their portfolio and got a "proficient" grade but didn't check the box, "submitted dashboard" and received level 2 fail – need to wait 3 months before resubmitting with additional cost.
    - Recommendation- that you print the completed form and send the printed one because PracticeWise's form template may not save changes. If you submit PracticeWise's form, you'll be sending an incomplete form.
    - Failed b/c supervisor didn't count clinical events for recertification for promotion review, therapist submitted 9, and needed 10.
    - Forgetting to check a box on page 2: "Cultural Diversity" resulted in level 2 fail.
    - Recommendation- second set of eyes to review before submitting.
    - Recommendation- 2 measures even though 1 is enough. They're lowering points for the videographic display if there's only 1.
    - Recommendation- Customize list of practice elements: delete the one(s) you're not using so presentation is cleaner.
    - Utilize "Treatment Planner" Guide to figure out focus (connect/care/cultivate. Map clearly how treatment is planned out from start of treatment, not after the fact. This also helps clinicians consider end-of-treatment from the start.
    - Focus Interference Framework = Treatment Planner Guide
        - (one agency) requires in paper charts

33. Must one maintain MAP Therapist certification in order to maintain MAP Supervisor certification?

No, maintenance of MAP Agency Supervisor status will not require renewal of MAP Therapist Status (The exception to this is that individual who achieve MAP Agency Supervisor status via "grandfathering" are required to successfully pass the MAP Therapist Portfolio when their initial 3-year "grandfathering" period expires).

Note: Grandfathering refers to people who were trained by PracticeWise as MAP therapists before the portfolio was in place. In those cases, people have a 3 year period from their initial training under which they can operate as a MAP therapist in LA County, but at the end of that period they will need to submit a full therapist portfolio.

34. How does one maintain MAP Supervisor certification? Must you train 6 additional staff and have 2 more pass portfolio in that 2 year period?

No. The renewal is basically an update not a retraining, so they will either need to (a) successfully complete a supervisee, (b) submit a case from a current supervisee, or (c) submit their own MAP direct service case, along with the other docs required. Please note that PracticeWise is currently working on policy documents for this and you will know what you need to do long before the time comes in two years.

35. Once we have a MAP Supervisor, if they provided week long training and 6 months of consultation calls to staff, will those staff be "certified" MAP Therapists officially? Can they then take the Supervisor course?

Those staff will have to successfully pass their portfolio review to be certified in MAP and obtain their MAP Therapist Status. Once MAP Therapist Status is achieved, staff are eligible to continue on to the Supervision and Consultation Series.

36. Can MAP Supervisors supervise MAP staff that are already certified outside of the 10 max set by LACDMH?
Yes.

37. If an agency has two MAP Supervisors, can one do the training (in a formal 5-day sense) and the other do the follow-up consultation meetings? Will the training hours count toward the 15 the first person needs?
We do not mind if agencies with multiple supervisors "tag team" on the training portion (e.g., three supervisors split up training duties, group their supervisees for a shared training event, and then each continue the supervision with their supervisees following the event) but a systematic "hand off" from one supervisor who does the training to others who do the clinical supervision is definitely not consistent with the spirit of the Agency Supervisor model. This issue is a little tough because therapists and supervisors do periodically get "reassigned" during the development period and if this is a rare event, we would not take issue, but if this is recurrent or systematic then it does violate the spirit of the model.

38. Can a licensed therapist who received MAP training from a MAP supervisor be eligible for DMH sponsored MAP Supervision and Consultation Series training?
Yes, as long as they successfully passed their Therapist Portfolio review and achieved MAP Therapist status, they are eligible for the MAP Supervision and Consultation series training.

39. I read through the document on certification for PracticeWise and DMH but I'm not clear on which documents need to be submitted and to whom for MAP trainees receiving training from MAP Supervisors at the agency. Since they have not completed the 5 day training, they would not get a certificate, so what do I submit to PracticeWise and what do I submit to DMH?
Upon completion of training, trainees must submit the portfolio to PracticeWise. Supervisors must also submit their trainee's learning log along with their MAP Supervisor's certificate to DMH for authorization to submit claims to MAP. Once the trainee has achieved MAP Therapist status, they must submit their therapist certificate to DMH.

40. Which of the PracticeWise Online Resources services are required for a user to pursue or maintain MAP Therapist or MAP Agency Supervisor Status?
The Progress and Practice Monitoring Tools (PPMT, a.k.a. Clinical Dashboards), Practitioner Guides, and PWEBS Database.

41. Do those completing the MAP Supervision and Consultation Series have to submit all 6 trainees' MAP therapist portfolios for review at the same time?
No. It is not necessary to submit all of the Therapist Portfolios at the same time. Sometimes this is recommended to minimize confusion, but it is not necessary.

General MAP-Related Topics

42. Are there age restrictions for MAP? I have heard that the clients must be 4 yrs old regardless of what data is available in the PracticeWise PWEBS database? If there are age range cut-off's both top and bottom of the range, what are they?

With MAP, a key part of service planning and revision involves the use of the PracticeWise EBS Database (PWEBS). The PWEBS Database summarizes over 450 studies involving mental health treatments for participants ranging in age from 0 to 23 and currently focuses on treatments that target anxiety, attention problems, autism spectrum, depression, disruptive behavior, eating problems, mania, substance use, suicidality, and traumatic stress. 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 to 13 years) and the PWEBS literature review is not comprehensive for youth above age 18. 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. 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 questions (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. 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. (See document: Direct Service Workshop Overview)

43. May I treat TAY youth with MAP?

Under PEI, if you have TAY funding, you can treat TAY using MAP. When using MAP with clients over 18 years, it is very important to recognize the limits of the system. The review underlying the PWEBS is only systematic through age 18 years, so when going "beyond the literature" practitioners are encouraged to consider other sources of evidence that may be more directly relevant to the client's characteristics (i.e., look at literature and literature review tools other than just the PWEBS). The PWEBS information is always about "similar" but not "identical" youth, so to the extent that the PWEBS does provide information about similar problem, gender, ethnicity, setting, etc. the generalization across age may be reasonable if not optimal. Also, we would encourage special attention to the "embracing diversity" issues to make thoughtful judgments about adaptations that may be necessary to the Practitioner Guide procedures to communicate them in a way that is appropriate for a young adult. Many of the other MAP components (e.g., PPMT, process guides) may translate more directly for use with older clients. Practitioners should be aware that the uncertainty of achieving positive outcomes is increased and especially conscientious use of outcome monitoring is warranted.

44. We are hearing from some of our MAP trained staff that clients with ADHD cannot be seen in MAP. Our understanding is that it is not diagnosis, but focus of treatment that drives the ability to use MAP. So, if you had a client with a

diagnosis of ADHD but a focus of treatment of Disruptive Behavior, could you use MAP?
Yes. The 4 target areas eligible for PEI are Anxiety and Avoidance, Depression and Withdrawal, Disruptive Behavior, and Traumatic Stress. The diagnosis of ADHD may or may not be eligible under PEI depending on the primary target area and focus of treatment. If the primary target area is one of the 4 target areas eligible under PEI, then the service and claim are eligible for PEI.

45. A number of the supervisors noted that they had recently heard through admin calls and LACDMH documentation that they are not able to claim for MAP for youth with depression issues under 8 years old. Likewise, their understanding is that they could not claim for MAP if kids fell under the lower age thresholds for the outcome measures. I am not sure if this is completely accurate, and wanted to be able to inform both my supervisees and our other training staff if this is in fact the case. Any insight into this issue would be much appreciated!
Please see answer to question #37 above. In addition, on admin calls and LACDMH documentation, the age limits are specific to standardized measurement normative age range, which have implications for outcome data collection only.

46. Is there a website where archived webinars are stored to view for clinicians that have not gone through live-webinars for standardized measures?
The Webinar is on both the CIBHS and PracticeWise websites.

47. If a client is in MAP, but the clinician feels that the parent would benefit from Triple P, would the clinician be able to allow the parent to do the Triple P Model and then resume MAP afterwards?
Yes, If Triple P is the intervention suggested that will work for the client.

48. Will DMH accept MAP certificates for staff trained by in house supervisors that then move to another agency?
PracticeWise has established a pathway for staff to maintain their MAP Therapist Status when moving to a new agency. Please contact PracticeWise for the transfer packet.

49. Can consultation by a MAP therapist with a non-MAP trained staff (e.g. MD) be claimed to MAP?
Yes.

50. Staff is not clear about administering RCADS, so will there be training to help them?
The Agency will have to train the staff on how the agency wants the RCADS done at their agency; however, there is a Webinar on the CiMH and PracticeWise websites. Please contact Cricket Mitchell at CiMH for further assistance (cmitchell@cimh.org).

51. Has DMH established a protocol for agencies regarding utilizing case managers with MAP clients who are not trained in MAP with the changes to PEI claiming?
Case Managers can claim for services provided within their scope of work as long

services are coordinated with the MAP Therapist, it is clinically appropriate, and there is documented justification of services.

52. Will I fail my portfolio if I don't have baseline measures?

No, baseline assessment is not specifically required to pass a MAP Therapist Portfolio review. A number of considerations are made in scoring dashboards for portfolio review. The score for the progress data availability criteria may receive a lower rating if multiple data points from multiple measures are not included. However, a low score on one criterion may be "offset" by a high score on another criterion.

53. Must I include the PPMT in my final chart before termination?

Yes, the PPMT (first page that shows the graph only) will need to be in your chart.

54. Must my progress notes cite specific MAP Practice Elements in order to pass an audit?

No.

55. I heard that we are only allowed to use one or two practitioner guides per session. What happens if we use more?

There is no "hard and fast" rule about the number of practitioner guides to use per session. The recommendation to limit use of multiple practitioner guides within a single session is designed to promote focus and depth in intervention. Ultimately, decisions about the number of guides to use and the depth to which each guide is addressed during a session is a clinical judgment. However, prior analyses of care patterns have identified a tendency toward use of many, lower "dose" practices, e.g., numerous practices endorsed for a single session, in actual care systems, whereas effective interventions tend to be characterized by fewer practices that are implemented with greater depth.

The MAP model guides but does not explicitly restrict or limit the number or ordering of practices used. However, MAP advocates that the selection of practices emphasizes a high degree of focus and that implementation of practices occur with sufficient intensity and depth to help clients develop expertise with the practice and effect change in their life as desired.

It is important to remember that the PPMT was created as a method for clinicians to keep track of their patterns of practice when numerous Practitioner Guides are endorsed for a single session. It can become hard to remember exactly what occurred in each session. The MAP Model emphasizes parsimony in selecting practices in sessions and on your PPMT so that you represent the things that were covered most thoroughly in the session. It is not necessary to endorse practices that were merely mentioned or reviewed in brief.

56. Can I claim for MAP if I have youth with secondary problem areas including things like bipolar, eating disorders, or autism?

You can claim PEI as long as the primary focus of treatment is one of the four target behaviors: Anxiety, Depression, Disruptive Behaviors, or Traumatic Stress, regardless of

the diagnosis. However, if the youth has more severe symptoms and/or requires more intensive treatment, he/she may not meet the criteria for the PEI target population and require services through a non-PEI Program.

57. Is family therapy considered part of MAP? It comes up in my PWEBs searches but there are no practitioner guides.

Yes, family therapy practices are included in MAP. Because the standard MAP terminology differs from that of the various family therapy literatures, learning the overlap and translations between terms may require a bit of extra initial effort. In MAP, family therapy structure, processes, and practices are represented in several ways.

One way that the MAP represents the structure of family therapy is through the "format" codes in the PWEBS, which indicate the patterns of participation in sessions. For example, interventions described as family therapy in the literature may have been tested in various formats such as conjoint family therapy which is coded as Family format, one-person family therapy which is coded as Family One format, dyadic family therapy which is coded as Parent Child format, or multifamily group which is coded as Multifamily format. Other formats such as Parent or Parent Group may also be coded as appropriate.

The various family therapy approaches also include numerous different practices that are coded into the standard practice elements wherever possible. For example, common family therapy techniques such as encouraging the family to speak directly to each other, encouraging interaction by asking the family to discuss something, etc. are addressed in the Communication Skills practitioner guide. The set of Cognitive practitioner guides incorporate family therapy techniques such as reframing, restructuring, or reconnection (e.g., recall and label positive feelings and thoughts about someone). The family therapy technique of validating changes with positive reinforcement is addressed as Therapist Praise/Rewards.

Family therapy strategies for working with boundaries and alliances are also covered in some of the standard practice elements, such as strengthening alliances by finding areas of common interest and encouraging their pursuit (e.g., Activity Selection, Attending), strengthening boundaries (weakening alliances) by collaborative rule setting between enmeshed and non-enmeshed adult with regard to an enmeshed child (Behavioral Contracting, Stimulus/Antecedent Control), opening up closed systems and detriangulation by focusing back on the parties in conflict, promoting direct address, labeling covert issues, and such (Communication Skills), etc.

Further, "other practice" descriptions are used in the PWEBS to provide additional specificity or to describe practices that are under consideration for inclusion in the standard practice element set. For example, aspects of the "Joining" technique are included in the Relationship/Rapport Building and Engagement practitioner guides but "Joining" is also explicitly identified as an "other practice" in the PWEBS.

The Family Therapy practice element itself has a few unique features. This practice emphasizes "shifting patterns of relationships and interactions within a family" and may

be thought of as relational restructuring. As previously indicated, the specific practices and exercises for doing this are often characterized by the other practice elements mentioned above. The family therapy practice element is coded in addition to the other specific practice elements, when practices are applied to restructuring family relationship. Also, the practice descriptions in some of the family therapy literature are not detailed enough to code the specific practices used, so the family therapy practice element may be coded to indicate these interventions.

PracticeWise regularly re-evaluates how well the practice coding system reflects diverse literatures but also integrates these diverse literatures into a coherent set of common elements. The MAP system was designed to be a transtheoretical infrastructure that links to a common set of evidence, but part of the continual learning process of MAP is the ongoing translation from each professional's preferred terminology to the common constructs and language of the MAP system.

58. May I use other EBP materials when I am employing MAP?

Yes. The MAP system provides tools and resources to promote high quality evidence-based practices, but there are many other good tools and resources available. When identifying and selecting appropriate alternative EBP materials for MAP, it is good practice to consult the PWEBS to identify those materials and models with the "best evidence" for similar clients and follow a structured decision-making process to guide generalizations as needed. When recording the use of these other evidence-based practices on your PPMT, you may either choose the practice element from your PWEBS search that best represents the generic concept of those materials you used. You may also write these practices in as an "Other" by using the name of the materials from the other EBP.

59. What counts as a "clinical event" in MAP? Can I include collateral sessions or teacher meetings as clinical events?

Clinical events may also be thought of a therapeutic interaction, clinical contacts, or intervention sessions during which components of the MAP system were used. If collateral sessions or teacher meetings include an active therapeutic practice then they may be "counted" as a clinical event.

60. Do my PPMT measures have to align directly with my treatment goals?

This is not technically required, but is strongly encouraged. Typically, PPMT target behaviors and measures should be closely related to CCCP goals since they both address client's needs and impairments and measure progress of treatment. If a discrepancy between the CCCP and PPMT does exist, a compelling rationale should be apparent.

Sometimes clinicians write broad CCCP goals that encompass a variety of behaviors within a symptom cluster. For example, "Client will reduce depressive symptoms including crying, isolating, angry outbursts, and sulking from 10 times a week to 3 times a week." When translating this goal to the PPMT, it may be helpful to break the component behaviors down for individual measures or find a way to measure them as a Gestalt. In the above example, the therapist might measure: 1) caregiver report of

youth's angry outbursts at home per week, 2) youth's report of crying episodes per week, 3) youth or caregiver reports of overall depression severity level that week.

Overall, your CCCP goals are best used to inform your PPMT measurements, consistency between these two should help to make it easier to keep track of progress of goals. They are meant to inform each other to benefit treatment planning and conceptualization.

61. Can certified MAP Therapists lead "MAP Support Groups" at their agency to provide informal clinical and PRACTICEWISE Tool support without being a MAP Supervisor?

Yes. Peer support, consultation, and review are encouraged and may be an effective and cost effective strategy for MAP quality assurance and improvement. Because this is different from MAP agency supervision and training, support groups will not qualify individuals for any advancement or promotion within the MAP Professional Development Program.

62. How much are the fees if I have to resubmit my portfolio and how do I order a new portfolio review?

Additional portfolio reviews can be purchased through the www.practicewise.com website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to Purchase Portfolio Review. Current pricing and a group order form are also available on that web page. Email requests may also be addressed to support@practicewise.com.

63. What should I do if I do not receive the MAP Update emails from Practicewise?

This generally occurs either because the email address registered to your account is incorrect or the email is being screened as junk mail by your email provider. To verify that the correct email addresses listed for your account, go to www.practicewise.com, login to your account, click on your username in the upper right hand corner, and update the email address field. If the email address is correct, please check your junk mail folder or contact your system administrator to verify that email from PracticeWise are approved for receipt. If the problem continues, send a notice to support@practicewise.com to request assistance.

64. Is it required that I save my PWEBs searches into my PPMT notes page? I heard that if you don't do this you will fail your portfolio review.

No. The PWEBS search may be submitted in the notes page of the PPMT, but it is also acceptable to submit it in another readable form (i.e., pdf .doc, fax, hard copy). During the review process, you will be notified if the submitted format is unreadable.

65. Is there a telephone number where I can call the PRACTICEWISE Central Office?

The phone and fax service number for the PracticeWise central office is 321-426-4109. However, the best way to get a prompt response to a question is to send an email to support@practicewise.com.

66. How many consultation calls must I participate in to pass my portfolio review?

Twelve (12) direct service consultation calls are required to pass the MAP Therapist Portfolio promotion review and six (6) supervision and consultation calls are required to pass the MAP Agency Supervisor Portfolio promotion review.

67. How long do the Training Event pages stay active?

Training Event pages used to stay active for about 9 months, but due to repeated requests for extensions PracticeWise has extended these pages for several years.

68. Will PracticeWise provide Training Event pages for MAP Supervisors when they lead trainings at their agencies?

No. PracticeWise does not provide web support for internal agency training events.

69. How do Supervisors determine the RSVP Code for tools subscription for their supervisees?

Supervisors should contact the individual assigned as the group administrator by their agency. If you have difficulty identifying your agency's group administrator, you may send an email request to support@practicewise.com and PracticeWise will try to assist you in identifying the assigned group administrator for your subscription.

70. Do I have to hold 20 clinical events across at least two cases or for two individual cases to pass my portfolio MAP Therapist review?

A total of 20 clinical events across at least two (2) cases is required. For example, two (2) cases with 10 events each would be sufficient experience.

71. Must I achieve a positive outcome with my cases in order to pass my MAP Therapist portfolio review?

No, it is not necessary to achieve positive outcomes with your cases to pass the MAP Therapist Portfolio promotion review.

72. If I send in my portfolio via email, how do I provide a signature on the case record?

An electronic signature is acceptable if the portfolio is submitted via email from the certifying account. You may create an electronic signature by typing your name on the line that reads "Signature" on the Case Record sheet of the portfolio.

73. When is the Therapist Portfolio due?

The Therapist Portfolio is due within one year of completing the Direct Services Training. Therapists are eligible to submit their portfolios for review as soon as they have completed 12 hours of consultation over a period of 6 months. The cost associated with the review of the Therapist Portfolio is included in the Direct Services Training contract which expires 1 year from the completion of the Direct Services Training. Submissions beyond that date will be accepted but there will be an additional cost for the review.

74. What do Level 1 and Level 2 failure mean in the portfolio review process?

Level 1 Review is performed to determine if the portfolio submission is properly

completed.

a. If results of the Level 1 Review are not satisfactory, then the submitter will be notified of problematic items and be allowed to resubmit within thirty (30) calendar days.
b. If results of the Level 1 Review for the resubmitted items are not satisfactory, then the review will fail and a new review process will need to be initiated.

Level 2 Review is performed to determine if the portfolio meets quality standards.

c. If Level 1 and Level 2 Reviews were completed successfully, the submitter will receive the appropriate Award of Status.
d. If Level 2 Review was not completed successfully, then the submitter will be notified of the problematic items and be eligible to initiate a new review process for a resubmitted portfolio thirty (30) days after an initial review.
e. If Level 2 Review was not completed successfully during the review of a resubmitted portfolio (i.e., upon second failure), then the submitter will again be notified of the problematic items. The submitter will be eligible to initiate a new review process for a second portfolio resubmission at least six (6) months after the failed resubmission review and following completion of an additional six (6) hours of consultation in the MAP System.

75. I heard that I cannot use the word "Psychoeducation" in documentation. However, these are the words used in Practitioner Guides. How should I describe these MAP sessions?
You can provide psychoeducation to youths and parents. For parents, make sure that you clearly demonstrate how the psychoeducation benefits the identified client and treatment goal(s).

76. Do PPMTs work on both Macs and PCs?
Yes, PPMTs can be used with both MAC and PCs if Excel is installed on the Mac or PC. (Note: Some macros on the PPMT may not be compatible with MACs.)

77. Is the Focus Interference Framework required documentation that must be present in my client's file? Must I do a FIF for every case?
No, the FIF is a process guide, not a required document. The FIF is intended to help develop a habit of mind and support integrative reasoning that should be applied to the analysis, understanding, and management of all MAP cases.

78. How can a therapist or supervisor make up missed consultation calls? Additional consultation calls can be purchased through the www.practicewise.com website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to purchase additional MAP Direct Service or MAP Supervision consultation.

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80. How does a therapist or administrator obtain verification of completed consultation calls?
Verification of attendance on a consultation call series can be requested by emailing support@practicewise.com.

81. How will renewals of the group subscriptions be handled?
Subscriptions are renewed on a yearly basis. The contact person listed as the Group Administrator on the PracticeWise Group and Custom Order Form will receive the renewal reminder. Each individual user will NOT be contacted about the expiration date. The first renewal reminders were sent to all of the Group Administrators on October 31st, 2011. A second reminder will be sent on November 30th to any agency that has not already completed its renewal. The most common reasons for a failure to receive the renewal notice is an invalid email address or automated screening of the reminder email by the Group Administrator's email system. If you would like to verify the email address for your account, please contact support@practicewise.com to request information about the current Group Administrator record.

82. Are the subscriptions for the LAC DMH supervisor trainings separate from the original MAP Implementation subscriptions?
Yes, the supervisor subscriptions are established when the trainee attends a MAP Supervision and Consultation Series training event. As with the original subscriptions, the supervisor subscriptions are funded for the first year by LAC DMH. The renewals for the supervisor subscriptions will be sent out at least 30 days prior to the one year anniversary of the training dates.

83. Can I increase or reduce the number of subscriptions at the time of renewal?
Yes, an agency can increase or reduce the number of subscriptions it wishes to renew within the 30 days prior to the expiration. Any changes will be effective when the renewal is processed.

84. Can I get a list of the current users assigned to the group subscription? Yes, please send your request to support@practicewise.com and you will receive the list of users and usernames currently assigned to the group subscription. **My agency has multiple subscriptions from different training cohorts. Can I consolidate them into a single group subscription for my agency?**
Yes if the multiple subscriptions are funded directly an agency and not a third party payor such as LACDMH. A single consolidated subscription may be established and a prorated credit applied for the unused portions of the multiple separate subscriptions. Please send your request to support@practicewise.com.

85. How do I know if my portfolio submission has been received properly? You will

receive an e-mail to the address listed on the submission within two business days confirming the receipt of the portfolio and including a unique tracking number for the submission.

PARENT-CHILD INTERACTION THERAPY (PCIT

1. What are the components of PCIT?

The model focuses on children who have externalized acting out behaviors. PCIT consists of two phases:

a) **Child Directed Interaction (CDI):** Focuses on enhancing the child-caregiver relationship by promoting positive caregiver-child interactions.
b) **Parent Directed Interactions (PDI):** Improves child compliance by teaching parents effective child management skills.

Both phases of treatment include didactic training, followed by 7-10 coaching sessions. During treatment sessions therapists coach caregivers via a "bug in the ear" during the caregiver-child play sessions.

2. What is the age range for PCIT?

It is for children ages 2 to 7 and their caregivers. PCIT targets dyads that are experiencing stress, or are at risk.

3. What is the goal of PCIT services?

The treatment goals of PCIT are to improve interactions and the relationship between caregiver and child, increase the caregivers' ability to parent the child and decrease clients acting out behaviors.

4. What is the length of treatment?

The average length of treatment is 16-18 sessions for 50 minute sessions once a week in the office. Treatment should not exceed 25 sessions.

5. Who can provide PCIT services?

Clinicians can provide PCIT services once they have been approved by UC Davis Training Institute as a certified PCIT clinician. In order to achieve certification status clinicians must graduate 2 successful cases, as determined by UC Davis. Additionally, untrained clinicians who are being supervised by appointed agency Trainer of Trainers (ToTs) are able to provide PCIT services.

6. Are there facility requirements to conduct PCIT treatment?

Appropriate space includes a stripped therapy room adjoining a separate observation room with a one way mirror and/or video monitoring. Additionally, there must be a communication system that allows the therapist to speak in real time to the parent during parent-child interaction. Additional materials include recommended age appropriate toys i.e. building blocks, play dough, colors, train set, etc.

7. What are the outcome measures for PCIT services?

The PCIT model will use the following measures at the beginning, midpoint and end of treatment:

1) Eyberg Child Behavior Inventory or Sutter–Eyberg Student Behaviors Inventory-Revised (ECBI or SESBI-R): for all children enrolled in PCIT

2) Youth-Outcome Questionnaire (Y-OQ): for children 4 years of age and older

8. What other resources that can be used to build clinician's capacity to serve PCIT clients?

Additional clinical, training and outreach resources can be found at the UC Davis PCIT website: http://pcit.ucdavis.edu

PROBLEM SOLVING THERAPY (PST

1. What is PST and who may use it?

Problem Solving Therapy (PST) has been approved as a "promising practice" for older adult contract agencies providing PEI services. Problem Solving Therapy (PST) has been a primary strategy in such EBP's as IMPACT/MHIP and PEARLS. PST has generally focused on the treatment of depression.

2. How is PST used in LA County DMH?

PST is to be used as an "early intervention" model intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally.

3. What is the target population?

Underserved Cultural/Ethnic Populations, Individuals with Early Signs of Mental Illness, Trauma – Exposed. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness (but who are not home-bound, isolated seniors for whom PEARLS would be the more appropriate treatment model.)

4. What are the goals of PST?

The goals of PST include: increasing the client's understanding of the link between current symptoms and their current problems in living, increasing the client's ability to clearly define their problems and set specific and measureable goals and finally to teach clients a specific structured problem-solving procedure that they can utilize throughout their lives.

5. Can PST be used with diverse cultural backgrounds?

This model is appropriate for both males and females and can be culturally and linguistically adapted to underserved cultural/ethnic populations.

6. What are the components of PST?

PST is a brief intervention model which involves 7 steps:

1. Clarify and define the problem
2. Set realistic goal
3. Generate multiple solutions
4. Evaluate and compare solutions
5. Select a feasible solution
6. Implement the solution
7. Evaluate the outcome

7. What are the minimum requirements for a practitioner to be able to provide PST?

Licensed and waivered clinicians may offer PST consistent with their scope of practice.

8. What are the Core services and codes that are provided as part of PST?

a. Assessment/Psychiatric Diagnostic Interview: 90791
b. Individual Psychotherapy: H0046, 90832, 90834, 90837
c. Targeted Case Management: T1017
d. Individual Rehabilitation Services: H2015
e. Team Plan Development: H0032

9. What is the length of treatment?

The number of sessions ranges from 6 – 10.The length of Initial session is 30-60 minutes; and should probably be guided by the client's capacity to actively engage in the various steps of PST. The frequency of sessions should also be guided by the urgency of the situation and the capacity of the client to have sufficient time and opportunity to implement each step of PST.

10. What is the timing of sessions?

Initial weekly sessions with increased time between sessions to bi-weekly sessions as client will have increased opportunities to practice skills. Initial session should last approximately 1 hour and the remaining sessions should last 30 minutes.

11. What outcome measures are used for PST for older adults?

The Outcome Questionnaire 45.2 (OQ) is the general measure used, and the Patient Health Questionnaire – 9 (PHQ-9) is the specific measure used. The OQ is designed to measure observed behavior change in a client from the beginning to the end of treatment. It should be administered at the beginning of treatment, possibly at the 6-month point, and at the end of treatment. The PHQ-9, the specific measure, should be administered every session to measure depressive symptom change throughout treatment. LAC DMH requires the use of the Outcome Questionnaire (OQ) and the PHQ-9 at the beginning of treatment to establish a baseline for all PEI programs for adults and older adults receiving PST. LAC DMH also requires that both of these measures be administered at the end of treatment to measure the effectiveness of treatment on symptom reduction and associated behavior change.

12. What is the training protocol?

Clinicians certified in PST, or trained in PEARLS, are qualified to implement this intervention model. PST Certification sessions are encouraged particularly when first learning this intervention model.

13. What is the setting where PST can be practiced?

PST services can be provided in any setting: outpatient clinics or field based.

14. Is there an adherence scale for PST?

Yes, there is a PST Therapist Adherence Scale called the PST Therapist Adherence Scale.

PROGRAM TO ENCOURAGE ACTIVE AND REWARDING LIVES FOR SENIORS (PEARLS)

1. What is the population to be served under PEARLS?

PEARLS for Older Adults was designed to treat minor depression and dysthymic disorder in adults aged 55 and older.

2. What are the age range limits for implementing PEARLS under the PEI Plan?

PEARLS is designed for adults aged 55 and older.

3. Are there exclusionary criteria?

The PEARLS Program should not be used with clients who screen for Psychosis, Major Depression, Bi-polar Disorder, Alcohol or Substance Abuse or significant Cognitive Impairment.

4. What screening tools are required?

Patient Health Questionnaire – 9 (PHQ-9)
Dysthymia Screening
Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment

5. What are the basic elements of the PEARLS Program?

- Focuses on teaching each client the skills necessary to move to action and make lasting life changes
- It is delivered in the client's home
- Takes a team-based approach, involving PEARLS counselors and supervisor or program manager
- Aims to improve quality of life as well as reduce depressive symptoms, and
- It is well-suited for individuals with chronic illness

6. What is the length of treatment?

During six to eight in-home sessions that take place in the client's home and focus on brief behavioral techniques, PEARLS Program counselors empower individuals to take action and to make lasting changes so that they can lead more active and rewarding lives.

7. How often should PEARLS sessions be conducted?

The PEARLS depression intervention is typically conducted over six to eight sessions in a six-month period and consists of problem solving treatment (PST), behavioral activation, and pleasant activities scheduling. During the course of the PEARLS treatment, the counselor must pay attention to different ways of conducting sessions depending whether it is a first, middle or last session. Throughout the period during which sessions are conducted, there is ongoing clinical supervision on a weekly or biweekly basis for the PEARLS counselor.

8. What are the required staffing patterns for PEARLS?

PEARLS has identified four key roles: Manager, Supervisor, Counselor and Data Coordinator. (A single individual may serve in the role of Manager and Supervisor; but the PEARLS Counselor duties must remain clear and separate from the other roles.) In either case, it is important that everyone involved in the PEARLS Program work closely together.

9. What is the staff-to-client ratio?

PEARLS counselors can typically have a caseload of 20 clients, which includes a mix of clients having weekly, bi-weekly and month in-person session and client in follow up phone calls.

10. Where can PEARLS be implemented?

PEARLS was studied and proven to be effective as a home-based program. The developers of this model report there are some agencies who have modified it to be implemented as an agency-based program and have been very successful with it. While the developer cannot say that their research proves this is effective, there is some real-world evidence to encourage such an effort. Therefore, DMH will allow providers to implement PEARLS in other settings.

11. Please describe the training model for PEARLS:

After completing the two-day tailored PEARLS Training Program, participants will be able to:

- Identify depression using scientifically validated instruments
- Effectively assess depressed individuals and recommend steps to improve their mental health and overall quality of life
- Recognize the psychosocial needs and stressors particular to older adults
- Describe key elements of this comprehensive, multi-component depression management program
- Review the evidence base supporting the effectiveness of the PEARLS treatment program
- Demonstrate practical skills—such as problem-solving treatment, behavioral activation, and pleasant event scheduling—for treating depression in community-dwelling individuals
- Understand the key elements and personnel required to effectively implement PEARLS in their communities

12. Is there a Fidelity Scale for PEARLS?

There is a self-report questionnaire which may be used as a fidelity instrument called The University of Washington PEARLS FIDELITY INSTRUMENT that we have been granted permission to use and disseminate. Additionally, the toolkit does include an adherence scale which is a self-rating tool called The PST Therapist Adherence Scale.

13. Are Outcome Measures required and how often do they need to be completed?

Yes, outcome measures are required. The PHQ-9 is integral to the PEARLS model and used at beginning of treatment and re-administered at every session. Additionally, LAC

DMH requires the use of the Outcome Questionnaire (OQ) and the PHQ-9 to at the beginning of treatment to establish a baseline for all PEI programs for adults and older adults receiving PEARLS. LAC DMH also requires that both of these measures be administered at the end of treatment to measure the effectiveness of treatment on symptom reduction and associated behavior change.

14. What are the CORE services and their codes that can be provided under PEARLS?

Psychiatric Diagnostic Interview: 90791
Individual Psychotherapy: H0046, 90832, 90834, 90837
Targeted Case Management: T1017; (The client's assigned case manager may address
•the client's needs through targeted case management). Individual Rehabilitation
•Services: H2015
•Plan Development: H003

15. What are the goals of PEARLS treatment?

The goals of PEARLS include: increasing the client's understanding of the link between current symptoms and their current problems in living, increase the client's ability to clearly define their problems and set specific and measureable goals and finally to teach clients a specific structured problem-solving procedure that they can utilize throughout their lives.

16. What are the components of PEARLS?

Three elements- Problem Solving Therapy, Behavioral Activation and Pleasurable Activity Scheduling

17. Please describe "Wrap-Up" Activities.

Following the last formal PEARLS sessions, the PEARLS counselor may provide periodic telephone "follow-up" calls for up to 60 days provided the following conditions are met:

- The follow-up phone calls are built into the treatment plan.
- There is discussion of skills used and what worked/didn't work.
- There is a clear plan, based on the of how the client will continue to use the skills
- There is some intervention to assist the client in continuing to use/start to use the skills learned. The conversation should involve an active role of the clinician.

PROLONGED EXPOSURE THERAPY FOR POST TRAUMATIC STRESS DISORDER (PE)

1. What is Prolonged Exposure for Post-Traumatic Stress Disorder (PE)?

PE is an evidence based practice (EBP), which is theoretically based and a highly efficacious treatment for chronic post-traumatic stress disorder (PTSD) and related depression, anxiety, and anger. Based on basic behavioral principles, it is empirically validated, with more than 20 years of research supporting its use. PE is a flexible therapy that can be modified to fit the needs of individual clients. It is specifically designed to help clients psychologically process traumatic events and reduce trauma-induced psychological disturbances. PE produces clinically significant improvement in about 80% of patients with chronic PTSD.

2. Who is appropriate for PE?

PE is intended for Adults (ages 26 to 59) and Older Adults (OA, ages 60+) in our Directly Operated programs. This EBP is appropriate for those who are experiencing symptoms of chronic PTSD resulting from one or more traumatic events including but not limited to the following: rape, physical assault, combat, community violence, motor vehicle accidents, natural disasters, and history of child abuse.

3. Does the client need to have a diagnosis of PTSD in order to receive this EBP?

Yes. The client must be diagnosed with chronic PTSD.

4. Who should not participate in PE Treatment?

PE is contraindicated for clients who are actively suicidal, homicidal, psychotic, experiencing a panic or anxiety attack, and/or at high risk of being assaulted.

5. What are the theoretical foundations of PE?

This EBP is based on the Emotional Processing Theory of PTSD. Specifically, traumatic memories must be activated in order to be processed on an emotional level while simultaneously correcting erroneous cognitions about the “world” and “self.”

6. What are the key components of PE?

PE is divided into the following four components: 1) Exposure Therapy, 2) Anxiety Management, 3) Psychoeducation, and 4) Cognitive Therapy.

(a) Exposure Therapy: a set of imaginal and in-vivo exposure techniques designed to reduce pathological, dysfunctional anxiety, and erroneous cognitions by encouraging the client to repeatedly confront trauma-related objects, situations, memoires, and images which have been avoided in the past.
(b) Anxiety Management: relaxation training, breathing techniques, positive self-talk, positive visualizing, social skills, and distraction techniques.
(c) Psychoeducation: educating the client about common reactions to trauma.

(d) Cognitive Therapy: identifying, challenging, and replacing dysfunctional thoughts and beliefs with positive ones.

7. What is imaginal exposure?

Imaginal exposure is repeated recollection of a traumatic event. Confrontation with traumatic memories enhances the processing of these events and modifies dysfunctional cognitions, such as "I cannot tolerate distress" or "What happened is my fault." This consists of asking the client to recall every detail, including events, thoughts, and feelings, of a troubling traumatic experience in the present tense.

8. What is in vivo exposure?

In vivo exposure is repeatedly approaching trauma-related situations that have been avoided because of their association with a traumatic event. It is very effective in reducing excessive fear and unnecessary avoidance. It enables the client to realize that the avoided situations are not dangerous, thus modifying dysfunctional cognitions that the world is a dangerous place. This is accomplished by asking the client to gradually increase their physical participation in activities and situations, via a hierarchy from the least to the most anxiety provoking, that have been avoided since the traumatic event occurred.

9. What are the treatment goals?

There are five main treatment goals for PE.

(a) Decrease avoidance of trauma-related situations (e.g., sleeping without a light or refusing to go out alone).
(b) Decrease avoidance of trauma-related thoughts and images.
(c) Decrease presence of dysfunctional cognitions: "The world is extremely dangerous" or "I am extremely incompetent."
(d) Increase ability to discuss thoughts and feelings related to the traumatic event.
(e) Increase engagement in activities related to the traumatic event.

10. What are the core interventions of PE?

The core interventions for PE are:

- Assessment (Procedural Codes 90801 and 90802)
- Individual Psychotherapy (Procedure Codes H0046, 90804, 90806,90808)

Other interventions which may be appropriate during the course of the 10 individual psychotherapy sessions and may include-Targeted Case Management (Procedure Code T1017)

The use of targeted case management may be appropriate if providing these services will assist in the reduction of the effects of the traumatic event.

11. What is the length of treatment?

PE treatment consists of 10 weekly, consecutive sessions. The individual sessions are 90 minutes in length.

12. How are the 10 sessions structured?

The 10 sessions are divided into four distinct segments.

(a) Introduction of the treatment program, in vivo hierarchy/exposure, and breathing training (Sessions 1-2).
(b) Introduce and conduct imaginal exposure (Sessions 3-5).
(c) Focus on "hot spots" (most distressing aspects of the recollected traumatic event; Sessions 6-9)
(d) Final imaginal exposure (Session 10)

13. Are more than 10 sessions allowed by the model?

Yes. If clinically indicated, additional sessions, up to 8, are allowed for additional processing of the imaginal exposures.

14. What happens if the client misses a session?

Therapeutic progress may be lost if a client misses more than 2 consecutive sessions. This may be due to the client reinforcing the negative aspects of the trauma rather than using the tools necessary to overcome the traumatic event.

15. Can this model be used in a group setting?

No. PE was developed and designed for individual use only. Multiple clients going through in vivo exposure techniques and revisiting traumatic memories simultaneously in a group setting would be counterproductive.

16. What happens if a client continues to experience disruption in their level of functioning?

The client may need to continue with additional PE treatment, be hospitalized, and/or obtain additional mental health services. It should be noted that each case is unique and each client must be treated on a case by case basis.

17. Who can provide this EBP?

At this time the developer only allows clinicians (Masters level and higher, registered/waived and higher level clinicians) to be the primary leads in treatment. Paraprofessional staff can provide support with check-ins and case management.

18. What role can a psychiatrist and medication play with this practice?

Generally in this model, clients are not seen for a medication evaluation by a psychiatrist. On the other hand, there may be certain circumstances where a clinician may determine referring a client for a medication evaluation is appropriate. In these cases, not providing such services may be more harmful to the client's wellbeing and may prevent the client from returning to their previous level of functioning, especially when additional symptoms are resulting in severe impairments.

19. Can a client from one of the Mental Health Service Act's (MHSA) Client Supportive Services (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnerships) or non-MHSA programs receive this EBP?

Yes. Any client receiving services in one of our MHSA CSS or non-MHSA programs can receive this and any EBP. The service will be claimed to the current MHSA plan in which the client primarily receives his/her services, NOT to PEI.

20. Can the client receive PE along with other EBPs?

Clients can receive 2 EBPs or Community Defined Evidence Practices simultaneously only when clinically indicated. However, the use of multiple EBPs for PEI clients should happen very infrequently.

21. What is the required training protocol?

Training consists of a 4-day workshop followed by weekly consultation and supervision of 2 active clients in regular treatment with client consent. Weekly consultation is conducted via review of audio-taped therapy sessions, which are be encrypted via electronic voice recorders, with certified PE Supervisors. Consultation will continue during the duration of active treatment for 2 clients.

22. Is "train the trainer" an option with this EBP?

No. The Department does not currently provide "train the trainer" as an option.

23. What are the outcome measures for PE?

There are two outcome measures which are required for PE:

-Post Traumatic Stress Diagnostic Scale (PDS) for ages 18-65 -
Outcome Questionnaire (OQ) for ages 18+

24. Can the clinician claim for completing the outcome measure?

No. Administering an outcome measure is not a claimable service. There are two exceptions: (1) if the primary clinician closes the case as a result of referring the client to another agency, and at discharge, completes the outcome measure; or (2) if the outcome measure is completed during a billable session, and not over the phone or at home by the client.

SEEKING SAFETY (SS)

1. What is the population to be served under PEI?

Directed toward individuals and families for whom a short duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

2. What are the age range limits for implementing Seeking Safety under the PEI Plan?

The age range begins at 13 years old and spans across all age groups.

- Children (13-15)
- Transition-Age Youth (16-25)
- Adults (26-59)
- Older Adults (60+)

3. What are the "Core Interventions" for Seeking Safety"?

The "Core Interventions" are:

- Assessment/Psychiatric Diagnostic Interview
- Family Psychotherapy
- Group Psychotherapy
- Group Rehabilitation Services
- Individual Psychotherapy
- Individual Rehabilitation Services

4. 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. On average, length of treatment will vary from 5 to 6 months.

5. How often should SS sessions be conducted?

SS sessions (individual or group) need to be conducted at minimum once per week to adhere to fidelity of the model.

6. Is there a maximum number of sessions and who monitors?

On average, each topic is conducted in 1 to 2 sessions. Therefore, if all 25 topics are conducted, number of sessions may range from 25 to 50.

It is recommended each provider monitors and tracks internal activities. Countywide and Service Area Administration will work collaboratively to monitor Seeking Safety services.

7. Does Seeking Safety have mandatory topics?

Yes. "Introduction to Treatment/Case Management" and "Safety" to be covered first to

provide a foundation. “Termination”, when possible, at conclusion of treatment.

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

9. With a minimum of two clinicians, approximately how many clients can be served (caseload)?
Dr. Lisa Najavits (developer) does not indicate a minimum or maximum number of clients to be served per caseload.

10. What is the staff-to-client ratio?
“Staff-to-client” ratio will vary depending on whether clients are seen in individual or group modality.

11. 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. Please refer to “Principles of Seeking Safety” in the SS Manual (pages 5 to 15) for more information.

12. Must my client have experienced trauma to qualify for SS?
Yes. For the purposes of claiming to the PEI Plan the client must have experienced trauma.

13. Do participants of Seeking Safety need to have any symptoms of PTSD? Yes.

14. Are the diagnoses of PTSD and Substance Use required for the SS model? No. PTSD and Substance Use do not have to be the diagnoses in order to use the SS model, but please use your clinical judgment to decide if SS is an appropriate model for your client. As is always the case, in order to claim to Medi-Cal, your client must meet criteria for a Medi-Cal eligible diagnosis and the service provided must be claimable to Medi-Cal.

15. Is Seeking Safety considered a crisis intervention? No.
It is a stabilization model.

16. Can a client do Seeking Safety and also attend AA or other substance abuse treatment?
Yes. Part of treatment is to support and encourage clients to connect with resources in their community.

17. Since family sessions are a core service, what should the content of the family session be?
Including family member(s) during session(s) is not limited to any specific topic(s).

18. Is there "train the trainer" model for SS?
No. Please see question below for internal agency training.

19. Can an "Adherence Rater" train new staff to SS instead of attending a developer approved training?
The primary role of an Adherence Rater is to rate only internal agency staffs' adherence to SS sessions. The Adherence Rater may also orient only internal agency new staff to SS instead of attending a developer approved training. Dr. Najavits, SS Developer, prefers to use "orient" instead of "train" to avoid any misrepresentation since there isn't "train the trainer model". Please see SS Fidelity and Adherence Guidelines for specific requirements and limitations.

20. Does the Department expect that agencies providing Seeking Safety will have their staff complete the SS Adherence Rater and Supervisor Trainings?
At this time, we are recommending Seeking Safety providers participate in the "SS Fidelity and Adherence Guidelines". This will allow for sustainability and adherence to fidelity of the model.

21. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs, YOQ-SRs, and OQs)?
Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation should be completed by a trained clinician who possesses a master's degree or higher. Data entry can be completed by trained non-clinical staff.

22. Can we verbally translate an Outcome Measure from English to client's language?
No, this would invalidate the outcome measure because the person translating may not translate items exactly as they are meant by the outcome measure's author. If an outcome measure cannot be completed due to language difficulties and there is no authorized translation in their native language available, then the appropriate "Unable to Collect" reason code should be indicated in PEI OMA for that outcome measure.

23. How often do the required Outcome Measures need to be completed?
Clinicians have 14 days from the date of the First EBP Treatment Session to collect the "Pre" measures, and 14 days from the date of the Last EBP Treatment Session to collect the "Post" outcome measures. PEI outcome measures should also be administered every 6 months (an "Update") to clients enrolled in an EBP that lasts 6 months or longer.

24. If I did not collect "pre" outcome measures then is it still required to collect "post" outcome measures?
Each required outcome measure must be acknowledged in PEI OMA in one of two ways:

- The outcome measure's score(s) is entered into the appropriate field(s) or
- "Unable to Collect" reason code is selected and entered into the "Unable to Collect" field.

25. Does SS Supervisor have to be a Clinical Supervisor?

Yes. At minimum, each agency at the Legal Entity or Directly Operated Clinic level is required to designate a "PEI SS Supervisor". "PEI SS Supervisor" is required to be a licensed mental health clinician, meets agency's requirements to provide clinical supervision, and trained in SS.

Please note "PEI SS Supervisor" is different from "SS Supervisor" as outlined in the SS Fidelity and Adherence Guidelines.

26. Do you have to be a mental health clinician to implement SS?

SS can be implemented by clinicians and non-clinicians (case managers, substance abuse counselors, etc.) operating within their "scope of practice".

27. What is the minimum amount of education required to be trained in and apply this evidenced based treatment, in order to stay within an appropriate "scope of practice"?

The services listed under Core Interventions for each evidenced based treatment will determine the rendering provider's scope of practice. For example, if one of the core services is Assessment, an Authorized Mental Health Discipline (AMHD) must complete the Assessment. If the core service is Individual Rehabilitation (Rehab), anyone within their scope of practice can provide Rehab services.

As it relates to non-licensed staff (Medical Case Worker, Substance Abuse Counselor, and Community Worker) providing individual/group rehabilitation will be based on the supervisor's discretion. This means that the supervisor has assessed the staff's knowledge, experience, and reviewed staff's documentation and decided that the staff is capable of providing and documenting Rehab services (with or without a co-signature).

28. Do non-clinicians (i.e. case managers, substance abuse counselors) need to be trained in Seeking Safety, if they are going to be providing services under Seeking Safety?

SS trained clinicians and non-clinicians are able to deliver SS services within their scope of practice; which means they are able to deliver the identified SS "core interventions" (as defined below) and claim to the PEI Plan. Staff not trained in the SS model, may only deliver "non-core interventions" (as defined below).

- "Core Interventions" are those services intrinsic to the delivery of expected outcomes for each of the PEI Programs.
- "Non-Core Interventions" are to be provided on a short-term basis to meet emergent client needs.

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

1. **Does the model address 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.

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. **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 non-core services for TF-CBT?***
   Yes.

Section 6

Data Collection and Outcomes

6.1 Meeting the Accountability Challenge in Mental Health Service Delivery

Cultural/Policy Shift in Mental Health Service Delivery: The New Culture

Data driven decision making has moved to the forefront in mental health over the last few decades. It is a core component of program implementation, meeting the requirement of accountability to funders. Data driven decision making ensures that there is evidence for performance and outcomes of each aspect of mental health programs. Over the years, there has been a shift in the way programs are evaluated. No longer does the field rely on anecdotal or conceptual evidence of its effectiveness. Observable achievements in service delivery are now emphasized at a governmental, programmatic and individual client level.

MHSA Data Collection and Outcomes

This shift towards a data driven culture in mental health is integral in the planning and implementation of the MHSA PEI Plan. DMH took a proactive stance in the development and implementation of a data driven approach to evaluate the process and impact of its PEI Program. Simultaneous with the roll out of PEI beginning in fiscal year 2010-2011, DMH developed and implemented a strategic approach to collecting, analyzing and evaluating data regarding its PEI services. This approach allows the Department to examine and inform program development and holds potential for informing policy, influencing funding, and providing the foundation for model replications by other provider systems.

Evolution of Outcome Evaluation in DMH PEI Program

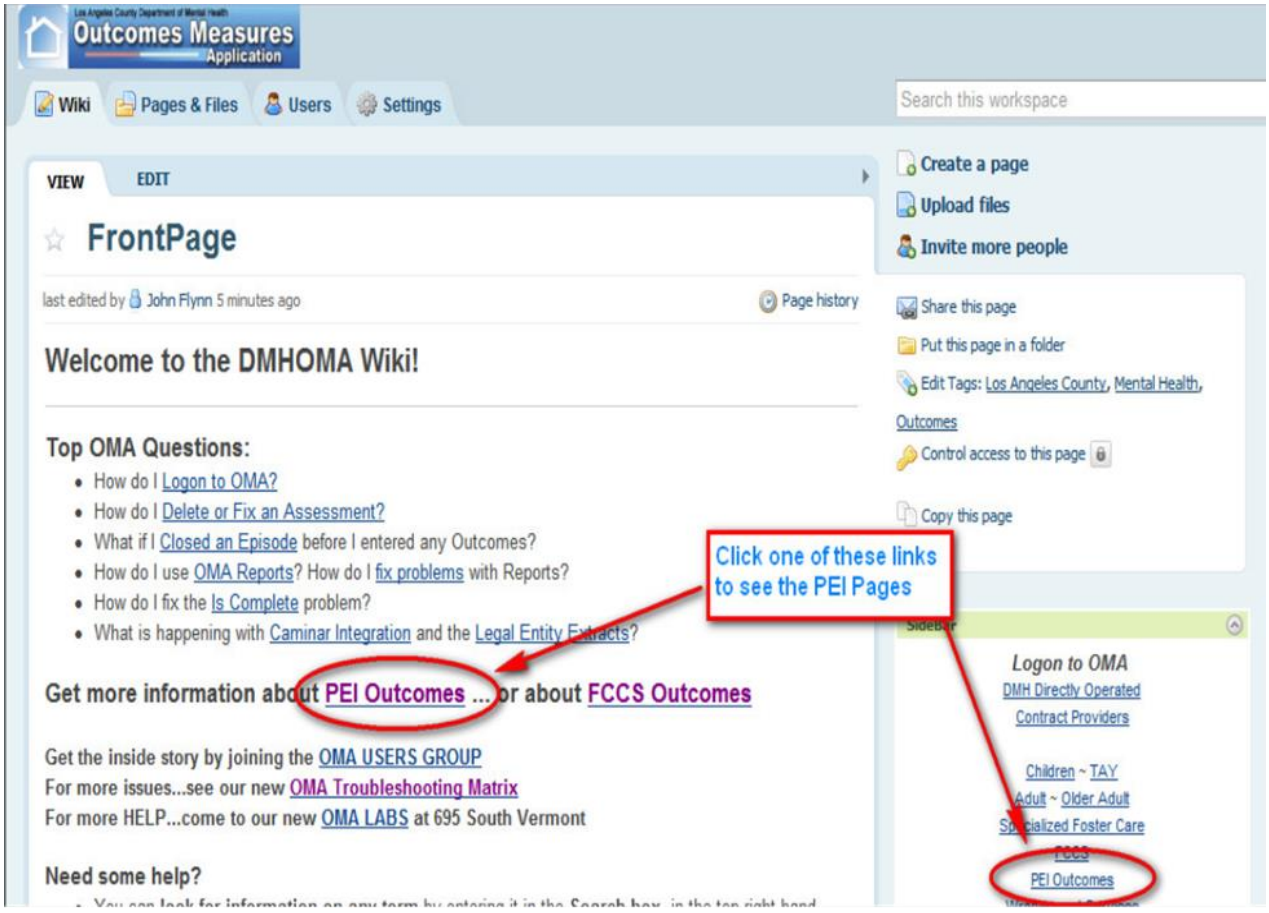
To address the DMH PEI Program evaluation, the Department designated the MHSA Implementation and Outcomes Division to oversee PEI Program evaluation. This division was charged with the development of a methodology for the collection and analysis of data across all agencies and directly operated programs within Los Angeles County. To support evaluation efforts, the MHSA Implementation and Outcomes Division developed a number of resources to assist providers in meeting the outcome requirements.

6.2 PEI Outcome Measure Process Supports

The DMH OMA Project Website (Wiki)

The DMH Outcome Measures Application project website (Wiki) was created to support providers with outcomes measurement and reporting. The OMA Wiki contains information for providers including forms, updates, news, handouts and trainings on Outcomes. The MHSA Implementation and Outcomes Division project website may be accessed at www.dmhoma.pbworks.com. The front page of the OMA Wiki provides an overview to the many helpful links and information to support providers. The PEI Outcomes page may be accessed from the front page or via the link below:
http://dmhoma.pbworks.com/w/page/36104184/PEI%20Outcomes.

PEI OUTCOMES PAGE



OMA History

The OMA is a web-based application that DMH created initially to collect and store outcome data for Full Service Partnership (FSP) and expanded for Field Capable Clinical Services (FCCS). When deciding what was needed for data collection and reporting for PEI, DMH opted to create a new web based application for PEI. This would enable DMH to create a more dynamic, flexible data collection system to better meet the needs of this specialized program.

In 2011, DMH began to develop this web-based application for the collection of outcome measures associated with all PEI Practices. This application allowed for centralized data entry and analysis of outcome data. At the inception of the PEI Plan, DMH partnered with California Institute for Behavioral Health Solutions (CIBHS), formerly known as California Institute for Mental Health (CiMH), to collect and report data for MAP, TF-CBT and Triple P. The MHSA Implementation and Outcomes Division piloted the OMA application in a pilot project with interested providers beginning in April 2011. The OMA is now fully functional and is utilized by all providers. DMH's agreement with CIBHS to collect data for the three practices ended June 30, 2014. To meet the need for continued outcomes collection, DMH made enhancements that allowed providers to enter data directly into PEI OMA.

Accessing the OMA

To gain access to the OMA, click the link on the sidebar labeled "Apply for Access" which will bring the provider to the Apply for Access page. The application instructions are included for both LE's and DO Clinics. To access the OMA, a provider needs to establish an identity in the IS, and if staff works at a Contract Provider site (as opposed to a DMH DO Clinic) they will need to apply for an RSA Secure ID card. If a provider reporting unit is completely new to the system, they will also need to file the Authorization to Sign CIOB Access Forms statement.

It is advisable to maintain copies of all applications submitted. The turnaround time for new access is about one month. A high volume of forms are received daily and are processed in the order they are received. The procedure for troubleshooting access is to call the CIOB Help Desk at 213-351-1335 to create a call tracking ticket. If the submit date is prior to the processing date, a fax number is given to fax the form for immediate processing. The form must be submitted with all required fields completed and under an authorized manager/designee signature. If the form is incomplete or signed by a manager other than the designee, it may cause a delay or may not be processed. For consideration, a "Sample" form is posted on the IS website at **http://dmh.lacounty.gov/hipaa/downloads/DMHAAFSAMPLE1.pdf.**

It is recommended to call the DMH Helpdesk at 213-351-1335 within two weeks of submitting an application should you not hear back. Helpdesk staff will create a HEAT ticket to track your application.

The DMH OMA Wiki PEI Outcomes Page: Forms, Guides and Support

The "Forms, Guides and Supports" section of the PEI Outcomes page provide links to documents which will prove helpful in support of the PEI program. Links to the following resources are included in this section:

1. *PEI Outcome Measures Table* which outlines the general and specific outcome measures required for each PEI Practice
2. *PEI Outcome Measures Request Form* which is used to order the general and/or specific measures required by PEI
3. *PEI Outcomes Report Request Form* which can be used to order several outcomes data reports that can be useful in looking at the health of your PEI program
4. *Quick Guides* which provide bullet points for each of the outcome measures being used countywide
5. *PEI Optional Worksheets* completed by clinicians to facilitate the outcome data entry by other staff
6. *PEI Outcomes Automated Scoring sheets* for the PTSD-RI, OQ Series, PCL-5 and RCADS
7. *PEI Outcomes Frequently Asked Questions*
8. *"A Closer Look"* a new publication focused on PEI Outcomes data

6.3 MHSA Implementation and Outcomes Division Trainings

PEI OMA Data Entry Training

PEI OMA Data Entry Training is designed for clerical and administrative staff that enter data from completed pre-post measures into the OMA. It provides practical experience in entering data into PEI OMA on the computer. The course objectives include methods to organize and check PEI Outcome questionnaire scores from clinicians and enter scores in the application, as well as spot and fix inaccurate data.

While the training is aimed at administrative support staff, EBP leads, supervisors, clinicians, data entry supervisors, and/or QA research staff may find it helpful to understand the data entry process to better monitor their outcomes and ensure that data entry is done correctly.

Information regarding the PEI OMA Data Entry Trainings can be found on the PEI Outcomes Page of the OMA Wiki. To enroll for the training, please:

1. Download the registration form at the link below:

http://dmhoma.pbworks.com/w/file/97264707/PEI%20OMA%20Data%20Entry%20Registration%20Form.xlsx

2. Email the completed form, in Excel format to: PEIoutcomes@dmh.lacounty.gov
   In the Subject line of the email enter: PEI OMA Data Entry Training Registration (insert date of training for which you are registering).

PEI Outcomes Questionnaire Trainings

PEI Outcomes Questionnaire Trainings are designed for clinical team members who will be administering, scoring or interpreting the PEI outcome measures. It is recommended that EBP leads, EBP supervisors, and/or QA Research staff persons also attend. Information regarding the PEI Outcomes Questionnaire Trainings is available on the PEI Outcomes Page of the OMA Wiki. To enroll for the training:

1. Download the registration form at the link below:
   http://dmhoma.pbworks.com/w/page/43920375/Outcomes%20Questionnaire%20Training%20for%20Clinicians%20and%20Clinical%20Team
2. Email the completed form, in Excel format to: PEIoutcomes@dmh.lacounty.gov
   Complete one registration form per staff member.

Please note that registration begins 30 minutes prior to each training session. Questions regarding the outcome questionnaire training should be emailed to:
PEIOutcomes@dmh.lacounty.gov.

6.4 MHSA Implementation and Outcomes Division Training Supports for PEI

PEI Practice Learning Networks

The PEI Practice Learning Networks offer providers from LE's and DO Clinics opportunities to get support and learn strategies on the implementation of specific PEI Practices from DMH Practice Leads and MHSA Implementation and Outcomes Division staff. Additionally, at the heart of the Learning Network experience, providers are able to share solution-focused strategies. As part of the Learning Network, participants may review countywide and their clinic specific data, discuss implementation successes and challenges, talk about clinical fidelity and drift, as well as, lessons learned along the way. PEI Practice Learning Networks are offered for ART, CORS, CPP, Ind. CBT, IY, and SS. The upcoming Learning Network meeting schedule may be accessed at:
http://dmhoma.pbworks.com/w/page/55516035/PEI%20Practice%20Learning%20Network

PEI Outcomes General Learning Network (GLN)

To broaden the audience for Learning Networks, the MHSA Implementation and Outcomes Division developed the General Learning Network (GLN) Series for PEI providers (e.g., clinicians, supervisors, and data entry staff) unfamiliar with PEI Outcome reports, practices for

which there is no active learning network (e.g., DTQI, MST, FFT, BSFT, DBT, etc.), and providers interested in using outcome reports to make data driven decisions.

Module-1 of the General Learning Network provides an introduction to using reports to make data driven decisions. Module-1 of the GLN is comprised of three sessions. The first two sessions focus on how to analyze practice specific countywide aggregate report and provider level reports. Sessions one and two are each an hour long and are presented via webinar. The third session, focuses on analysis of provider/EBP specific data, is two-hours long and conducted in-person. Those who have completed session one and two are able to participate in session three.

Future GLN sessions will be offered, but have not been scheduled as of yet. For more information please contact **PEIOutcomes@dmh.lacounty.gov.**

OMA Users' Group

The OMA Users' Group is a platform for our PEI Providers to discuss all things OMA. In this meeting, the MHSA Implementation and Outcome Division provides updates on the various applications (FSP, FCCS, and PEI), discuss reports/reporting, present other related news that may be of interest to providers, as well as, host an Open Forum where questions may be asked. Attendance may be in person at DMH office or via webinar. Registration for the OMA Users Group may be downloaded from the Wiki Front Page or accessed directly at **http://dmhoma.pbworks.com/w/page/31419869/OMA%20USERS%20GROUP.**

OMA Newsletter

The OMA Newsletter is a publication produced by the MHSA Implementation and Outcomes Division's data team that is meant to be an easy read, filled with useful information and tips to help with outcomes collection. It may be accessed via the Wiki Front Page or accessed directly at **http://dmhoma.pbworks.com/w/page/95754338/OMA%20Newsletter.**

6.5 PEI Outcome Measures

PEI Practices in the OMA

As an accountability requirement of MHSA funding, the State mandated counties to report outcome data for PEI programs. Outcome measures (questionnaires) are the tools utilized to assess the effectiveness of PEI Practices. These tools provide indices of change from pre-post treatment and during treatment. The indices are used to demonstrate the impact PEI services for clients. As a result, clinicians countywide are being trained in collecting outcomes and utilizing the data for a variety of different PEI Practices. These outcome measures are an essential part of the toolkit for mental health providers, as they allow clinicians to identify main concerns, make treatment determinations, measure progress, and assess treatment outcomes for their clients. Providers are required to enter pre-post measures into the PEI OMA for all clients being served with PEI funding. Data can be entered in PEI OMA for the following practices. Practices that have more than one focus are listed separately.

PEI PRACTICES IN THE OMA	
• Aggression Replacement Training – Skill Streaming (ART)	• Managing and Adapting Practice (MAP) - Depression and Withdrawal
• Alternatives for Family-Cognitive Behavior Therapy (AF-CBT)	• Managing and Adapting Practice (MAP) - Disruptive Behavior
• Brief Strategic Family Therapy (BSFT)	• Managing and Adapting Practice (MAP) - Traumatic Stress
• Caring for Our Families (CFOF)	• Mental Health Integration Program (MHIP) - Anxiety
• Center for the Assessment and Prevention of Prodromal States (CAPPS)	• Mental Health Integration Program (MHIP) - Depression
• Child Parent Psychotherapy (CPP)	• Mental Health Integration Program (MHIP) - Trauma
• Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	• Mindful Parenting (MP)
• Crisis Oriented Recovery Services (CORS)	• Multidimensional Family Therapy (MDFT)
• Depression Treatment Quality Improvement (DTQI)	• Multisystemic Therapy (MST)
• Dialectical Behavioral Therapy (DBT)	• Parent–Child Interaction Therapy (PCIT)
• Families OverComing Under Stress (FOCUS)	• Problem Solving Therapy (PST)
• Functional Family Therapy (FFT)	• Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
• Group Cognitive Behavioral Therapy of Major Depression (Group CBT)	• Prolonged Exposure for PTSD (PE)
• Incredible Years (IY)	• Promoting Alternative Thinking Strategies (PATHS)
• Individual Cognitive Behavioral Therapy - Anxiety (Ind. CBT Anxiety)	• Reflecting Parenting Program (RPP)
• Individual Cognitive Behavioral Therapy - Depression (Ind. CBT Depression)	• Seeking Safety (SS)
• Individual Cognitive Behavioral Therapy - Trauma (Ind. CBT Trauma)	• Strengthening Families Program (SFP)
• Interpersonal Psychotherapy for Depression (IPT)	• Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
• Loving Intervention Family Enrichment (LIFE)	• Triple P Positive Parenting Program (Triple P)
• Managing and Adapting Practice (MAP) - Anxiety & Avoidance	• UCLA Ties Transition Model (UCLA TTM)

PEI Outcome Measures

Outcome measures were selected by focus of treatment and practice. DMH selected valid and reliable measures that were either copyrighted or available in public domain. To allow for comparisons across practices, a general measure was selected: the Youth Outcome Questionnaire/Outcome Questionnaire. Specific measures were also selected based on the focus of treatment, and in some cases, were recommended by the developer of the practice. All general and specific outcome measures are to be completed at the start and end of treatment. A copy of the form for ordering outcome measures is on the following page and is available at the following link:
http://dmhoma.pbworks.com/w/file/97686736PEI%20Outcome%20Measures%20Order%20Form%2006302015.xlsx

On May 13, 2011, an Outcome Measures Kick-Off was held and outcome measures were distributed to each provider based on PEI practices being implemented. DMH continues to provide outcome measures to providers, if available. Below is a brief overview of each outcome measure:

General Outcome Measures

- **Outcome Questionnaire (OQ)**
- **Youth Outcome Questionnaire (YOQ)**
- **Youth Outcome Questionnaire-Self Report (YOQ-SR)**

The OQ series of measures are used to assess client perceptions of a variety of specific domains of mental health functioning and associated symptoms. The YOQ (completed by parent or caregiver for children 4-17 years of age) and YOQ-SR (completed by youth 12-18 years of age), and OQ (completed by adults ages 19+) are standardized measures of mental health functioning.

Specific Outcome Measures

Specific outcomes measures were identified based on the focus of treatment for the following:

1. Anxiety
2. Trauma
3. First Break (TAY)
4. Depression
5. Emotional Dysregulation Difficulties
6. Disruptive Behavior Disorders and Parenting and Family Difficulties
7. Severe Behaviors/Conduct Disorders

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
Program Support Bureau-MHSA Implementation Outcomes Division

PEI Outcome Measures Order Form

INSTRUCTIONS

Complete one PEI Outcome Measures Order Form per provider number

1.) Fill in all fields in the Provider Information, Staff Information, and Evidence Based Practice(s) sections.

2.) In the Outcome Measure Order section, include the name(s) and amount(s) of the outcome measure(s) wanted. For reference, see the PEI Outcome Measures Catalog, which lists all outcome measures DMH has available for PEI practices. **The PEI Outcome Measures Catalog is on the second tab of this excel file.**

3.) Submit the PEI Outcome Measures Order Form by email to PEIoutcomes@dmh.lacounty.gov.

The PHQ-9, GAD-7, DERS and RCADS are available for free in the public domain; you do not need to order them from DMH. If your agency already has master version of the OQ, YOQ, YOQ- SR or PTSD-RI, you do not need to order more copies from DMH; you can photocopy the master versions to replenish stock.

Provider Information			
Legal Entity Name	**Legal Entity #**	**Provider Name**	**Provider #**

Staff Information		
Name	**E-mail Address**	**Phone Number**

Evidence Based Practice(s)

Outcome Measure Order (see PEI Outcome Measures Catalog on the next tab for available items)			
Outcome Measure(s)	**Amount**	**Outcome Measure(s)**	**Amount**

Section completed by MHSA Implementation & Outcomes Division Staff

Form Rec'd by _____ Form rec'd date _____

Process Order Yes ☐ No ☐

Reason(s) order cannot be processed _____

Date order delivered _____ Date agency informed order could not be processed _____

Outcomes Rec'd by _____
Print Name

_____
Signature

6/30/2015

FOCUS OF TREAT-MENT	DESCRIPTION OF OUTCOME MEASURES	PEI PRACTICE
ANXIETY	▸ **Revised Child Anxiety and Depression Scales (RCADS) and** ▸ **Revised Child Anxiety and Depression Scales-Parent Version (RCADS-P)** The RCADS and RCADS-P (completed by children and parents/caregivers of children ages 6-18) are measures of anxiety and depressive symptoms that correspond to DSM-IV diagnostic criteria. The RCADS and RCADS-P are used to assess outcomes when the focus of treatment is anxiety. Electronic scoring tools (Excel files) for both the RCADS and RCADS-P are available through the Resource section of the Child First website. However, these scoring tools, which include automatic T Score conversions, are intended for use for children in grades 3-12; they should not be used with children younger than grade 3. Users of these measures are encouraged to refer to the UCLA Child First website at **www.childfirst.ucla.edu/resources.html** for updates on administration and scoring information.	• MAP (Anxiety & Avoidance)
	▸ **Generalized Anxiety Disorder-7 (GAD-7)** The GAD-7 (completed by clients ages 18 and older) is useful for assessing symptoms and severity of anxiety at the start of treatment, and monitoring the client's symptoms over the course of treatment. The GAD-7 is used when anxiety is the focus of treatment. The GAD-7 is to be completed at the start and end of treatment targeting anxiety.	• Ind CBT (Anxiety Focus) • MHIP
TRAUMA	▸ **Trauma Symptom Checklist for Young Children (TSCYC)** The TSCYC (completed by the parent/care provider for children ages 3-6) provides valuable clinical information regarding a child's mental health functioning following a traumatic event and has subscales showing which symptoms are most prominent.	• CPP
	▸ **Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)** ▸ **UCLA PTSD-Reaction Index for DSM-5 (PTSD-RI-5 Child/Adolescent and Parent versions)** The PCL-5 for adults and the PTSD-RI-5 Child/Adolescent and Parent versions are measures of posttraumatic stress disorder symptoms that correspond to DSM-5 diagnostic criteria. The measures are used to assess outcomes when the focus of treatment is trauma. The PCL-5 (completed by clients 19+) is the adult trauma measure currently being used under PEI. The PTSD-RI-5 (Child/Adolescent version) is completed by children 7-18 years of age. The Parent version is completed by the parents of children 7-18 years of age.	• CBITS • AF-CBT • Ind. CBT (Trauma Focus) • MAP (Traumatic Stress) • SS • TF-CBT

TRAUMA	▸ **Posttraumatic Stress Diagnostic Scale (PDS)** The PDS (completed by adults ages 18-70) is a screening instrument based on DSM-IV diagnostic criteria for Posttraumatic Stress Disorder (PTSD). It is designed to assess the presence and severity of PTSD symptoms experienced in the past month. It is sensitive enough to monitor short-term treatment progress for individuals exhibiting symptoms of PTSD.	• PE
FIRST BREAK (TAY)	▸ **The Scale of Prodromal Symptoms (SOPS)** The Scale of Prodromal Symptoms (SOPS) was developed to assess prodromal symptoms of psychosis and change over the course of treatment. This symptom severity rating scale is derived from the Structured Interview for Psychosis-Risk Syndromes (SIPS). The interview inquires about the experience of the patient over the lifetime and the ratings on the SOPS are based on the client's self-report over the past month only. Four domains of symptoms are measured: Positive, Negative, Disorganized, and General.	• CAPPS
DEPRESSION	▸ **Patient Health Questionnaire-9 (PHQ-9)** The PHQ-9 is a brief measure that assesses the severity of depressive symptoms. It is used as a screening tool as well as a measure of treatment outcomes for individuals ages 12 and older.	• DTQI • Group CBT for Major Depression • Ind. CBT (Depression) • IPT • MAP (Depression & Withdrawal) • PST • PEARLS • MHIP
EMOTIONAL DYSREGULATION DIFFICULTIES	▸ **Difficulties in Emotional Regulation Scale (DERS)** The DERS (completed by adults 18 years of age and older) is a measure of emotional dysregulation. The DERS can be used to track changes in a client's ability to self-regulate throughout the course of treatment.	• DBT
DISRUPTIVE BEHAVIOR DISORDERS	▸ **Eyberg Child Behavior Inventory (ECBI) or** ▸ **Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R)** The ECBI (parent/caregiver report for children ages 2-16) and SESBI (teacher report for children ages 2-16) are measures of child disruptive behaviors and are used when such behaviors are the focus of treatment. Only the ECBI or the SESBI-R is required, however providers are able to enter both scores into PEI OMA, if they choose to do so.	• ART • ART (Skill-Streaming) • PATHS • MAP

PARENTING AND FAMILY DIFFICULTIES	▸ **Eyberg Child Behavior Inventory (ECBI) or** ▸ **Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R)** The ECBI (parent/caregiver report for children ages 2-16) and SESBI (teacher report for children ages 2-16) are measures of child disruptive behaviors and are used when such behaviors are the focus of treatment. Only the ECBI or the SESBI-R is required, however providers are able to enter both scores into PEI OMA, if they choose to do so.	• Triple P • IY • PCIT • UCLA TTM • CFOF • LIFE • RPP
	▸ **The Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)** The DECA-I/T is completed by parent/caregiver or teachers/daycare provider for infants, ages 1 to 18 months, and toddlers, ages 18 to 36 months. It is designed to be utilized as both a screening and assessment tool that focuses on identifying key social and emotional strengths to promote children's resilience, protective factors and to screen for potential risks in the social and emotional development of very young children.	• MP
	▸ **McMaster Family Assessment Device (FAD)** The FAD (completed by family members, ages 12 and older) is intended to assess individual family members' perceptions of family functioning, based on principles of the McMaster Model of Family Functioning (MMFF). It is also utilized as a tool to encourage family members to better understand each other's points of view and as a measure of change over the course of treatment. For the purposes of entering a score into PEI OMA, only the identified client's score will be entered into the application.	• FOCUS
SEVERE BEHAVIORS/ CONDUCT DISORDERS	▸ **Revised Behavior Problem Checklist (RBPC)** The RBPC is completed by parent/care provider or teacher, when parent is not available for clients in grades K to 12 (approximately ages 5-18). It is used to rate problem behaviors observed in children and adolescents to screen for a wide range of behavior problems and measure behavioral severity and change over time.	• BSFT • MDFT • SFP (Disruptive Behavior Disorders)

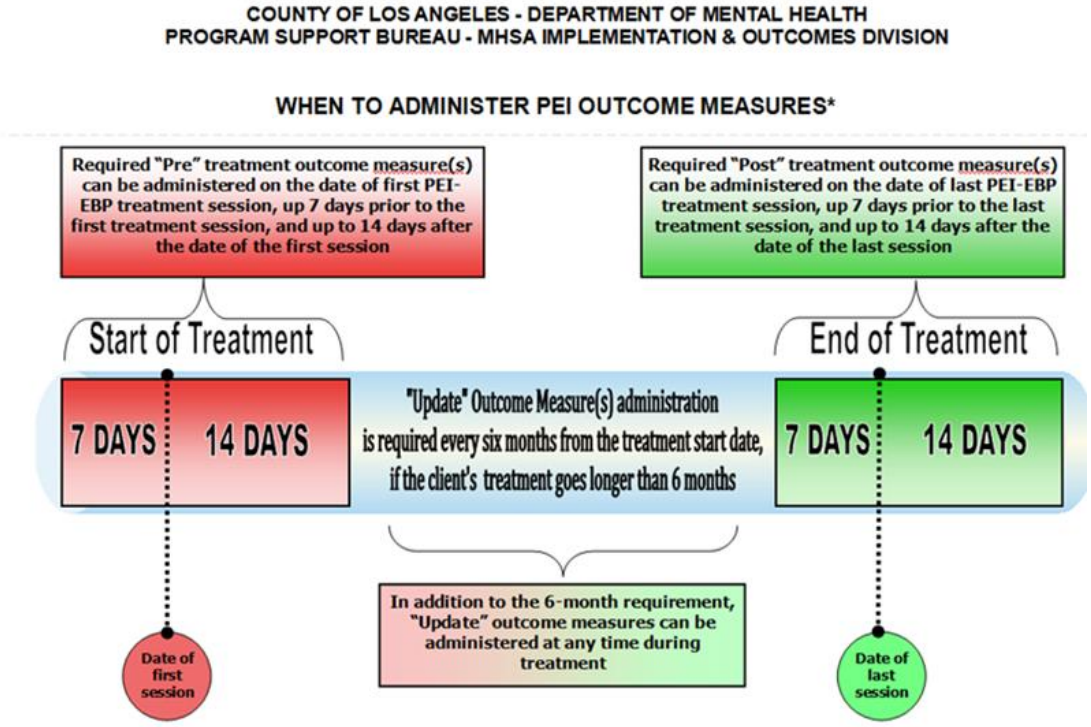
PEI Outcome Measures Table

The PEI Outcome Measures Table lists all the different EBP/PP/CDEs and their required outcome measures based on the focus of treatment, age, and available languages. A copy of the Outcome Measures table is included at the end of this Section 6. To check for the most updated version of the document, go to the PEI Outcomes Page or at the following link:
http://dmhoma.pbworks.com/w/file/103712099/PEI%20Outcome%20Measures%20TABLE%20%2012-11-15.pdf

6.6 Outcome Data Collection Process

Administration of Outcome Measures

Outcome measures are required to be administered at the start and end of a PEI EBP. The "Pre" measure can be administered seven (7) days prior to the first day of EBP treatment session or up to fourteen (14) days after. The same timeline applies for the last day of EBP treatment session and the "Post" measure. The timeline for measure administration is illustrated below.



Agencies can elect to administer outcome measures at any time within the administration date range of 21 days at the beginning and at the end of treatment. If the outcome measure is administered outside of this date range for a pre or a post outcome measure, an "Unable to Collect" reason (i.e., "Administration date exceeds acceptable range") will need to be selected.

Updates or re-administration of outcome measures are required every 6-months if the treatment goes for more than 6-months. Updates may be done as frequently as every 7 days and can be entered into PEI OMA accordingly. Outcome measure updates are encouraged as they allow for tracking clinical progress and refinement of the treatment. Should a client "drop out" of treatment, the update questionnaire score may be considered as the Post-treatment score should it fall within the 21 day window, and if the score is saved as the "Post." If not, an "Unable to Collect" reason will be required to enter into PEI OMA.

Scoring and Interpretation of Outcome Measures

The MHSA Implementation and Outcomes Division offers trainings on all measures. These trainings highlight a step by step process for scoring the measure. Also, outlined in the training is a systematic approach to understanding or interpreting the results of the measure, so that it can be utilized to inform treatment and linked to the client's goals. Attention in the training is also given to understanding and utilizing the outcome measure's critical items, if any, which may reveal risk factors that need to be addressed in the treatment.

Electronic scoring sheets for some of the outcome measures are available on the PEI Outcomes page of the PEI OMA Wiki under the heading "Scoring Sheets." The link to these scoring sheets is below: **http://dmhoma.pbworks.com/w/page/36104184/PEI%20Outcomes.**

In addition, Optional PEI Worksheets are available for each practice and may assist clinical and/or data entry staff in collecting/entering data that is required for opening a treatment cycle in PEI OMA. For each practice, there is a unique worksheet designed for the beginning of treatment information, update(s), and the end of treatment information. These Optional PEI Worksheets may be found at the following link:
http://dmhoma.pbworks.com/w/page/40178480/PEI%20Worksheets.

Submission of Outcome Data to PEI OMA

Agencies are encouraged to create their own approach in facilitating data entry into PEI OMA. The process of collecting and sorting the information is important but may vary from provider to provider. Data entry staff may find it helpful to use the aforementioned optional worksheets to ensure that the required information is being entered in the same sequence as its being requested. There is no specific timeframe in which outcomes data needs to be entered into PEI OMA, but it is encouraged that providers enter the data as soon as possible as to prevent a backlog, and to assure that outcome measure reports are updated with new and useful information.

Recommendation for Outcome Oversight

Agencies benefit by having procedures for outcomes collection. The goal is the effective integration of outcome measures as part of mental health treatment and the utilization of the data collected to inform both client treatment directly and trends in mental health service delivery. A recommendation, when possible, is to designate a staff member(s) with the responsibility of supporting outcome collection. This individual(s) may provide consultation to other staff tasked with outcome data entry, clinical staff responsible for the administration of the outcome measures, and facilitation of trainings on the collection and utilization of these measures. In addition, this staff member(s) can find creative ways of disseminating outcomes data information (i.e., in-person trainings, discussion groups, supervision groups, newsletters, brown bag lunches, etc.) within their agency so data driven decisions can be made.

Outcomes Monitoring and Tracking System

The development and implementation of an Outcomes Monitoring and Tracking System contributes to the timely and accurate collection of outcomes data. An agency's system should be able to determine the appropriate measures to administer based on the focus, treatment model, and client's age at the

start of the practice; alert appropriate staff persons of when measures need to be administered for each client; have standards for how frequently data should be entered in PEI OMA as well as a means of tracking the progress of data entry into the PEI OMA. The Outcomes Tracking and Monitoring system could be integrated into the Electronic Health Records, be maintained as a spreadsheet, or hard copy depending on the agency's needs and resources.

Storage of Outcome Measures

All copyrighted outcome measures such as the ECBI, SESBI-R, TSCYC, RBPC, etc. are to be stored in a secured and locked cabinet. Outcome measures found in public domain can be uploaded onto providers Electronic Health Record (EHR) system including completed copies of the YOQ, YOQ-SR, OQ, and all versions of the UCLA PTSD-RI.

Billing and Claiming Outcomes

Administration of outcome measures for clinical purposes, such as assessing and monitoring client's symptoms and treatment progress, and guiding treatment planning might be claimable services. For clarification or further guidance, please consult with your Quality Assurance team, your service area quality improvement committee, and/or appropriate DMH quality assurance staff.

6.7 Benefits of Outcome Monitoring

The use of routine outcome monitoring in mental health service delivery has strengthened over the last decade. Outcome monitoring has been shown to improve quality of care, clinician performance, patient satisfaction, and resource allocation. In addition, the analysis of outcome data provides the support needed to justify continued funding for mental health services. Therefore the integration of routine outcome monitoring into mental health treatment has become a necessity in our field. Providers may request a report reflecting the results of the outcome data entered for their agency on a number EBP/PP/CDE practices. A copy of the order form is provided on the next page and is available at the following link: **http://dmhoma.pbworks.com/w/file/91419456/PEI%20Outcomes%20Report%20Order%20Form_Fillable%201-16-15.pdf**

Best Practice for Outcome Measures

A script, introducing outcomes can be useful for beginning the process. The script should include the reason for outcomes, how measures are administered, the benefits of outcomes to clinical care, and the use of critical items in understanding client risk factors. Educate your client about the purpose of completing outcome measures and be empathic to their concerns and needs. It's essential to assist clients to engage in the outcomes process and to discuss the potential benefits for care. It can be helpful to demonstrate the link between the results of the measures to a client's goals and expectations.

Outcome measures can provide clients and their families with more definite goals in treatment. The therapist and clients have a better sense of where they are heading, where they have come from and what they are achieving. Used correctly, outcome measures can help clients and their families feel listened to and reinforce their engagement in the treatment process.

Ensure the collaborative process by reviewing results of outcomes measures with clients. Be mindful that children can also benefit from understanding the result of their outcome measures. Provide feedback in a way that is congruent with the client's maturation. Explaining the results to parents allows them to better understand their child and may be used to engage them into the treatment protocol.

When clients endorse critical items on a measure, it is important to explore their response and assess any potential risks that need to be assessed further. At times, a client's response may be discrepant from their verbal reports or observable behavior. Reviewing results provides the opportunity to explore the discrepancy and test the limits to better understand the client's experience and perceptions of their symptoms and functioning. Working to understand any discrepancies among the reporters on a measure contributes to a more nuanced understanding of the client and better treatment.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - MHSA IMPLEMENTATION & OUTCOMES DIVISION

PEI Outcomes Report Order Form

Complete one PEI Outcomes Report order form per provider number.

1) Please fill in fields: Date, Evidence-Based Practice(s) (EBP), legal entity name, legal entity number, provider name, provider number, and the name, email address, and phone number of the person completing this form.
2) Indicate with an "X" the report output (PDF or Excel) you are requesting. A PDF report will provide you with print ready reports. An Excel report provides you with data in a raw format that you can re-format.
3) Submit the PEI Outcomes Report Order form by email to PEIoutcomes@dmh.lacounty.gov with "Reports Request" in the subject line.
4) Reports will be emailed and those containing protected health information (PHI) will be sent via secure email.

Date

Provider Information			
Legal Entity Name	Legal Entity #	Provider Name	Provider #

Staff Information		
Name	Email Address	Phone #

Evidence-Based Practice(s)

Report	Report Description	PDF	Excel
Client Service Summary Detail (contains PHI)	Provides a list of clients (active and inactive) entered into the PEI OMA by EBP by Provider.		
Clients billed to an EBP without Core Services	Provides a list of PEI clients billed to an EBP without a core intervention.		
Clients Claimed to PEI but not in OMA (contains PHI)	Provides a list of clients claimed to PEI but not entered in OMA by Provider.		
Clients Claimed to an EBP for PEI (contains PHI)	Provides a list of clients claimed to EBPs by Provider and PEI plans.		
Clients in OMA not claimed to PEI EBP (contains PHI)	Provides a list of clients entered in OMA by Provider but not claimed to a PEI EBP.		
Compliance Stats by Provider	Reports on the compliance rate of outcomes entered and client treatment cycle statistics by PEI Focus and Practice Name at the Provider level.		
Compliance Stats by Service Area	Reports on the compliance rate of outcomes entered and client treatment cycle statistics by PEI Focus and Practice Name at the service area level.		
Compliance Stats by County	Reports on the compliance rate of outcomes entered and client treatment cycle statistics by PEI Focus and Practice Name at the County level.		
Core Services by Legal Entity	Used to compare PEI units of service and cost by core and non-core services for a selected Legal Entity.		
Core Services by Provider	Used to compare PEI units of service and cost by core and non-core services for a selected provider number.		
EBP Exception	Provides a list of claims by Provider. Claims included in the report have either selected multiple EBPs, multiple EBPs with one service strategy and/or only one or multiple service strategies.		
EBPs Billed to Non PEI Plans	Provides a list of clients billed with an EBP to a non-PEI plan by provider.		
Overlapping EBPs billed to PEI	Provides a list of clients billed to more than one EBP during the same time period.		
Questionnaire Stats by Legal Entity	Shows the number of scored questionnaires by practice in OMA at the Legal Entity level.		
Questionnaire Stats by Provider	Shows the number of scored questionnaires by practice in OMA at the Provider level.		
Questionnaire Stats by County	Shows the number of scored questionnaires by practice in OMA at the County level.		
Unable to Collect	Shows the percentage of unable to collect reasons for questionnaires by practice.		

Use of Outcome Measures in Supervision

Outcome measures can be a useful tool for supervision as well. The practice of incorporating outcome results into supervision allows the client's experience to be represented. Through the collaborative supervision framework, supervisees are often able to expand their understanding of a case from outcome measure data. Within the supervision framework, the results of the measure can be understood in the context of multiple factors in the client's life, facilitated by the supervisor's guided exploration. The supervisor is usefully positioned to help the supervisee identify when interventions appear to be on or off track. This information contributes to the case conceptualization and allows for refined treatment based on scores over time. The measures may serve as a fidelity monitoring tool, as well to note if the practice is addressing the intended focus.

Supervision may be a forum for ongoing education regarding the use of outcome measures in clinical practice resulting in the advancement of skills aligned with trends in the field. Supervision provides a unique opportunity to develop and maintain mindful awareness of feelings and attitudes about the outcomes process. Such an approach has been shown to positively impact clinical outcomes.

6.8 Using Outcomes in Programmatic Decision Making

Data collected through outcome measures have inherent value when utilized to inform programmatic decision. Providers are expected to integrate outcome measures into their program planning and therefore help their delivery of services to PEI clients. Providers must define the policies and procedures that function best for their organization in order to ensure the regular and effective use of the outcome measures.

6.9 PEI Outcomes FAQs

Frequently Asked Questions (FAQs) Regarding the Use of Outcomes Measures for Evidence Based Practices (EBP) and the Prevention and Early Intervention (PEI) Outcome Measure Application (OMA) were developed. A copy of the most recent FAQs (updated on March 22, 2016) is attached at the end of this Section 6. Be sure to check the website for the most current version at the following link:
http://dmhoma.pbworks.com/w/page/40360716/PEI%20Outcomes%20FAQ

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH

Program Support Bureau-MHSA Implementation and Outcomes Division

FREQUENTLY ASKED QUESTIONS (FAQS)

REGARDING THE USE OF OUTCOMES MEASURES FOR EVIDENCE BASED PRACTICES(EBP) AND THE PREVENTION AND EARLY INTERVENTION (PEI) OUTCOME MEASURE APPLICATION (OMA)

Updated 3/11/2016

To check that you are have the most current outcomes information, go to the PEIOMA website at **http://dmhoma.pbworks.com/w/page/40360716/PEI%20Outcomes20FAQ**

1. DATA COLLECTION QUESTIONS

i. When should I administer PEI Outcome Measures?
ii. What do you do if you cannot collect either a "Pre," "Update," or "Post" outcome measure?
iii. What are the responsibilities of data entry staff for clients with no "Pre", "Update" or "Post" outcome measure scores?
iv. Can "Update" outcome measure scores be entered if "Pre" outcome measure data have not been entered?
v. Can "Post" outcome measure scores be entered if "Pre" outcome measure scores have not been entered?
vi. Should my agency collect a "Post" outcome measure(s) if an EBP was not fully completed?
vii. When does a lockout occur in PEI OMA, causing PEI OMA to reject outcome measure data?
viii. How often/frequently should I enter data into PEI OMA?
ix. How do we collect and enter data in PEI OMA if the client is receiving multiple EBPs simultaneously from a single legal entity (e.g. ART and Seeking Safety)?
x. If a client was too young to complete any PEI Outcome Measures do I still have to enter the client into PEI OMA?
xi. I made a mistake when I entered a client into PEI OMA, and now I can't fix it. What should I do?
xii. Can completed outcome measures be uploaded to a client's electronic health record (EHR)?

2. ADMINISTRATION OF OUTCOME MEASURES

i. Can you bill for administering, scoring, and interpretation of outcome measures?
ii. Can "Pre" outcome measures be administered during the initial assessment phase?
iii. Can case managers and/or non-clinical staff persons administer, score or interpret outcome measures if they've received training on the measure?
iv. If a client has a birthday during treatment and ages out of the "Pre" outcome measure, do you still give the same "Post" outcome measure, and if necessary, "Update" outcome measure?
v. Can family members, clinicians, or other persons provide on-the-spot interpretation of outcome measures from one language to another?
vi. What outcome measures can be administered verbally (i.e., read) to respondents?
vii. Can you answer a clarifying question that a respondent has about an outcome measure if the person doesn't understand a certain question or item?
viii. What should be done if, during administration of an outcome measure, it is determined that the respondent does not comprehend the items?
ix. Is there a standard definition of the terms "EBP Completed" and "Client's treatment a success," in PEI OMA?

3. TRAINING

i. How Can I register for a PEI Outcomes Training?
ii. Does each staff person who will be administering outcome measures have to come to one of these PEI outcome measure trainings, or can agencies send a representative to the trainings and have the person who attended then train other staff?

4. DISTRIBUTION OF OUTCOME MEASURES

i. How do I obtain additional outcome measures?
ii. Do outcome measures not available for reproduction in the public domain have to be given to us by LACDMH?
iii. Can outcome measures provided by LACDMH be sent to our agency electronically or by mail?
iv. How do I get non-English versions of outcome measures?

5. PTSD-RI QUESTIONS

i. Regarding the PTSD-RI, if a child answers "No" to the first page of the Child/Adolescent Self-Report, that no "bad thing" happened to them, would you continue completing the measure or stop?
ii. For the PTSD-RI, what if you have more information about specific trauma incidents which could be troubling the child, but the child does not mention them when completing the outcome measure?

6. OTHE6R OUTCOME MEASURES

i. Do I have to administer and enter data for both the ECBI and SESBI-R?
ii. Do I have to administer and enter data for the RBPC for both parent and teacher?

7. USE OF OUTCOME MEASURE DATA

i. Will DMH be releasing our raw data from the PEI OMA?
ii. How will data gathered through PEI OMA be used with regard to individual, agency, and EBP performance?

1. DATA COLLECTION QUESTIONS

i. When should I administer PEI Outcome Measures?

"Pre/post" treatment outcome measures can be completed as early as 7 days prior to the date of the first/last session, on the date of the first/last session, and up to 14 days after the date of the first/last session. "Update" outcome measures should be administered every six months, if treatment lasts longer than 6 months. There is no hard administration window for "update" outcome measure completion.

ii. What do you do if you cannot collect either a "Pre," "Update," or "Post" outcome measure?

There is an "Unable to Collect" field in PEI OMA. If a numeric score could not be collected, instead provide the "Unable to Collect" reason. This answer applies to "Pre," "Post," and "Update" outcome measures.

iii. What are the responsibilities of data entry staff for clients with no "Pre", "Update" or "Post" outcome measure scores?

The person who gives data entry staff all information required by PEI OMA should provide the "Unable to Collect" reason.

To facilitate communication between staff members responsible for outcome measure data collection and staff members responsible for outcome measure data entry, the MHSA Implementation & Outcomes Division has developed optional worksheets, available at the DMH OMA Wiki. Here's how to use them. The person who is responsible for outcome measure data collection fills out the worksheet and then give it to the staff person responsible for data entry, who would then input and save that information in PEI OMA.

iv. Can "Update" outcome measure scores be entered if "Pre" outcome measure data have not been entered?

Yes. "Update" outcome measure scores can be entered into PEI OMA, as long as an "Unable to Collect" reason is entered in lieu of "Pre" outcome measure scores. Each required outcome measure needs be acknowledged in PEI OMA in one of two ways: (a) collect a numeric score or (b), choose an "Unable to Collect" reason if a score couldn't be collected.

v. Can "Post" outcome measure scores be entered if "Pre" outcome measure scores have not been entered?

Yes. DMH is interested in the "Post" treatment data as well as data reflecting change from "Pre" to "Post" treatment. Therefore, "Post" outcome measure scores should be entered into PEI OMA, as long as the "Pre" treatment outcome measure is already acknowledged in PEI OMA by choosing an "Unable to Collect" reason. Remember, each

required outcome measure needs be acknowledged in PEI OMA in one of two ways: (a) collect a numeric score or (b), choose an "Unable to Collect" reason if a score couldn't be collected.

vi. Should my agency collect a "Post" outcome measure(s) if an EBP was not fully completed?

If the client does not complete the EBP, "Post" measures may collected but their collection is not required by DMH. Each agency determines policies regarding collecting "Post" outcome measures when an EBP is not completed.

However, entering End of Treatment Information into PEI OMA is still required, which includes date of last treatment session, number of treatment sessions, and treatment disposition, e.g., the client moved away or started a different treatment.

vii. When does a lockout occur in PEI OMA, causing PEI OMA to reject outcome measure data?

When the outcome measure is completed outside of the administration window, PEI OMA will generate an error message indicating that the data from that outcome measure cannot be submitted. Additionally, PEI OMA requires all fields from each outcome measure to be entered (excluding "Unable to Collect" field). PEI OMA will not allow data to be saved if any fields are left blank. Further, data entry staff must complete all score fields for each outcome measure OR enter an "Unable to Collect" reason code if there is no score.

viii. How often/frequently should I enter data into PEI OMA?

Entering data as soon as it is available will ensure that any reports developed will contain the most up-to-date information. This in turn helps providers, DMH and the State receive the most up-to-date information. Persons entering data into PEI OMA should follow the policies/procedures set by each legal entity regarding the frequency of data submission into PEI OMA.

ix, How do we collect and enter data in PEI OMA if the client is receiving multiple EBPs simultaneously from a single legal entity (e.g. ART and Seeking Safety)?

Before answering this specific question, it needs to be stated that in most cases, clients should be enrolled in only one PEI funded EBP at a time.

To answer the question posed above, data for clients enrolled in more than one EBP simultaneously can be entered into PEI OMA if the EBPs do not have the same focus, e.g., data can be entered for client simultaneously is enrolled in IPT, a depression focused treatment, and ART, a disruptive behavior focused treatment but not if the client is enrolled both in ART and PATHS because both are under the Disruptive Behavior Disorder focus.

x. If a client was too young to complete any PEI Outcome Measures do I still have to enter the client into PEI OMA?

Yes. In these situations you would open a Treatment Cycle in PEI OMA and provide the required client information. PEI OMA will recognize instances when an outcome measure's score is not entered due to a client's age being below minimum age requirement and it will not create space for entering the outcome measure's score.

xi. I made a mistake when I entered a client into PEI OMA, and now I can't fix it. What should I do?

Certain entries can't be edited or undone by users; for example, if you save the wrong Date of First Service or if you start your client under the wrong EBP. When the entry can't be edited, erase the client's treatment cycle; then create a new one with the correct information.

xii. Can completed outcome measures be uploaded to a client's electronic health record (EHR)?

It depends on the copyright rules established by the outcome measure's publisher.

Completed outcome measures that may be uploaded to a client's record in an EHR:

- OQ Series (YOQ, YOQ-SR, OQ)
- PTSD-RI
- RCADS
- PHQ-9
- GAD-7
- FAD
- PCL-5
- PCL-C
- SOPS
- DERS

Completed outcome measures that may not be uploaded to the client's record in an EHR:

- DECA-I/T
- ECBI
- PDS
- RBPC
- SESBI-R
- TSCYC

2. ADMINISTRATION OF OUTCOME MEASURES

i. Can you bill for administering, scoring, and interpretation of outcome measures?

No, but you can bill for using the outcome measure in your clinical work with clients, for example, discussing the meaning of scores with the client, follow-up assessment if results suggests the client is engaging in high risk behavior, discussing the treatment progress suggested by change/lack of change in outcome measure scores over time.

ii. Can "Pre" outcome measures be administered during the initial assessment phase?

"Pre" outcome measures need to be administered within the administration window. Agencies can elect to administer outcome measures at intake if they determine the treatment model prior to intake and incorporate EBP interventions at intake, according to the EBP model. Agencies should keep in mind several factors in making this determination. First, if there is a long wait between intake and the next session of the EBP, there is the potential that "Pre" outcome measure data collected during the initial intake will become invalid due to the long wait period. Second, PEI OMA will reject data from outcome measures completed outside of the administration window. Third, agencies should consider the challenges clinicians may face if they attempt to complete an initial assessment while simultaneously conducting the first session of an EBP, and collecting all outcome measures.

iii. Can case managers and/or non-clinical staff persons administer, score or interpret outcome measures if they've received training on the measure?

For all PEI outcome measures, interpretation must be done by a clinical staff person who has completed or is currently enrolled in a graduate training program in psychology, counseling, social work, or other related field.

The authors of each measure have created rules regarding who can administer and score outcome measures and these rules vary from measure to measure. Information about these rules is available in outcome measure Quick Guides, at outcome measure trainings, and in outcome measure manuals.

iv. If a client has a birthday during treatment and ages out of the "Pre" outcome measure, do you still give the same "Post" outcome measure, and if necessary, "Update" outcome measure?

Yes.

v. Can family members, clinicians, or other persons provide on-the-spot interpretation of outcome measures from one language to another?

No, this would invalidate the outcome measure because the person interpreting may not interpret items exactly as they are meant by the measure's author. If an outcome measure cannot be completed due to language difficulties and there is no authorized

translation in their native language available, then the appropriate "Unable to Collect" reason code should be indicated in PEI OMA for that outcome measure.

vi. What outcome measures can be administered verbally (i.e., read) to respondents?

The following outcome measures can be verbally administered to respondents:

- YOQ/YOQ-SR/OQ
- ECBI/SESBI-R
- UCLA PTSD-RI
- GAD-7
- PHQ-9
- DERS
- FAD
- RCADS
- YSR
- PCL-C
- CBCL-1.5-5/CBCL
- DECA/DECA-IT

vii. Can you answer a clarifying question that a respondent has about an outcome measure if the person doesn't understand a certain question or item?

Depending on the outcome measure being administered, questions can be clarified. Other outcome measures encourage respondents to make their best guess, answer no/never, or to leave it unanswered if they do not understand the item. With some measures (e.g., ECBI, SESBI-R) agencies may need to standardize the manner in which they clarify some of the language included (e.g., sasses, dawdles, minds) when asked by respondents, so that the measures are administered in a uniform manner. Information about these rules is available in outcome measure Quick Guides, at outcome measure trainings, and in outcome measure manuals.

viii. What should be done if, during administration of an outcome measure, it is determined that the respondent does not comprehend the items?

Administration of the outcome measure should be discontinued if the respondent cannot complete it in any of the appropriate modes of administration. The outcome measure would be considered invalid and the appropriate reason that scores were not collected should be entered into PEI OMA in the "Unable to Collect" section.

ix. Is there a standard definition of the terms "EBP Completed" and "Client's treatment a success," in PEI OMA?

For each EBP, agencies should contact their EBP Practice Leads to clarify the practice's definitions of "success in treatment" and "completion of treatment."

3. TRAINING

i. How Can I register for a PEI Outcomes Training?

You can register for a PEI Outcomes Training by completing a PEI Outcomes Training Registration form, available on the DMH OMA Wiki and submitting it to PEIoutcomes@dmh.lacounty.gov.

ii. Does each staff person who will be administering outcome measures have to come to one of these PEI outcome measure trainings, or can agencies send a representative to the trainings and have the person who attended then train other staff?

DMH recommends that each agency send as many clinicians as they can to the PEI outcome measure trainings in order to receive the same training on the administration, scoring, and interpretation of these measures and to learn about the protocols for the collection and submission of outcome measure data. However, an agency may send one representative to get trained on a particular outcome measure and then have that person train of their staff.

4. DISTRIBUTION OF OUTCOME MEASURES

i. How do I obtain additional outcome measures?

To order outcome measures, complete a PEI Outcome Measures Order form, available on the DMH OMA Wiki, and submit the form to PEIoutcomes@dmh.lacounty.gov

Outcomes Re-ordering information:

- Outcome measures that are available freely online and may be reproduced by agencies:
  - PHQ-9 www.phqscreeners.com
  - GAD-7 www.phqscreeners.com
  - PCL-C www.ptsd.va.gov/professional
  - PCL-5 www.ptsd.va.gov/professional
  - RCADS http://www.childfirst.ucla.edu/resources.html
- Outcome measures DMH has provided a master version agencies can use to replenish their stock as needed:
  - YOQ
  - YOQ-SR
  - OQ
  - PTSD-RI for DSM-IV
  - PTSD-RI for DSM-5
  - FAD

- Outcome measures that may not be reproduced by agencies and must be ordered either from LACDMH or vendors:
    - ECBI
    - SESBI–R
    - PDS
    - TSCYC
    - CBCL 1.5-5
    - CBCL 6-18
    - V. C-TRF
    - TRF
    - YSR
    - RBPC
    - DECA-I/T

ii. Do outcome measures not available for reproduction in the public domain have to be given to us by LACDMH?

No. There is no policy regarding who provides agencies with outcome measures, just that agencies collect data using the outcome measures appropriate for each practice. Agencies can purchase outcome measures directly from vendors.

iii. Can outcome measures provided by LACDMH be sent to our agency electronically or by mail?

At this time, the only outcome measure DMH is allowed to send electronically is the PTSD-RI for DSM-5. All other outcome measures must be distributed, in person, to agency personnel by a staff member from the MHSA Implementation & Outcomes Division.

iv. How do I get non-English versions of outcome measures?

The options are:

- Option One: DMH has some translated outcome measures available. It is the goal of DMH to eventually have all outcome measures translated into each of the County's 13 threshold languages. DMH will provide updates as new translated outcome measures become available. To find out which translations are currently available for distribution by DMH, refer to the PEI Outcome Measures Table located on the DMH OMA Wiki.

- Option 2: Legal entities can contact vendors selling the outcome measure to see if translations of the outcome measure are available for purchase. If the outcome measure is not currently available in a particular language, the legal entity can attempt to work with the vendor to create a translation for that legal entity to purchase.

5. PTSD-RI QUESTIONS

i. Regarding the PTSD-RI, if a child answers "No" to the first page of the Child/Adolescent Self-Report, that no "bad thing" happened to them, would you continue completing the measure or stop?

You would discontinue administration if a client did not meet criteria A (were not exposed to a single traumatic event) in the first place. The first part of the PTSD – RI Child/Adolescent version (the "Trauma History Profile" and the "Self-Report Trauma History Profile") establish if Criterion A was met; in other words, whether or not the client was exposed to at least one traumatic event in their lives.

ii. For the PTSD-RI, what if you have more information about specific trauma incidents which could be troubling the child, but the child does not mention them when completing the outcome measure?

You can make a note of supplemental information on the Trauma History Profile and in the client's charting notes, but, allow the child to complete the whole outcome measure and self-identify what is bothering him/her the most (Self-Report Trauma Profile) and his/her reactions to it (Reaction Index). The outcome measure is designed to isolate the trauma experience and symptoms the child reports are most bothersome at the time. Those experiences and symptoms may relate to the unmentioned trauma and/or are likely to arise as treatment progresses. If the child later identifies a different trauma as most bothersome you can administer the Self-Report Trauma Profile and the Reaction Index again in order to see there is a change in the problem that bothers the child the most and/or the symptoms reported have changed.

6. OTHER OUTCOME MEASURES

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i. Do I have to administer and enter data for both the ECBI and SESBI-R?

While you may administer both the ECBI and SESBI-R, you do not have to administer both. It is recommended to administer the ECBI if possible and administer the SESBI-R when, in your judgment, the ECBI should not or cannot be administered.

Regarding data entry for the ECBI and SESBI-R, if you have administered both the ECBI and SESBI-R and have valid scores for both, you may enter the scores for both. If you have administered and have valid scores for one of the two outcome measures you would enter the scores for the outcome measure that you collected and enter the other measure as "Unable to Collect," and choose the reason that best explains why the outcome measure's scores were not entered.

ii. Do I have to administer and enter data for the RBPC for both parent and teacher?

While you may administer both the RBPC Parent and RBPC teacher you do not have to administer both. Administering the RBPC to a caregiver is recommended, if possible, and administration to teacher is recommended when, in your judgment, the outcome measure should not be or cannot be administered to a caregiver.

Regarding data entry for the RBPC, you can enter scores for teacher or the parent, but not for both. If you have valid scores for both, use your best clinical judgment in determining which measure's scores to enter into PEI OMA.

7. USE OF OUTCOME MEASURE DATA

i. Will DMH be releasing our raw data from the PEI OMA?

We plan to make PEI OMA data available to providers. This will be part of the third release of PEI OMA.

ii. How will data gathered through PEI OMA be used with regard to individual, agency, and EBP performance?

While clinicians may utilize outcome measures data to inform their treatment planning with each of their clients, data gathered through PEI OMA will be utilized for analysis at multiple levels. These data will be used to provide information such as where services are being most utilized and by whom, and what is being shown to be effective and for whom. A vision of the MHSA Implementation & Outcomes Division is to support the success of PEI Learning Networks using data reports.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division

Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

WELLNESS · RECOVERY · RESILIENCE

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - Anxiety & Avoidance**	3 - 19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Revised Child Anxiety and Depression Scales - Parent (RCADS-P) Revised Child Anxiety and Depression Scales (RCADS)	6 - 18	**RCADS-P**: English, Korean, Spanish **RCADS**: Chinese, English, Korean, Spanish
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire 45.2	16 - 17 16 - 18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18+	No general measure is required				
TRAUMA	Child Parent Psychotherapy (CPP)	0 - 6	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Armenian, Chinese, English, Korean, Spanish
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10 - 15	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent***	7 - 18 7 - 18	**PTSD-RI 5 Child/Adolescent**: English, Spanish **PTSD-RI-5 Parent**: English, Spanish **PCL-5**: English, Spanish
	Alternatives for Families-Cognitive Behavioral Therapy [formerly: Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	6 - 15					
	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)*	3 - 18					
	Managing and Adapting Practice (MAP) - Traumatic Stress**	2 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	7 - 17 12 - 18 19+	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent*** PCL-5***	7 - 18 7 - 18 19+	
	Seeking Safety (SS)	13+					
	Individual Cognitive Behavioral Therapy - Trauma (CBT-Trauma)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent*** PCL-5***	16 - 18 16 - 18 19+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 65	English
	Mental Health Integration Program (MHIP)-Trauma	18+	No general measure is required		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division

Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

WELLNESS · RECOVERY · RESILIENCE

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
CRISIS	Crisis Oriented Recovery Services (CORS)	3+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	No specific measure is required		
FIRST BREAK / TAY	Center for the Assessment and Prevention of Prodromal States (CAPPS)	16 - 25	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	Scale of Prodromal Symptoms (SOPS)	16 - 35	English, Spanish
DEPRESSION	Interpersonal Psychotherapy for Depression (IPT)	12+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	8 - 17 12 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	12+	Available in all 13 threshold languages
	Depression Treatment Quality Improvement (DTQI)	12 - 20					
	Managing and Adapting Practice (MAP) - Depression and Withdrawal**	8 - 23					
	Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	18+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	16+	Available in all 13 threshold languages
	Individual Cognitive Behavioral Therapy - Depression (CBT-Depression)	16+					
	Problem Solving Therapy (PST)	60+	Outcome Questionnaire - 45.2	19+			
	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+					
	Mental Health Integration Program (MHIP) - Depression	18+	No general measure is required				
EMOTIONAL DYSREGULATION DIFFICULTIES	Dialectical Behavioral Therapy (DBT) DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Difficulties in Emotional Regulation Scale (DERS)	18+	English

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division

Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

WELLNESS · RECOVERY · RESILIENCE

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
DISRUPTIVE BEHAVIOR DISORDERS	Aggression Replacement Training (ART)	12 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [If parent is unavailable]	2 - 16	**ECBI**: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Aggression Replacement Training - Skillstreaming (ART)	5 - 12					
	Promoting Alternative THinking Strategies (PATHS)	3 - 12					
	Managing and Adapting Practice (MAP) - Disruptive Behavior**	0 - 21	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+			
SEVERE BEHAVIORS/ CONDUCT DISORDERS	Brief Strategic Family Therapy (BSFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Revised Behavior Problem Checklist - Parent (RBPC) Revised Behavior Problem Checklist - Teacher (RBPC) [If parent is unavailable]	5 - 18	Armenian, Cambodian, English, Spanish
	Multidimensional Family Therapy (MDFT)	11 - 18					
	Strengthening Families Program (SFP)	3 - 16					
	Functional Family Therapy (FFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18	Developer Required: Clinical Services System: • Counseling Process Questionnaire • Client Outcome Measure • Therapist Outcome Measure • YOQ/YOQ-SR/OQ	10 - 18	English
	Multisystemic Therapy (MST)	11 - 17			Developer Required: Therapist Adherence Measure Supervisor Adherence Measure	11 - 17	English
PARENTING AND FAMILY DIFFICULTIES	Triple P Positive Parenting Program (Triple P)	0 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable]	2 - 16	**ECBI**: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Incredible Years (IY)	0 - 12					
	Parent – Child Interaction Therapy (PCIT)	2 - 7					
	UCLA TIES Transition Model (UCLA TIES) CDE	0 - 9					
	Caring For Our Families (CFOF) CDE as of 12/1/12	5 - 11					
	Loving Intervention Family Enrichment (LIFE) CDE as of 12/1/12	10 - 17					
	Reflective Parenting Program (RPP) CDE	0 - 12					
	Mindful Parenting Groups (MPG) CDE	0 - 3	No general measure is required		Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	1m - 36m	English, Spanish

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division

Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

WELLNESS · RECOVERY · RESILIENCE

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
PARENTING AND FAMILY DIFFICULTIES	Caring For Our Families (CFOF) CDE prior to 12/1/12	5 - 11	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	As of 12/1/12, the Eyberg Child Behavior Inventory (ECBI) and Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable] are being used for all new clients instead of the Child Behavior Checklist for Ages 1 ½ - 5 (CBCL 1.5-5)	2 - 16	**ECBI**: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Loving Intervention Family Enrichment (LIFE) CDE prior to 12/1/12	10 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18	Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)		
	Families OverComing Under Stress (FOCUS)	5+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	McMaster Family Assessment Device (FAD)	12+	English

* Providers started collecting outcomes for TF-CBT in December 2010 (MHSA Implementation Memo, dated 12/14/2010).
** Providers started collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).
*** For treatment cycles beginning before November 1, 2015 the DSM-IV UCLA PTSD-RI Child/Adolescent, Parent, and Adult Short Form will be required.
PEI EBP's that are not entered into PEI OMA are shaded.
1. Youth Outcome Questionnaire - 2.01 (Parent); Youth Outcome Questionnaire-Self-Report - 2.0; Outcome Questionnaire - 45.2; and PHQ-9 are available in all 13 threshold languages: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Tagalog, Japanese, Korean, Russian, Spanish, and Vietnamese.

Section 7

EBP Training Requirements

Training is essential to successful implementation of EBPs as well as sustainability and fidelity to the model.

7.1 PEI Training Guidelines

The Department has developed training guidelines in order to define and standardize training procedures across all staff providing PEI EBP/PP/CDE services. The adherence to a standardized training protocol by all provider agency staff eliminates unclear direction, while simultaneously enhancing a more organized and seamless method of service delivery that is critical to the goals of DMH.

The training protocols apply to any and all mental health rendering providers and clinical supervisors involved with the delivery of direct PEI services utilizing EBP/PP/CDE models for DMH and funded by PEI for fiscal years 2009-2010 and beyond. Agency training coordinators/designees and quality assurance staff should refer to the training protocols to determine if new and/or existing staff meet minimum training standards. Staff who fail to meet any of the training standards are deemed ineligible to provide the EBP/PP/CDE services under MHSA PEI funding and may not submit claims for this service until they reach full compliance. For staff that have had prior training, but may not have been actively practicing the service, a refresher course or booster training session is highly recommended. See the Training Protocols for Prevention and Early Intervention Practices (Revised December 1, 2015) attached at the end of this Section 7.

Note that in most instances the training protocols follow the guidelines of the developer. In a few instances, DMH has added enhancements to the basic training originally specified by the developer so that the training addresses the needs of the population served with PEI funds. The DMH training protocols are the required standard for PEI services. When arranging for training through a non DMH-sponsored source, agencies should first reference the PEI training protocols to confirm that the training being offered complies with the PEI training protocols.

7.2 Training Coordinator Required

Each DMH LE contract agency and DO clinic must identify a licensed staff as their PEI training coordinator/designee and supply their contact information to PEI Administration. PEI Administration Division must have ongoing contact with the agency PEI training coordinator/designee to verify staff information. In addition, notices about upcoming training workshops, changes in protocols, and other pertinent training information are distributed to their Training Coordinator.

The agency/clinic Training Coordinator has the following tasks:

- Identify staff suitable for training who meet the minimum professional qualifications to provide the EBP/PP/CDE service.
- Identify staff who have had sufficient (as defined by this document) prior training to offer the EBP/PP/CDE service.
- Coordinate with DMH on all aspects of training or re-training of agency staff deemed necessary to maintain a high standard of care and treatment fidelity.
- Submit documentation attesting that identified staff has met the standards set forth in this protocol.

To notify PEI Administration Division of a change in the agency's training coordinator/designee, providers should use the "EBP Training Verification Contact Request" form, a copy of which is shown on the next page. The form may be emailed to MHSAPEI@dmh.lacounty.gov

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT (MHSA)
Program Support Bureau (PSB)
PREVENTION AND EARLY INTERVENTION (PEI) ADMINISTRATION

EBP TRAINING VERIFICATION CONTACT REQUEST

DATE _____

AGENCY NAME _____

LEGAL ENTITY # _____ PROVIDER # _____

MAILING ADDRESS _____

_____

_____

FAX NUMBER _____

EXECUTIVE DIRECTOR NAME _____

EMAIL ADDRESS _____

PHONE NUMBER _____

LICENSED EBP/TRAINING COORDINATOR NAME _____

TITLE & LICENSE # _____

EMAIL ADDERESS _____

PHONE NUMBER _____

ATTESTATION By signing this form, I verify that all staff members, listed on the PEI Staff Registry Training Verification form, have successfully completed or are in the process of completing the training protocol items as endorsed on the form. I also acknowledge that our agency will maintain records for staff trainings and that these records are subject to audit at any time.

PRINT NAME _____ **SIGN NAME** _____
(Licensed person authorized to attest to staff training verifications at your agency)

Please email to: MHSAPEI@dmh.lacounty.gov

7.3 Training Required to Provide PEI EBP/PP/CDE Services

Agency training coordinators and quality assurance staff should refer to the PEI Training Protocols (a copy of which is attached at the end of this section) to determine if new and/or existing staff meet minimum PEI training standards. Staff failing to meet any of the standards are deemed ineligible to provide the EBP/PP/CDE service under MHSA PEI funding and may not submit claims for this service until they reach full compliance.

For staff that had prior training, but may not have been actively utilizing the service, a refresher course and/or booster training session is highly recommended. Verification of previous training must still be provided to DMH. The entire training protocol for a specific practice must be completed in its entirety in order for staff to be deemed qualified to provide a certain practice. In general, the full protocol should be completed within one year, although for certain practices, it may take a bit shorter or longer for completion.

Minimum Training Required Before Claiming to Core PEI Services Allowed

There are differences at which stage staff may begin claiming services to PEI because each practice has different protocols. The training protocols state the minimum training that must be completed before staff are authorized to begin claiming. Staff are not considered fully trained in a practice until all required training protocols are completed, nor are staff considered eligible to begin claiming until the required minimum training has been completed. Claiming for services by untrained staff or by staff that have not completed the minimum training requirements may have an impact on audit and/or approval of claims.

Provisional Authorization to Claim Not Allowed

As of July 1, 2013, provisional authorization to claim for PEI was no longer permitted for any PEI practice. Providers should refer to the training protocol for the specific EBP to determine the "Minimum Training Required before Claiming to PEI is Allowed" and for details on how soon after training starts that staff may begin claiming services to PEI.

7.4 Authorized Training

Staff may be trained by three means: 1) DMH sponsored training, 2) Training provided by DMH approved and/or certified trainers; and 3) Agency staff trained as a Train-the-Trainer in an EBP/PP/CDE practice that DMH has approved for such training.

DMH Sponsored Training

Since the onset of the PEI Plan implementation, DMH has provided training at no cost to PEI Providers, in multiple EBPs, including ART, CPP, FFT, MAP, MHIP, IPT, PEARLS, PE-PTSD, PST, SS, TF-CBT, and Triple P. The Department contracts either directly with the practice developer or with individuals who have been authorized/certified by the developer to provide

training. LEs were given PEI one-time training funds to contract or pay for training services directly, and as a result, DMH sponsored training has been reduced over the past several years.

Training by Authorized/Certified Trainers

With the fastpaced transformation in 2010 and the overwhelming demand for training, some agencies opted to pay for staff training out of their own funds. Starting in 2010, DMH allocated one-time training funds to agencies so that providers could contract directly with developers and/or authorized/certified trainers or pay to attend training put on by developers and/or trainers. Only trainers who are currently authorized and acknowledged by the specific EBP/PP/CDE developer (or individual or corporate entity holding copyrights and/or intellectual property rights for the EBP/PP/CDE) are considered sufficiently qualified to train agency staff under the scope of the training protocol.

It is the responsibility of the provider agency and training coordinator to ensure that only authorized trainers are used. In past instances, agencies have utilized trainers who were not authorized and/or certified by the developer to provide training and/or the trainer did not follow the required DMH protocols for the specific EBP. If you are unsure if a trainer is authorized and ackowledged by the specific EBP/PP/CDE developer you may contact PEI Administration or the PEI Practice Lead for approval.

Train-the-Trainer (ToT)

Planning for long-term sustainability for a certain practice is critical to ensure the fidelity to the model as well as quality of services to our clients and consumers. To this end, DMH has strongly encouraged and collaborated with EBP/PP/CDE developers to design and establish protocols where the developer or a designated trainer teach practitioners how to become trainers in their own agency in a specific practice. As a result of these collaborative efforts, a number of practices now have Train-the-Trainer models. However, the decision of whether or not to provide a Train-the-Trainer protocol for agencies is ultimately the decision of the developer. Providers can refer to the PEI Training Protocols for more information about a specific EBP Train-the-Trainer model or contact the practice lead should they have any questions about an EBP.

7.5 Staff Registry Database

The Department's PEI Administration Division monitors and verifies completion of training protocols by agency staff. It is critical that training verification information is complete and accurate so that DMH can ensure all staff claiming to PEI practices have been fully trained to provide the highest quality of care to their clients as well as maintain transparency within our Department.

The Department developed the Staff Registry Database to maintain a record of agency staff trained in each EBP/PP/CDE. The database lists contract agency staff as well as DMH directly-operated clinic staff that have initiated or completed their EBP/PP/CDE required training in order to claim PEI services. The Staff Registry has multifaceted utility for DMH and its providers. These include monitoring for appropriate claiming, adherence to training protocols and

timelines, and establishment of supervisory staff (if applicable to that EBP/PP/CDE) to maintain fidelity of the models.

As of August 1, 2014, DMH requires each agency to designate licensed staff member(s) to submit updated information on the training status of their staff to PEI Administration on a quarterly basis. Agencies retain proof of staff training at their agency locations, including either a certificate signed by the trainer and/or sign-in-sheets. These records are subject to audit and may be reviewed by DMH at any time. Periodically, PEI Administration contacts agencies to verify information regarding their trained PEI staff, such as the PEI MTASVs, public inquiry about staff, etc.

Acceptable training proof is either a certificate signed by the approved/authorized trainer and/or sign-in sheets. For providers that wish to host their own training, DMH recommends the use of a standardized sign in sheet format that captures all the required information of a training. See the sign-in sheet template on the next page.

Your Agency Name
Your Agency Address

Workshop:

Date:

Times:

Trainer:

Location:

LAST	FIRST	Contract Provider #	Rendering Provider # (DMH Employee #)	NPI #	Agency Name	Discipline & License #	Mailing Address, City & Zip	Email Address	Phone Number	Morning		Afternoon	
										Sign-In	Sign-Out	Sign-In	Sign-Out

7.6 Training Verification

Providers must provide DMH PEI Administration with EBP Training Verification Forms on a quarterly basis or more often if needed, detailing their staff compliance with the training protocols. The forms include a staff list identifying professional credentials, licensure/waivers, discipline, workshop/training attended with dates of attendance, any certifications that resulted from training activities, and any other appropriate information.

By signing this form, the agency representative verifies that all staff members, listed on the PEI Staff Registry Training Verification form, have successfully completed or are in the process of completing the training protocol items as endorsed on the form. The representative signing the form acknowledges that the agency will maintain records for their staff trainings and that these records are subject to audit at any time. See the end of this Section 7 for a copy of the Training Verification form. For a fillable Excel form, contact MHSAPEI@dmh.lacounty.gov.

Completing the Form

Agencies' designees must complete one EBP Training Verification Form for all clinicians who completed or are in the process of completing an EBP training protocol. The verification form is organized by columns and rows. Each staff is assigned a single row for each EBP training protocol completed/in process. The EBP is selected from a drop-down menu in a column of the spreadsheet and the succeeding columns will auto-populate with corresponding training levels/protocol components for that specific EBP.

Each column heading provides a short description of requested information. Detailed information prompts appear when the column cell is clicked. A drop-down menu, from which a response will be selected, accompanies the prompt for a number of the columns. Other columns require typed insertion of the completion date or the trainer name per training component. If no information is required for a column, a blue-filled cell will auto-populate with a reminder to leave the cell blank. If having difficulty completing the form, or no drop down menus are available, please note which version of Excel is being used. Forms are available to accommodate Excel versions 97 and 2010. However, using the 2010 versions and above is highly recommended.

Completion of all columns in the Training Verification Form is mandatory for each entry. The EBP Training Verification Form lists the protocols for all of the PEI EBP/PP/CDEs. At the end of this Section 7, you can find the EBP Traning Verification Form, the titles of each of the columns are listed, followed by instructions for completing the form. The following page illustrates an example with all columns completed.

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA)
Program Support Bureau (PSB)
PREVENTION AND EARLY INTERVENTION (PEI) ADMINISTRATION

Dear PEI Providers:

The Program Support Bureau (PSB) Mental Health Service ACT (MHSA) Prevention and Early Intervention (PEI) Administration Division is continuing to monitor and verify completion of training protocols by agency staff. It is critical that training verification information is complete and accurate so that Department of Mental Health (DMH) can ensure all clinicians claiming to PEI practices have been fully trained to provide the highest quality of care to their clients.

Verification of Training

Effective July 1, 2014, agencies are responsible for retaining proof of staff training for each staff and for each EBP they have been trained in. Acceptable training proof is either a certificate signed by the trainer and/or sign-in-sheets. These records are subject to audit and may be reviewed by DMH.

EBP Training Verification Contact Request Form

As of August 1, 2014, DMH requires each agency to designate **licensed** staff member(s) to attest to training verification information and to submit the **EBP Training Verification Contact Request Form** (attached) to PEI Administration. One staff member may serve as the designee for the agency as a whole, or each site may select its own designee. Contact information for the agency's Executive Director or equivalent position is also required.

EBP Training Verification Form

Agencies' designees must complete one EBP Training Verification Form for all clinicians who completed or are in the process of completing an EBP training protocol. Agencies are responsible for inputting updated information, since last submission, and marking it as updated in the column labeled "date submitted", into the EBP Training Verification Form (attached Excel spreadsheet) and submitting it to PEI Administration on a quarterly basis.

The verification form is organized by columns and rows. Each staff is assigned a single row for each EBP training protocol completed/in process. The EBP is selected from a drop-down menu in a column of the spreadsheet and the succeeding columns will auto-populate with corresponding training levels/protocol components for that specific EBP.

Each column heading provides a short description of requested information. Detailed information prompts appear when the column cell is clicked. A drop-down menu, from which a response will be selected, accompanies the prompt for a number of the columns. Other columns require typed insertion of the completion date or the trainer name per training component. If no information is required for a column, a blue-filled cell will auto-populate with a reminder to leave the cell blank. If you are having difficulty completing the form, or no drop down menus are available, please note which version of Excel you are using. We have the form to accommodate Excel versions 97 and 2010.

Completion of all columns in the Training Verification Form is mandatory for each entry. For more detailed information regarding the training protocols, please refer to the PEI Training Protocols on the DMH MHSA PEI Website.

Form(s) Submission Procedures

Please provide updated information on the attached **EBP Training Verification Form** for each clinician at your agency and save an electronic copy for your records. Email updated forms to MHSAPEI@dmh.lacounty.gov no later than **Monday February 1, 2016.**

Updates

EBP Training Verification Contact Request Form(s) must be on file with DMH. Agencies are required to update the EBP Training Verification Contact Request Form and the EBP Training Verification Forms on a quarterly basis. Updates may be requested for your site visit and/or submitted more frequently as the agency experiences changes in staffing and training status. An e-mail reminder will be disseminated prior to the due date.

Contact

Please feel free to contact MHSA PEI at MHSAPEI@dmh.lacounty.gov should you have questions or need additional information.

Thank you for your assistance.

TRAINING VERIFICATION FORM

EXAMPLE: CLINICIAN TRAINED IN SEEKING SAFETY

(Please note that the actual form spans several columns and the columns are horizontal)

Last Name	First Name	Other Names (e.g. AKA, Maiden Name, etc..)	Practitioner Type (LCSW, LMFT, etc.)	License Number	Rendering Provider Number	NPI Number	Staff Email Address	Legal Entity/DO Clinic Name	Legal Entity Number	Provider Number
Doe	John		ASW		123456	123456789	jdoe@dmh	LA Clinic	01234	

EBP Name	Pre-Training Requirements	Pre-Training Requirement Status	Initial Training(s)	Initial Training Completion Date	Intial Training Trainer Name	Consultation	Consultation Requirement Status	Consultation Trainer Name
29 Seeking Safety (SS) Option 1-Initial Training by Developer-Approved Trainer	Not Required		Initial training (6 hours)	1/1/2015	Gabriella Grant	Recommended		

Video/Audiotape /Material Submissions	Video/Audiotape /Material Submissions Status	Video/Audiotape/ Material Submissions Trainer Name	Booster Training (s)	Booster Training Completion Date (month, date, year)	Booster Training (s) Trainer Name	Other Practice Requirements (1)	Other Practice Requirement (1) Status	Other Practice Requirement Trainer (1)
Not Required			Not Required			Not Required		

Other Practice Requirements (2)	Other Practice Requirement (2) Status	Other Practice Requirement Trainer (2)	Optional Training (Not Required)	Optional Training (Not Required) Status	Optional Training Trainer	Certification	Certification Status
Not Required			Theme Based Calls (consultation calls)			Not Required	

Re-certification	Re-certification Status	Entire Training Protocol Requirements Completed (yes/no)	Date Training Protocol Requirement Completed (month, date, year)	Agency Representative Signature and Attestation on File (yes/no)	Date Submitted	Notes
Not Required		yes	1/1/2015	yes	10/2/2015	

Form Submission Procedures

Updated information on each clinician providing PEI services must be submitted on the EBP Training Verification Form. Agencies are responsible for inputting any and all new and updated information, since last submission, and marking it as updated in the column labeled "date submitted," into the EBP Training Verification Form and submitting it to PEI Administration Division on a quarterly basis.

Current EBP Training Verification Contact Request Form(s) must be on file with DMH. Agencies are required to update the EBP Training Verification Contact Request Form and the EBP Training Verification Forms on a quarterly basis. Updates may be requested for your site visit and/or submitted more frequently as the agency experiences changes in staffing and training status.

Providers should submit any updated information on the EBP Training Verification Form for each clinician at their agency and save an electronic copy for their records. Updates may be submitted more frequently as the agency experiences changes in staffing and training status. The updated EBP Training Verification Form should be emailed to MHSAPEI@dmh.lacounty.gov. For more detailed information regarding the training protocols, providers can refer to the PEI Training Protocols.

7.7 Not Qualified to Claim to Specific EBP/PP/CDE Practices for PEI Services

Beginning in 2016, DMH began verifying completion of PEI training protocols by LE contract agency and DO clinic staff. To ensure the highest quality of services, only staff trained or in process of being trained within a timely manner are authorized to bill treatment modalities to the EBP. The timelines for completion of EBP trainings are defined in the PEI Training Protocols. The majority of protocols are designed to be completed within one year. PEI Administration Division has informed agencies at PEI Quarterly meetings and site visits that the next step in the training verification process would be a review of the completion of all staff training. DMH will now require staff, who have no record of training or who have not completed all of the training protocol within a timely manner, to stop billing and providing EBP services.

DMH has developed an extensive verification process to ensure that all training information available is updated and correct. In order to verify that staff is compliant with the EBP/PP/CDE training protocols, providers must return submit the Not Qualified to Claim (NQC) Report with the required information. If an agency is are unable to provide verification of completion, then the agency must indicates its proposed corrective training plan on the NQC Report to show compliance in 90 days. If the identified NQC staff has not completed all the steps in the EBP training protocol, within the 90 days, the individual must stop billing services to PEI.

7.8 PEI Training Protocols

Each EBP/PP/CDE has specific training protocols that must be followed. The "Training Protocols for Prevention and Early Intervention Practices" on the next page, lists detailed information for each EBP/PP/CDE that DMH has approved for PEI providers. The information is provided regarding the required training protocols, supervisor training, certification and accreditation, train-the-trainer protocols, and provisional authorization to claim.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION DIVISION

TRAINING PROTOCOLS

FOR

PREVENTION AND EARLY INTERVENTION

PRACTICES

REVISED APRIL 1, 2016

The Training Protocols for Prevention and Early Intervention Services are updated on an annual basis. Information about changes in training protocols for PEI approved Evidence-based Practices, Promising Practices, and Community-Defined Evidence Practices is disseminated by the PEI Administration Division and PEI Practice Leads, throughout the year as needed.

There are DMH staff assigned as PEI Practice Leads for all of the DMH PEI practices. The list of Practice Leads is provided in the Attachments. Note that changes may occur in staff designated as Practice Leads.

For questions about PEI approved training protocols and/or

updated contact information for PEI Practice Leads, please contact:

MHSAPEI@dmh.lacounty.gov

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I. OVERVIEW OF PEI TRAINING PROTOCOLS

1. PURPOSE

After an extensive stakeholder planning process, the County of Los Angeles Department of Mental Health's (DMH) PEI Plan was approved by the Mental Health Services Act (MHSA) Mental Health Services Oversight and Accountability Committee in August 2009. The Department proceeded with the implementation of the Prevention and Early Intervention (PEI) Plan through a transformation process starting in spring 2010. The new PEI Programs included Evidence-Based Practices (EBPs), Promising Practices (PP), and Community-Defined Evidence (CDE) Programs, all of which include evaluation and outcomes. Due to the massive implementation of PEI EBP/PP/CDE programs, the capacity of developers and trainers, in many instances, could not match the needs of clinics. During this initial implementation phase and thereafter, the Department has worked with developers and trainers to identify the required training components, facilitate training opportunities, and advocate for Train-the-Trainer models to promote sustainability.

The purpose of the training protocol guidelines is to define and standardize training procedures for all staff providing PEI services through EBPs, PPs, and CDEs. Adherence to a standardized training protocol by all provider agency staff helps in eliminating unclear direction while simultaneously enhancing a more organized and seamless method of service delivery that is critical to the goals of the Department.

2. SCOPE

The training protocols apply to any and all mental health rendering providers and clinical supervisors involved with the delivery of direct PEI services utilizing EBP/PP/CDE models for DMH and funded by the MHSA PEI for Fiscal Years (FY) 2009-10 and beyond. The practices listed in this guide are those approved by DMH for PEI services.

Note that in most instances the training protocols follow the guidelines of the developer, but in a number of instances, DMH has added enhancements to the basic training originally specified by the developer so that the training addresses the needs of the population served with PEI funds. When arranging for training through a non DMH-sponsored source, agencies should check first with the PEI training protocols to confirm that the training being offered complies with the PEI training protocols.

Agency training coordinators and quality assurance staff should refer to this document in order to determine if new and/or existing staff meets minimum PEI training standards. Staff failing to meet any of the following standards is deemed ineligible to provide the EBP/PP/CDE service under MHSA PEI funding and may not submit claims for this service until they reach full compliance. Unless approved by DMH, agency staff must be sufficiently trained in the EBP/PP/CDE model prior to providing the EBP/PP/CDE program as a direct service. For staff that has had prior training, but may not have been actively practicing the service, a refresher course or booster training session is highly recommended. The entire training protocol for a specific practice must be completed in its entirety in order for staff to be deemed qualified to provide a certain practice. In general, the full protocol should be completed within one year, although according to certain practices, it may take a bit shorter or longer for completion.

3. TRAINING COORDINATORS

Each DMH contract agency must identify a licensed Training Coordinator and supply their contact information to PEI Administration at MHSAPEI@dmh.lacounty.gov. PEI Administration is in contact with the Training Coordinator to verify staff information. The agency Training Coordinator has the following tasks:

- Identify staff suitable for training who meet the minimum professional qualifications to provide the EBP/PP/CDE service.
- Identify staff who have had sufficient (as defined by this document) prior training to offer the EBP/PP/CDE service.
- Coordinate with DMH on all aspects of training or re-training of agency staff deemed necessary to maintain a high standard of care and treatment fidelity.
- Submit documentation attesting that identified staff has met the standards set forth in this protocol.

To notify PEI Administration of a change in Training Coordinator, please use the "PEI Training Coordinator Contact Information Update Request" form (see Attachment A).

4. PRIOR APPROVAL TO IMPLEMENT AN EBP/PP/CDE

Agencies must request prior approval from their Lead District Chief and PEI Administration before proceeding with training in a new EBP and adding the EBP to their list of PEI Practices. If prior approval is not obtained, agencies may find themselves in a situation where staff have been trained in a practice but then cannot claim to PEI for the practice. As part of the add process, agencies must list clinicians who are currently being trained in the practice and/or clinicians who have completed the entire training protocol, in order to ensure that the agency has clinicians who can claim to the practice once it is approved. See Attachment B for the Provider Form to Add/Drop a PEI Practice and the Trained Clinicians attachment that must be submitted to the agency's Lead District Chief and PEI Administration. Please contact MHSAPEI@dmh.lacounty.gov for a fillable form.

5. AUTHORIZED TRAINERS

Only trainers who are currently authorized and acknowledged by the specific EBP/PP/CDE developer (or individual or corporate entity holding copyrights and/or intellectual property rights for the EBP/PP/CDE service) are considered sufficiently qualified to train agency staff under the scope of this protocol. It is the responsibility of the provider agency and training coordinator to ensure that only authorized trainers are used.

Caveat: It is highly recommended that agencies check first with DMH PEI Administration and the Practice Lead in order to: 1) verify that the trainer they are planning to use is authorized/certified to provide training in the specific practice, and 2) ensure that the training offered by the proposed trainer does in fact follow the required training protocols. In past instances, agencies have utilized trainers who were not authorized/certified by the developer to provide training and/or the trainer did not follow the required DMH protocols for the specific EBP.

Further, it is highly recommended that agencies arrange for the entire training protocol to be completed by the same trainer. In some instances, a trainer may indicate they only do the initial

in-person training but decline to do, or subsequently are unable to do, the rest of the protocols, especially the consultation calls and/or audio/videotape reviews. This has caused a problem for some agencies because subsequent trainers will not take on the responsibility of completing the rest of the training protocols, citing lack of information on the quality of training provided by the first training and unfamiliarity with the ability of the staff trained to provide such services based on the initial training.

When submitting invoices for reimbursement for trainings, providers must submit receipts for trainings as well as travel expenses incurred by the trainers.

6. TRAIN-THE-TRAINER PROTOCOLS

The Department recognizes the need to continually plan for staff training given a number of critical factors that impact staff in Los Angeles County, including high staff turnover, lack of readily available training opportunities, training costs, etc. More importantly, planning for long-term sustainability for a certain practice is critical to ensure the fidelity to the model as well as quality of services to our clients and consumers. To this end, the Department has strongly encouraged and collaborated with EBP/PP/CDE developers to design and establish protocols where the developer or a designated trainer teach practitioners how to become trainers in their own agency in a specific practice. As a result of these efforts, since 2010 a number of practices now have Train-the-Trainer models. However, the decision of whether or not to provide a Train-the-Trainer protocol for agencies is ultimately the decision of the developer.

7. NO PROVISIONAL AUTHORIZATION TO CLAIM ALLOWED

In order to promote the provision of quality services to LA County's consumer population as quickly as possible in 2010, provisional training protocols were approved for three practices where the developer allowed such minimal initial training. By following specific requirements, agency staff could obtain "provisional authorization to claim for PEI programs," upon completion of the initial provisional training and provided the rest of the requisite training protocol was completed within one year. As of July 1, 2013, provisional training for agency employees is no longer permitted for any PEI practice. Instead, see the section on "Minimum Training Required before Claiming to PEI is Allowed" for details on how soon after training starts that staff may begin claiming services to PEI.

8. MINIMUM TRAINING REQUIRED BEFORE CLAIMING TO PEI IS ALLOWED

Because each practice has different protocols, the stage at which staff may begin claiming services to PEI differs. The training protocols state the minimum training that must be completed before staff is authorized to begin claiming. Staff is not considered fully trained in a practice until all required training protocols are completed, nor is staff considered eligible to begin claiming until the required minimum training has been completed. Claiming for services by untrained staff or by staff that has not completed the minimum training requirements may have an impact on audit and/or approval of claims.

9. WHO RETAINS CERTIFICATION

Upon completion of the training protocol, an individual may be fully trained and certified as an authorized practitioner, or the certification may remain with the agency at which the individual was trained/certified. If the certification remains with the agency, then the individual is no longer considered certified if he or she discontinues employment with that agency.

10. STUDENTS/TRAINEES/INTERNS

If an agency utilizes students, trainees, or interns to provide PEI services, it is the agency's obligation to ensure that these individuals complete the full practice protocol before leaving the agency. Consequently, all plans for training these temporary rendering providers must include completion of the full training protocol for whichever EBP/PP/CDE they are utilizing. Students, trainees, and interns are generally not eligible for provisional authorization to claim, unless at the time of requesting such authorization, the agency submits a plan to the PEI Administration at MHSAPEI@dmh.lacounty.gov to complete their training within six months.

11. TRAINING MATERIALS

Only curricula authorized and acknowledged by the EBP/PP/CDE developer (or individual or corporate entity holding copyrights and/or intellectual property rights for the EBP/PP/CDE service) are considered valid training content under the scope of this protocol. This is meant to include all forms of electronic or print content and primary teaching exercises, strategies, and other educational techniques. The training requirements list the required training manuals, educational materials, etc. for each EBP/CDE/PP. If any training materials are available for staff as reference material (e.g. videotapes, master training documents, research articles, etc.), they should be maintained in good, usable condition and in an area where staff can easily access them.

12. ONE-TIME TRAINING FUNDS

In FY 2010-11, the Department allocated PEI one-time training funds that its contracted agencies could utilize to purchase outside, i.e., non-DMH sponsored training, and invoice for staff time spent in the training sessions. These funds were always marked as "one-time funds" inasmuch as the monies came from unspent dollars due to the initial slow implementation of the PEI funds. Over the past five years, the amount of one-time training funds has been reduced greatly. For FY 2015-16, the amount allocated represents about only one-fifth of the original allocation. Agencies are strongly advised to select, promote, and support practices that they can sustain on their own, without continuing reliance on DMH one-time training funds. The costs involved in sustaining EBPs include training new staff, booster trainings where required, and ong0ing licensing or other requirements.

The same PEI invoicing process as in previous years is still in effect to claim these training funds. For future years requests for PEI training reimbursements will not be approved without proof of the required plans to complete the training. That is, training cannot be purchased piecemeal with PEI funds, e.g., just the initial in-person training without the accompanying consultation calls, booster trainings, audio/videotape reviews, etc. would not be authorized. When negotiating training, agencies should be sure that all the components are being provided

by the same source. Reimbursable training costs are based on what the Department considers to be "reasonable" rates.

13. QUALITY ASSURANCE

The agency should include the Training Coordinator tasks and responsibilities into normal agency quality assurance procedures. Agencies will be asked to provide DMH with periodic written reports detailing their compliance with this training protocol. Such reports shall include a staff list identifying professional credentials, licensure/waivers, discipline, workshop/training attended with dates of attendance, any certifications that resulted from training activities, and other appropriate information.

14. PROVISION OF CORE VS. NON-CORE SERVICES

MHSA PEI services include both "core" interventions and "non-core" services. Core interventions are those services that are intrinsic to the delivery of expected outcomes for each EBP/PP/CDE. Non-core services are those services not core to the EBP/PP/CDE that are provided on a short-term basis to meet the emergent client needs and support the client's participation in the EBP model. It is expected that EBP Core Interventions, with the exception of Assessment/Psychiatric Diagnostic Interview (90791) and Targeted Case Management (T1017), be delivered by staff trained in the model. While Assessment/Psychiatric Diagnostic Interviews may be conducted by a clinician not trained in the EBP, it is expected that the clinician have baseline knowledge of the EBP/PP/CDEs provided at the agency so that he or she may place clients in the most appropriate model. Targeted Case Management may be provided by non-clinicians who are not trained in the EBP/PP/CDE.

15. SPECIFIC EBP/PP/CDE TRAINING PROTOCOLS

Each EBP/PP/CDE has specific training protocols that must be followed. On the following pages detailed information is provided for each EBP/PP/CDE that the Department has approved for PEI contracted agencies. The information is provided regarding the required training protocols, supervisor training, certification and accreditation, train-the-trainer protocols, and provisional authorization to claim. See Section 3 for an explanation of the information provided under each category.

II. CHART INFORMATION AND ORGANIZATION

1. DESCRIPTION OF CHART INFORMATION

The following is a description of the information contained in each item of the individual EBP/PP/CDE Practice chart.

NAME OF PRACTICE	
Authorized Ages	Indicates the PEI age range authorized for this practice and covered by the training protocol. Providers may not claim services for individuals not included in this age range, and training for ages outside the authorized practice age range does not constitute completion of the required practice training protocol.
Required Training Protocols	Indicates the required training components that staff must complete in order to be considered fully trained in and to provide services in the specific practice. Examples of the required components may include: ▪ Initial in-person training ▪ Booster training ▪ Consultation calls (individual/group, weekly/monthly, in-person/telephone) ▪ Audiotape and/or videotape submissions ▪ Pre-accreditation workshops ▪ Accreditation workshops ▪ Re-certification workshops after a specific length of time ▪ Experiential training ▪ Technical assistance ▪ Review of webinar ▪ Review of training materials and manuals
Supervisor Training Required?	Indicates whether the practice requires that both the clinician and a Supervisor be trained in the practice before services may be provided.
Certification or Accreditation Required?	Indicates whether certification or accreditation is mandatory, i.e., staff is not considered fully qualified to provide the practice unless the developer or trainer has certified or accredited the staff as authorized to provide the practice.
Train-the-Trainer Allowed?	Indicates whether the practice has a Train-the-Trainer model available that allows an agency to train its own staff. In the majority of practices, there is no Train-the-Trainer model available. Unless specifically authorized, agencies may not train their own staff in a practice; staff are only authorized to provide the services if trained by an authorized trainer.

Minimum Training Required Before Claiming Allowed	Indicates the minimum training that must be completed before staff may start claiming the practice to the PEI Plan. If claiming is authorized before full training is completed and/or accreditation/certification is completed, the deadline for completion of the full training protocol is stated. If the full training protocol is not completed before this date, staff may not continue to claim this practice to PEI. For issues arising from a delay in completing the full protocol, contact the specific Practice Lead.
Who Retains Certification?	Indicates whether the individual who completes the training protocol is fully trained and certified as an authorized practitioner, or if the certification remains with the agency at which the individual was certified.
Fidelity Measure?	Indicates whether the Practice has an associated instrument/tool to monitor the clinicians' implementation of the components of a Practice with fidelity to the model, as denoted by the Practice Developer or DMH Practice Lead.
Estimated Training Cost	Indicates the estimated training cost for a cohort of clinicians and/or the individual clinician to be trained in the Practice in LA County.
Comments	Additional information that should be considered in selecting a practice or arranging for training is included for some practices.

2. SUMMARY CHART OF PEI PRACTICE TRAINING PROTOCOLS

SUMMARY CHART OF PEI PRACTICE TRAINING PROTOCOLS * P = Practitioner, **A = Agency									
Approved PEI Practices EBP/PP/CDE	**Authorized Ages**	**Required Training Protocols (page #)**	**Supervisor Training Required?**	**Certification or Accreditation Required?**	**Train-the-Trainer Allowed?**	**Minimum Training Required Before Claiming Allowed**	**Certification P* or A****	**Fidelity Measure?**	**Estimated Training Costs**
1. Aggression Replacement Training (ART)	5-17 depending on component	p. 12	NO	YES	YES	Initial 2-day	P	YES	$41,500 (Cohort = 24)
2. Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)	5-17	p. 13	YES	NO	NO	Initial site & staff readiness day, 3-day experiential	P	YES	$1,500 Per Ind.
3. Brief Strategic Family Therapy (BSFT)	10-18	p. 14	NO	YES	NO	3 workshops (9 days)	P	YES	$145,908 (Cohort = 4)
4. Caring for Our Families (CFOF)	5-11	p. 15	YES	YES	NO	3-day (13 hours)	P	YES	$300 Per Ind.
5. Center for the Assessment & Prevention of Prodromal States (CAPPS)	16-25	p. 16	YES	YES	YES	Initial 3-day	A (TOT) P (EBP)	YES	$116,000 (Cohort = 40)
6. Child-Parent Psychotherapy (CPP)	0-6	p. 18	YES	NO	NO	Initial 2½ -day	P	YES	37,100 (Cohort = 40)
7. Cognitive Behavioral Intervention for Trauma in School (CBITS)	10-15	p. 19	YES	YES	YES	2-day on-site	P	NO	$10,040 (Cohort = 16)
8. Crisis Oriented Recovery Services (CORS)	3+	p. 20	NO	NO	NO	6-hour initial	P	NO	$2,000 (Cohort = 50)
9. Depression Treatment Quality Improvement Intervention (DTQI)	12-20	p. 21	NO	YES	YES	Three 1-day trainings	P	YES	$27,000 (Cohort = 24-32)
10. Dialectical Behavior Therapy (DBT) -- DMH Directly Operated Clinics Only	18+	p. 22	YES	NO	NO	2-day introductory, 1-day "Nuts and Bolts"	P	YES	$200 (for manuals)

SUMMARY CHART OF PEI PRACTICE TRAINING PROTOCOLS * P = Practitioner, **A = Agency									
Approved PEI Practices EBP/PP/CDE	**Authorized Ages**	**Required Training Protocols (page #)**	**Supervisor Training Required?**	**Certification or Accreditation Required?**	**Train-the-Trainer Allowed?**	**Minimum Training Required Before Claiming Allowed**	**Certifi-cation P* or A****	**Fidelity Measure?**	**Estimated Training Costs**
11. Families OverComing Under Stress (FOCUS)	5+	p. 23	NO	YES	NO	Complete Basic Level Training	P	NO	$2,000 Per Ind.
12. Functional Family Therapy (FFT)	10-18	p. 24	NO	YES	NO	Initial 3-day (21-hours)	A	YES	$134,400 (Cohort = 8-16)
13. Group Cognitive Behavioral Therapy for Depression (Group CBT)	18+	p. 26	NO	NO	YES	Initial 2-day	P	YES	$80,100 (Cohort = 25)
14. Incredible Years (IY)	0-12	p. 27	NO	NO	YES	Initial 3-day	P	YES	$21,200-$37,100 (Cohort= No limit)
15. Individual Cognitive Behavioral Therapy (Ind CBT)	16+	p. 28	NO	NO	YES	Initial 3-day	P	YES	$187,735 (Cohort = 100)
16. Interpersonal Psychotherapy for Depression (IPT)	12+	p. 30	NO	NO	YES	Initial 2-day	P	YES	$45,000 (Cohort = 40)
17. Loving Intervention Family Enrichment Program (LIFE)	4-19	p. 32	YES	YES-parenting NO-youth & multi-family	NO	Phase 1 or Phase 2 depending on type of group	P	YES	$1,000 Per Ind.
18. Managing and Adapting Practice (MAP)	Range of 0-23 depending on focus	p. 33	NO	NO	YES	8-hours	A	YES	$2,105 Per Ind.
19. Mental Health Integration Program (MHIP)	18+	p. 35	NO	NO	YES	2-day	P	N/A	N/A
20. Mindful Parenting Groups (MP)	0-3	p. 36	NO	YES	NO	Level 1 Protocol (2-day) plus commencement of Level 2	P	YES	$27,950-$45,450 (Level 1 Cohort = 24)
21. Multidimensional Family Therapy (MDFT)	12-18	p. 38	YES	YES	YES	Initial 4-day	P	YES	$35,000 Per Ind.
22. Multisystemic Therapy (MST)	12-17	p. 40	YES	YES	NO	5-day orientation training	A	NO	$70,000-$72,600 (Cohort = Team)

SUMMARY CHART OF PEI PRACTICE TRAINING PROTOCOLS * P = Practitioner, **A = Agency									
Approved PEI Practices EBP/PP/CDE	**Authorized Ages**	**Required Training Protocols (page #)**	**Supervisor Training Required?**	**Certification or Accreditation Required?**	**Train-the-Trainer Allowed?**	**Minimum Training Required Before Claiming Allowed**	**Certification P* or A****	**Fidelity Measure?**	**Estimated Training Costs**
23. Parent-Child Interaction Therapy (PCIT)	2-7	p. 42	YES	YES	YES	10-hour web course, current participation in training program	P	YES	$28,633 (Per agency)
24. Problem Solving Therapy (PST) -- Older Adults and MHIP Providers Only	60+	p. 43	NO	NO	NO	1-day (for PST standalone)	P	YES	$5,000
25. Prolonged Exposure for Post-Traumatic Stress Disorder (PE-PTSD) -- DMH Directly Operated Clinics only	18+	p. 44	NO	NO	NO	4-day workshop	P	NO	$16,300 (Cohort = 20)
26. Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	60+	p. 45	NO	NO	NO	Initial 2-day	P	YES	$38,500 (Cohort = 30)
27. Providing Alternative Thinking Strategies (PATHS)	5-12	p. 46	NO	YES	YES	Initial 2-day	P	YES	$8,900-$11,200 Per Ind.
28. Reflective Parenting Program (RPP)	0-12	p. 47	NO	YES	NO	Level 1 Protocol (2-day) plus commencement of Level 2	P	YES	$18,650-$23,900 (Level 1 Cohort = 24)
29. Seeking Safety (SS)	13+	p. 49	YES	YES	YES	Initial 6-hour	P	YES	$36,950 (Initial Training Cohort = 100)
30. Strengthening Families (SF)	3-16	p. 51	NO	YES	YES	2-day group leader training	P	YES	$3,300-$3,900 (Cohort = 15-35)

SUMMARY CHART OF PEI PRACTICE TRAINING PROTOCOLS * P = Practitioner, **A = Agency									
Approved PEI Practices EBP/PP/CDE	**Authorized Ages**	**Required Training Protocols (page #)**	**Supervisor Training Required?**	**Certification or Accreditation Required?**	**Train-the-Trainer Allowed?**	**Minimum Training Required Before Claiming Allowed**	**Certification P* or A****	**Fidelity Measure?**	**Estimated Training Costs**
31. Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	3-18	p. 52	YES	YES	NO	Webinar and initial 2-day (permanent staff); students and interns have provisional authorization	P	YES	$16,000 (Cohort = 5-7)
32. Triple P Positive Parenting Program (Triple P) – Levels 4 and 5	0-18	p. 54	NO	YES	NO	Initial training (1-3 days)	P	NO	$27,430 (Cohort = 20)
33. UCLA Ties Transition Model (TTM)	0-8	p. 55	NO	NO	YES	Initial 2-day	P	YES	$82,500 (Cohort = 8)

III. SPECIFIC EBP/PP/CDE TRAINING PROTOCOLS

1. AGGRESSION REPLACEMENT TRAINING® (ART)	
Authorized Ages	12-17 years old (All 3 components) 5-12 years old (Skillstreaming component only)
Required Training Protocols	▪ Initial 2-day (14-hours) training. ▪ 1-day (7-hours) booster training held 4-5 months after initial training. ▪ 16 weekly, 1-hour consultation calls. ▪ 2 videotape submissions for review, with a rating of at least a "2" on the competency scale in each component of the scale. ▪ Co-facilitate a minimum of 36 ART groups in a 12-month period, with at least 12 groups in each component (required for certification).
Supervisor Training Required?	NO. ART specific group supervision is recommended as a fidelity and sustainability strategy.
Certification or Accreditation Required?	YES. Certification through CIBHS after completion of training protocol. Certification does not expire.
Train-the-Trainer Allowed?	YES. <u>Train-the-Trainer prerequisites:</u> ▪ Completion of required ART training protocol. ▪ Co-facilitate a minimum of 72 groups within a 12 month period, with at least 12 groups in each component. ▪ Rating of competency on each item of the Trainer Competency Rating Scale on at least one submitted videotaped session that occurred within 12 months. <u>Train-the-Trainer protocol:</u> ▪ 2-day Agency Trainer training. ▪ Participation in 15 consultation calls. ▪ Conduct and complete ART required training protocol with 2-6 trainees. ▪ Videotape submission of excerpts of conducted training. ▪ Demonstration of trainer proficiency on videotape reviews of trainees. ▪ Attend one-day training every 3 years.
Minimum Training Required Before Claiming Allowed	Completion of Initial 2-day (14-hours) training with plan to complete all training requirements within one year for certification.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $41,500 (Cohort of 24 for Initial Training; Cohort of 5 for Agency Trainer) Cost per Individual: $4,342
Comments	California Institute for Behavioral Health Solutions (CIBHS) is the only entity in the State of California authorized by the developer to conduct ART training in California.

2. ALTERNATIVES FOR FAMILIES: A COGNITIVE-BEHAVIORAL THERAPY (AF-CBT)	
Authorized Ages	5 – 17 years old
Required Training Protocols	**Program/Staff Readiness (2 months before training)** ▪ Participation in agency/staff preparation calls/activities ▪ Completion of pre-training evaluation and material review **Learning Community: Intensive Skills-Training** ▪ 3-day basic training workshop (didactic/experiential) ▪ 12 case consultation calls (1-2 per month for 6 to 12 months) ▪ 2 case presentations during consultation calls. ▪ 2 session audio files submitted for fidelity feedback ▪ 1-day advanced ("booster") training (6 months after initial training) ▪ Review of all updated materials and exchanges with trainer **Performance Review (at end of training)** ▪ Completion of post-training evaluation and agency metrics ▪ Review of eligibility for Clinician Certification program with trainer ▪ After completion of the training program, interested clinicians who meet initial eligibility criteria can apply to be considered for the AF-CBT Clinician Certification program (see below)
Supervisor Training Required?	▪ Supervisor is encouraged to complete this clinician training program ▪ During training, 4-6 supervisor-only calls are conducted to promote AF-CBT supervision and implementation ▪ After training has ended, a separate advanced supervisor training option can be requested/negotiated
Certification or Accreditation Required?	NO. Certification is not necessary at this time. There is a voluntary AF-CBT Clinician Certification program. Information about this program is available through our website (www.afcbt.org).
Train-the-Trainer Allowed?	At this time, an approved Train-the-Trainer program is limited and available by invitation only.
Minimum Training Required Before Claiming Allowed	The initial site and staff readiness activity day and the 3-day experiential training are to occur before claiming for AF-CBT can begin.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $37,000 (Cohort of 20) Cost per Individual: $1,850
Comments	Additional information on AF-CBT is available through the website: www.afcbt.org

3. BRIEF STRATEGIC FAMILY THERAPY (BSFT)	
Authorized Ages	10 – 18 years old
Required Training Protocols	▪ 1-2 day Organizational Consultation visit. ▪ 3 workshops (9 days total) delivered on site over 8 months to a cohort of 4-6 trainees. ▪ Weekly supervision begins 2 weeks after Workshop 1 and continues for 4-6 months. Entails weekly phone/video reviews of trainees' videotaped sessions, group feedback, and consultation. ▪ Certified after training and supervision.
Supervisor Training Required?	NO. However, supervisor training is highly recommended. In-house supervisor training protocol: ▪ Supervisor first completes the required initial BSFT training protocol. ▪ Implement BSFT for at least 1 or 2 years. ▪ Certification of BSFT Supervisor is free of charge.
Certification or Accreditation Required?	YES. Certification is granted by the Family Therapy Training Institute of Miami's Competency Board after completing the required training protocols and showing competency in the BSFT principles. For the first 3 years, annual recertification is required to continue practicing BSFT. Thereafter, recertification occurs every 2 years.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	3 workshops (9 days total)
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $145,908 (Cohort of 4) Cost per Individual: $36,447

4. CARING FOR OUR FAMILIES (CFOF)	
Authorized Ages	5 – 11 years old
Required Training Protocols	▪ 3-day (13-hours) training. ▪ The mental health provider (or management-level representative for the agency) must agree to participate in monthly Clinical Oversight meetings to assure model fidelity. ▪ Technical assistance and consultation available as needed. ▪ Certified at the end of the training, does not expire.
Supervisor Training Required?	YES. Supervisors are to complete the same required training protocol as staff.
Certification or Accreditation Required?	YES. Certification is received after completion of the 3-day training. Certification does not expire. However, the mental health provider (or management-level representative for the agency) must participate in ongoing monthly Clinical Oversight meetings.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	The 3-Day (13-hours training) is to be completed before claiming for CFOF can begin.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $7,500 (Cohort of 25) Cost per Individual: $300

5. CENTER FOR THE ASSESSMENT & PREVENTION OF PRODROMAL STATES (CAPPS)	
Authorized Ages	16-25 years old
Required Training Protocols	▪ Initial 3 day (21 hours) training in Family Focused Therapy approach to work with youth at risk for psychosis. ▪ Participate in weekly consultation calls Clinical Treatment until certified as competent in the practice by Developer or Train-the-Trainer. ▪ Participate in weekly Group Assessment supervision on assessment tools and data collection procedures until competence is reached to administer, score, and interpret the SIPS. ▪ Submit videotaped sessions for review until achieve scores of 5-7 on all scales of the Therapist Competency and Adherence Scale with developer for at least 2-3 cases to achieve proficiency in the practice. ▪ 1 day (8 hours) Booster Training follow up after one year to ensure fidelity to model.
Supervisor Training Required?	YES. ▪ Supervisor to receive 3 day initial training and participate in ongoing training and consultation for at least one 18 session treatment cycle utilizing family focused therapy approach for monitoring and supervision of staff. ▪ To be trained in co-rating trainees' sessions to achieve high rates of inter-rater reliability with developer on the Treatment Competence & Adherence Scale. ▪ To review and rate 1-2 sessions of one trainee on full therapy case of 18 sessions and reach proficiency in inter-rater reliability scores with developer. ▪ Supervisors to continue with monthly consultation calls for the first year.
Certification or Accreditation Required?	YES. Certification is required. Must demonstrate proficiency in the practice of the model based on the inter-rater reliability ratings with Developer or Train-the-Trainer.
Train-the-Trainer Allowed?	YES. Train-the-Trainer Protocol: ▪ Complete initial 3 day training. ▪ Complete the additional weekly videotaped training required of clinical supervisors to become trainers. ▪ Demonstrate proficiency in the practice and the monitoring of the treatment model as determined by the Treatment Competence and Adherence Scale and Inter-rater reliability scores with developer. ▪ In addition, particularly skilled licensed therapists at the clinic can become identified and considered as possible trainers for new employees. ▪ This certification is non-transferable.
Minimum Training Required Before Claiming Allowed	Initial 3-day training
Who Retains Certification?	Agency for Train-the-Trainer Practitioner for the EBP
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $116,000 (Cohort of 40) Cost per Individual: $2,900

6. CHILD-PARENT PSYCHOTHERAPY (CPP)	
Authorized Ages	0 – 6 years old
Required Training Protocols	▪ Initial 2 ½ day training. Supervisors attend **additional** ½ day training. ▪ 6-month booster training (1 ½ days). Supervisors attend **additional** ½ day. ▪ 12-month booster training (1 ½ days). Supervisors attend **additional** ½ day booster. ▪ Bi-weekly group consultation with CPP trainer/consultant for a period of 18 months. ▪ Trainees and supervisors must carry CPP cases during training period. ▪ Trainees must receive Reflective Supervision by a supervisor trained or being trained in CPP. ▪ Average training cycle is 18 months. ▪ Continued phone consultation is available upon request. NOTE: Agency must have a team of at least 4, 1 team member must be case-carrying CPP supervisor.
Supervisor Training Required?	YES. <u>Supervisors Training Protocol:</u> ▪ Complete the required initial training. ▪ Carry CPP cases during the initial training period. ▪ Attend 7 ½ hours of didactic supervisor training on the basics of CPP supervision (last day of the initial 3 day training for 3 ½ hours) and 2 hours during each of the following booster sessions (LS2 & 3). ▪ Possible additional 18 supervisor calls where supervisory cases are discussed.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	NO. There is no current Train-the-Trainer component for CPP.
Minimum Training Required Before Claiming Allowed	Initial 2 ½ day training
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $45,000 (Cohort of 30) Cost per Individual: $1,500
Comments	ICARE training is recommended but not required.

7. COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOL (CBITS)	
Authorized Ages	10 – 15 years old
Required Training Protocols	▪ 2 day on-site training ▪ Participate in weekly CBITS consultation for at least one 10-week group cycle by a CBITS trainer or approved supervisor. ▪ Booster training and consultation available as needed.
Supervisor Training Required?	YES. Supervisors are required to complete 2 day CBITS training and participate in ongoing consultation calls for at least one group cycle.
Certification or Accreditation Required?	YES. Staff is considered certified after completing indicated training/consultation protocol. Certification does not expire.
Train-the-Trainer Allowed?	YES. <u>Train-the-Trainer protocol:</u> ▪ Complete indicated required initial training protocol. ▪ The trainer or approved supervisor must approve the group cycle was well implemented. ▪ Attend one day Trainer training. ▪ Co-lead CBITS training with CBITS Trainer, who completes the training competency rating sheet. Must receive score of at least 80% on all elements of the competency rating sheet. ▪ New trainers are able to conduct CBITS training independently within their organization unless otherwise arranged with CBITS Faculty.
Minimum Training Required Before Claiming Allowed	2 day on-site training
Who Retains Certification?	Practitioner
Fidelity Measure?	NO.
Estimated Training Cost	Cost per Cohort: $10,040 (Cohort of 16) Cost per Individual: $628

8. CRISIS ORIENTED RECOVERY SERVICES (CORS)	
Authorized Ages	3+ years old
Required Training Protocols	▪ 1-day (6-hour) initial training or 2 half day (3 hours each, total 6 hours) initial training. ▪ Optional phone or in-person consultation at a half day (3-hour) booster training with approved CORS trainer (not required).
Supervisor Training Required?	NO. Supervisors are encouraged to complete the above training protocol.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Completion of the 6-hour initial training.
Who Retains Certification?	Practitioner
Fidelity Measure?	NO.
Estimated Training Cost	Cost per Cohort: $2,000 (Cohort of 50) Cost per Individual: $40

9. DEPRESSION TREATMENT QUALITY IMPROVEMENT INTERVENTION (DTQI)	
Authorized Ages	12 – 20 years old
Required Training Protocols	Basic Level DTQI: ▪ Attend a sequence of three 1-day training events. ▪ Participate as part of a DTQI team in 10 consultation calls. Each team is not to exceed 8 therapists. ▪ The protocol is typically completed within 6 to 12 months.
Supervisor Training Required?	NO. There is no separate Supervisor Training. Supervisors are recommended to attend the Basic Level DTQI protocol.
Certification or Accreditation Required?	YES. Certificate of proficiency is provided upon completion of protocol. Certificate does not expire.
Train-the-Trainer Allowed?	YES. Train-the-Trainer must be negotiated with the developer.
Minimum Training Required Before Claiming Allowed	Sequences of three 1-day training events are to occur before claiming can begin.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $27,000 (Cohort of 32) Cost per Individual: $1,125

10. DIALECTICAL BEHAVIOR THERAPY (DBT) DMH DIRECTLY-OPERATED CLINICS ONLY	
Authorized Ages	18+ years old
Required Training Protocols	▪ Commit to maintain DBT Team (1 supervisor and 4 clinicians) ▪ 2-Day (6 hours/day) Introductory DBT Training. ▪ 1-Day (6 hours/day) DBT "Nuts and Bolts" Training. ▪ Participation in weekly DBT Consultation Team meeting (1.5-hours/week). ▪ 1-year of monthly in-person consultation with DBT trainer at weekly DBT team Consultation Team Meeting. ▪ Other DBT trainings completed by staff will be evaluated for approval on an individual basis by Practice Leads. ▪ Optional online training via Behavioral Tech.
Supervisor Training Required?	YES. One Licensed Team Lead to be trained in DBT and carrying at least 1 DBT client on their caseload.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Completion of 2-day introductory DBT training and 1-day "Nuts and Bolts" training. Staff must complete the 1-year of monthly in-person consultation within one year of taking the initial 2-day and 1-day training.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $200 (for 4 manuals; training provided by Harbor UCLA) Cost per Individual: $50

11. FAMILIES OVERCOMING UNDER STRESS (FOCUS)	
Authorized Ages	5+ years old
Required Training Protocols	Web based introductory training ▪ A six-hour, web-based program. ▪ Overview of FOCUS services and background information related to the impact of deployment and other stressors on families. Basic Level Training ▪ Attend a sequence of two 1-day training events. ▪ Carry 5 cases. ▪ Participate in weekly consultation calls until the 5 cases are seen. Advanced Level Training ▪ Attend a 1-day training event. ▪ To be completed after successfully completing 5 cases.
Supervisor Training Required?	NO. Supervisors are encouraged to complete Web-based training and attend Basic Level Training, but are not required.
Certification or Accreditation Required?	YES. Certificate provided once protocol is completed.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Completion of the Basic Training.
Who Retains Certification?	Practitioner
Fidelity Measure?	NO.
Estimated Training Cost	Cost per Cohort: $50,000 (Cohort = 25) Cost per Individual: $2,000
Comments	FOCUS is applicable for both military and civilian families.

12. FUNCTIONAL FAMILY THERAPY (FFT)	
Authorized Ages	10 – 18 years old
Required Training Protocols	Training & certification are at team level, not individual. (Team consists of at least 3, but no more than 8 practitioners). 3 Phase Protocol: Phase I (Year 1): ▪ Two 2-hour Intro and Implementation planning meetings. ▪ 3-day (21-hours) initial FFT training. ▪ Weekly ongoing national consultation calls through the first year of training. ▪ The consultation calls commence upon completion of the 3-day initial FFT training. ▪ Three, 2-day on-site follow-up trainings. ▪ 2-day Clinical Training. ▪ FFT externship (Three, 3-day trainings conducted over 3 months). Phase II (Year 2) ▪ Site Supervisor Training, see Supervisor Training Required. Phase III (Year 3, Maintaining certification): ▪ 1-day (8-hours) Site Supervisor Training. ▪ Monthly Consultation for Site Supervisor. ▪ Monthly Administrator conference calls. ▪ 1-hour Site Supervisor Conference Calls (optional).
Supervisor Training Required?	NO. Optional, but recommended. If no on-site supervisor, then staff needs to arrange for ongoing weekly consultation with FFT Statewide Consultants. On-site supervisor training protocol (Phase II): ▪ Two, 2-day Site Supervisor training. ▪ 1-day on-site supervisor training. ▪ National consultation calls, 2x/month. ▪ Monthly administrator consultation calls with CIBHS.
Certification or Accreditation Required?	YES. Certification required on annual basis. See Phase III requirements in Required Training Protocol.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Completion of Initial 3-day (21-hours) training with plan to complete all training requirements during the specified time and maintain ongoing certification.
Who Retains Certification?	Agency. Certification remains with the site/team.
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $134,400 (Phase 1 & 2 Training, Cohort of 8; Replacement Training, Cohort of 16) Cost per Individual: $12,800
Comments	California Institute for Behavioral Health Solutions (CIBHS) is the only entity in the State of California authorized by the developer to conduct FFT training in California.

13. GROUP COGNITIVE BEHAVIORAL THERAPY FOR DEPRESSION (GROUP CBT)	
Authorized Ages	18+ years old
Required Training Protocols	▪ 2-day Initial Group CBT for Depression Training (6 hours/day, 25 attendees). ▪ Participate in 12 out of 16 weekly consultation calls (1 hour/week, 5 attendees/call). ▪ 1-day booster training (6 hours/day, 25 attendees). ▪ Submit 3 audio taped sessions for review. At least one audio tape must be rated as "satisfactory" on all domains of adherence rating scale.
Supervisor Training Required?	NO. It is recommended at least one clinical supervisor also complete the abovementioned training protocol.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	YES. ▪ Clinical Champion must have completed entire required training protocol listed above. ▪ 2-day Group CBT for Depression Clinical Champion Training (6 hours/day, 12 attendees). ▪ Participate in 20 weekly consultation calls (1 hour/call, 4 champions/call). ▪ 1-day Advance Booster training for Clinical Champions (6 hours, 12 attendees). ▪ If possible, attend 2-day (6 hours/day) Group CBT for Depression Initial training with new cohort. ▪ Co-facilitate 16 weeks of Group CBT for Depression group therapy with newly trained clinicians or listen to weekly audio recordings of groups with newly trained clinicians and provide feedback in supervision. ▪ Participate in joint consultation call with consultant and all supervisees; 1 per module, totaling 3 calls/1 hour long. ▪ If possible, attend 1-day (6 hours long) Initial Booster training with new cohort of clinicians.
Minimum Training Required Before Claiming Allowed	The clinician must complete the 2-day Initial Group CBT for Depression Training to initiate billing. The clinician must complete the remaining training protocol within a year of taking the 2-day initial training.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $80,100 (Cohort of 25) Cost per Individual: $3,204

14. INCREDIBLE YEARS (IY)	
Authorized Ages	0 – 12 years old
Required Training Protocols	▪ 3-day training for each program selected (Babies, Toddlers, Early Child (3-6yrs), School Age Basic (6-12yrs), and Advanced (6-12yrs)). ▪ Attend 1 consultation day per program (trainees must bring in videos of their sessions). ▪ Additional consultations are available upon request.
Supervisor Training Required?	NO. However, supervisors are recommended to attend the staff training protocol to be able to sustain model fidelity and provide specific program-level supervision.
Certification or Accreditation Required?	NO. Certification is not required, but recommended. Certification protocol: ▪ Complete initial required training protocol. ▪ Complete two implementations of the model. ▪ Submit a certification packet and two videos for review. ▪ Certification is lifetime.
Train-the-Trainer Allowed?	YES. Mentors are authorized to train group leaders in their own agency, and mentor and supervise group leaders, their (group leader's) groups and group videotapes. Mentor Training Prerequisites: ▪ Complete certification as a group leader in the corresponding program (age group). ▪ Successful completion of multiple groups as both observer and co-trainer. ▪ Participate in a consultation day led by a certified trainer. ▪ Nomination by letter from a mentor or trainer. ▪ Submission of recent video tape (within 9 months) of a group for review. ▪ Attend at least one mentor-training consultation. Mentor Training Protocol: ▪ Attend 3-day mentor training. ▪ Submit video tapes of portions of leading a workshop. ▪ Attend mentor updates at least once every 5 years, including consultation days.
Minimum Training Required Before Claiming Allowed	3-day training for each program selected (Babies, Toddlers, Early Child (3-6yrs), School Age Basic (6-12yrs), and Advanced (6-12yrs)).
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $21,200 (Cohort = 25) Cost per Individual: $848
Comments	IY website: www.incredibleyears.com

15. INDIVIDUAL COGNITIVE BEHAVIORAL THERAPY (IND CBT) For Depression, Anxiety, or Trauma	
Authorized Ages	16+ years old
Required Training Protocols	**Option 1 (Participate in a DMH Ind CBT Training Cohort Program):** ▪ 3-day Initial Ind CBT training (18 hours, up to 100 trainees). ▪ 16 weekly 55-minutes consultation calls with a maximum of 8 trainees per call (to start 1-2 weeks after 3-day training). Clinician can miss up to 2 calls if needed. ▪ Submission of 1 audiotape/transcript and 1 case write up/diagram (CCD) on **3** current CBT clients reviewed by CBT trainer or designated consultant. Trainee must receive a satisfactory rating score of 36+ on Cognitive Therapy Rating Scale (CTRS) on 2 audio recordings and a satisfactory rating score of 20+ on Case Review Rating Scale (CRRS) on 2 case conceptualizations. ▪ 1-day CBT Booster training (6 hours, up to 100 trainees). **Option 2:** ▪ 9-month Harbor UCLA CBT class ▪ Submit 1 audiotape or case conceptualization for review by trainer. Trainee must receive a satisfactory rating score of 36+ on Cognitive Therapy Rating Scale (CTRS) and a satisfactory rating score of 20+ on Case Review Rating Scale (CRRS).
Supervisor Training Required?	NO. Supervisors are encouraged to complete the above training protocol.
Certification or Accreditation Required?	NO. Certification is not required. A CTRS score of 36+ and a CRRS score of 20+ achieves a level of competency in CBT meeting the DMH requirement to provide this EBP in LA County. A CTRS score of 40+ and a CRRS score of 20+ achieves a level of certification in CBT **IF** received by a national organization accredited to provide certification, such as the Academy of Cognitive Therapy (ACT). Staff are welcome and encouraged but not required to become certified as a CBT trained therapist through a national organization such as ACT or the Beck Institute.
Train-the-Trainer Allowed?	Yes. DMH has approved the OPTIONAL Ind CBT Clinical Champion Training protocol to establish sustainability. Those who successfully complete the CC training protocol will only provide under Required Training Protocol Option 1 the steps 2 and 3. Steps 1 and 4 will still need to be provided by a DMH approved CBT trainer/institute. **Licensed Clinical staff who have completed either Options under Required Training Protocol are eligible to apply:** 1. Initial 1-day training for Ind CBT CC (5 hr/day, 50 staff/training). 2. Consultation Calls: 1 time/week, 55 minutes long, 1 consultant to 5 Ind CBT CC per call, 12 calls total. Calls to start 1-2 weeks after 1-day training. 3. During the 12 weeks, Ind CBT CC will provide individual supervision to a staff clinician in house providing CBT to at least 1 client age 16 and older. 4. Audio Recordings: each Ind CBT CC will submit 1 audio recording of a supervisory session with the staff clinician in house providing CBT to be rated by the CBT trainer or designated consultant. Ind CBT CC must receive a minimum score of 40 or higher on the CTRS.

15. INDIVIDUAL COGNITIVE BEHAVIORAL THERAPY (IND CBT) For Depression, Anxiety, or Trauma CONTINUED)	
Train-the-Trainer Allowed?	5. During the 12 weeks, Ind CBT CC will provide individual supervision to a staff clinician in house providing CBT to at least 1 client age 16 and older. 6. Audio Recordings: each Ind CBT CC will submit 1 audio recording of a supervisory session with the staff clinician in house providing CBT to be rated by the CBT trainer or designated consultant. Ind CBT CC must receive a minimum score of 40 or higher on the CTRS. 7. During the 12 weeks, each Ind CBT CC will review and rate 2 audio recordings of a clinician providing CBT and rate the recording using the CTRS. To ensure congruence/adherence, an Ind CBT CC will pass if their CTRS score falls within a 5 point range of the assigned CBT trainer or designated consultant's CTRS. 8. During the 12 weeks, each Ind CBT CC will review and rate 2 case write-ups/diagrams (CCD) by a clinician providing CBT and rate the CCD using the CRRS. To ensure congruence/adherence, an Ind CBT CC will pass if their CRRS score falls within a 4 point range of the assigned CBT trainer or designated consultant's CRRS. 9. Personal Supervisory Model based on CBT Principles: Ind CBT CC will submit a personal supervisory model write-up for review. Must receive a minimum score of 20 on Supervisory Scale.
Minimum Training Required Before Claiming Allowed	Under Option 1 of the Required Training Protocol, staff can start claiming Ind CBT to the PEI billing plan after completing the 3-day Initial CBT training **and** upon registering for the 16 weeks of Ind CBT consultation calls. Staff must complete the remaining part of the training protocol (consultation calls, uploading of audio recordings/case conceptualizations to meet adherence, and booster training) within six months of initiating the CBT training protocol. Under Option 2 of the Required Training Protocol, staff can start claiming to the PEI billing plan after obtaining verification documentation from DMH the clinician has obtained a passing score on the CTRS and CRRS from an approved CBT consultant/trainer.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $187,735 (Cohort of 100) Cost per Individual: $1,878
Comments	Required manuals for Ind CBT training protocol: For Initial Training Process: 1. Clinician's Guide to Mind Over Mood- Greenberger & Padesky 2. Overcoming Resistance in Cognitive Therapy- Leahy 3. Mind over Mood: Change How you Feel BY Changing the Way You Think- Greenberger & Padesky For Clinical Champion Process: 1. Teaching and Supervising Cognitive Behavioral Therapy- Donna M. Sudak, R. Trent Codd, Marci G. Fox, Leslie Sokol

16. INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION (IPT)	
Authorized Ages	12+ years old
Required Training Protocols	▪ 2-day Initial IPT training (12 hours, 50 trainees). ▪ 10-12 weekly one-hour consultation calls with a maximum of 10 trainees per call. ▪ Submission of 2 audiotapes of a current IPT client reviewed by IPT trainer or designated consultant. Trainee must receive a satisfactory rating on an IPT adherence rating scale for both tapes. ▪ 1-day IPT Booster training (6 hours, 50 trainees).
Supervisor Training Required?	NO. Supervisors are encouraged to complete the above training protocol.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	Yes. DMH has approved the IPT Clinical Champion Training protocol. Successful completion of protocol enables Champion to provide consultation groups and portfolio review only. A. Pre-Requisites ▪ Licensed Mental Health Clinician. ▪ Completed required IPT Initial Training Protocol. ▪ Implemented IPT for at least 6 months. ▪ Maintains ongoing caseload. B. Training Protocol ▪ 2-day Initial IPT Champion training (12 hours). ▪ Attend 10 weekly 1-hour IPT Champion consultation calls with a maximum of five (5) IPT Champions per call. ▪ Provide 10-12 weekly 1-hour IPT consultation calls to new cohort of IPT trainees with a maximum of 10 trainees per call. ▪ Review and rate 2 audiotapes of trainees utilizing an IPT adherence rating scale. ▪ 1-day Advanced IPT Champion Booster training (6 hours). C. Responsibilities ▪ Provide consultation within their own clinical setting to newly trained IPT clinicians. ▪ Provide ongoing consultation calls and review of audio recordings for adherence. ▪ Champions are not approved to provide initial or booster trainings.
Minimum Training Required Before Claiming Allowed	Staff can start claiming after completing the 2-day Initial IPT training. Staff must complete the remaining part of the training protocol (consultation calls, uploading of audio recordings to meet adherence, and booster training) within one-year of initiating the IPT training protocol.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $45,000 (Cohort of 40) Cost per Individual: $1,125
Comments	Required manuals: a published IPT manual pre-approved by DMH/ASOC/PEI. Required IPT adherence rating scale pre-approved by DMH/ASOC/PEI.

17. LOVING INTERVENTION FAMILY ENRICHMENT PROGRAM (LIFE)	
Authorized Ages	4-19 years old (criteria for TAY-aged clients is client should be living in the home)
Required Training Protocols	▪ Initial physical walk-through of space to be utilized for the LIFE program is required as ample multiple group rooms are necessary. 2 phases of training: Phase 1: (only required for staff facilitating the parent groups) ▪ 5-day (40-hours) Parent Project training. Phase 2: (required for staff facilitating the youth and multi-family groups and the parent groups) ▪ 1-2 day training, specific to youth and multi-family intervention. ▪ On-site consultation and TA are provided monthly and as needed for 6-12 months depending on agency needs. ▪ Primary service delivery staff must include a Licensed & Registered Occupational Therapist, and a social worker or marriage and family therapist. ▪ Technical assistance and consultation available as needed.
Supervisor Training Required?	YES. Supervisors are to attend the same staff-required training protocol.
Certification or Accreditation Required?	YES. Staff implementing the parenting component of LIFE model is required to be certified in Parent Project. NO. Staff implementing the youth and/or multi-family components does not require Parent Project certification, but certification is recommended.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Only staff facilitating the parent groups needs to complete Phase 1 before claiming LIFE. Staff facilitating the parent groups and staff facilitating the youth and multi-family groups need to complete Phase 2 before claiming LIFE.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $10,000 (Cohort of 10) Cost per Individual: $1,000
Comments	The youth and parent components cannot be separated. The LIFE model includes both the parent and youth piece.

18. MANAGING AND ADAPTING PRACTICE (MAP)	
Authorized Ages	Anxiety & Avoidance: 2 – 19 years old Depression & Withdrawal: 8 – 23 years old Disruptive Behavior: 0 – 21 years old Traumatic Stress: 2 – 18 years old
Required Training Protocols	▪ 52 total hours of training and/or consultation/supervision. Can be split however you want. ▪ 1-hour consultation calls, 2x/month for 6 months (Not needed for clinicians trained by agency-based supervisor). ▪ Successful portfolio submission (therapist portfolio = 2 client dashboards with a minimum of 20 sessions total). ▪ MAP therapist status received after completed protocol.
Supervisor Training Required?	NO. ▪ Supervisor training is not required for an agency to conduct MAP services; however, for an agency to be able to train staff, the supervisor needs to be trained by a MAP-certified supervisor. ▪ MAP supervisor training is available and is considered a Train-the-Trainer protocol for in-house-agency training. <u>Supervisor protocol</u>: ▪ Complete the initial required training protocol. Must be a MAP-certified therapist. ▪ 2-day additional supervisor training (includes supervisor portfolio- dashboards and portfolios for 6 trainees). ▪ Consultations calls- one per month for 6 months. ▪ Successful supervisor portfolio submission and 6 valid Trainee Portfolios (with 2 trainees achieving Therapist status. ▪ During consultation period, the supervisor will supervise 6 therapists and train those therapists in MAP. ▪ Award of status as MAP Supervisor is renewed every 2 years.
Certification or Accreditation Required?	NO. Trainees receive an Award of Status as MAP therapist after completion of protocol. MAP therapists need to be in training or have a valid award of status as MAP therapist in order to provide MAP services. Award of status as MAP therapist is renewed every 3 years.
Train-the-Trainer Allowed?	YES. Train-the-Trainer is available for in-house trainings. Please see MAP supervisor training protocol.
Minimum Training Required Before Claiming Allowed	8-hours by either Practice Wise trainers or agency supervisor. Agency supervisors need to submit a copy of the clinicians' portfolio as well as a request for authorization to bill PEI for MAP services to Children's System of Care Practice Lead.
Who Retains Certification?	Agency *If trained by Practice Wise, certificate remains with clinician. If trained by agency, certification remains with agency. However, there is a transfer protocol available through Practice Wise in order to transfer the therapist's award of status to the new agency if clinician changes agency. Same process is available for supervisors.
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $42,100 (Cohort of 20) Cost per Individual: $2,105

19. MENTAL HEALTH INTEGRATION PROGRAM (MHIP)	
Authorized Ages	18+ years old
Required Training Protocols	Basic Level: ▪ 2-day training. ▪ Certificate of completion is provided upon completion of the required training protocol.
Supervisor Training Required?	NO. There is no separate Supervisor Training. Supervisors may attend the Basic Level training.
Certification or Accreditation Required?	NO. ▪ Certification is not required but recommended by the developer and DMH. ▪ Participate in a 2-month certification process. ▪ Attendees must carry a caseload. ▪ Certification process requires audio recordings of client sessions.
Train-the-Trainer Allowed?	YES. It involves an additional 2-month certification process and is only available to clinicians who have already completed the PST certification process.
Minimum Training Required Before Claiming Allowed	2-day training.
Who Retains Certification?	Practitioner
Fidelity Measure?	N/A
Estimated Training Cost	N/A
Comments	MHIP is an approved early intervention program for use with individuals who suffer from mild to moderate symptoms of depression and/or anxiety and/or PTSD. Agencies offering MHIP will require department approval prior to initiating this evidence-based practice.

20. MINDFUL PARENTING GROUPS (MP)	
Authorized Ages	3 months to 3.5 years old
Required Training Protocols	Two-level training to be an MPG Facilitator. **Level 1 protocol:** ▪ 2-day (12-hours) MPG fundamentals training (lecture, discussion, video). **Level 2 protocol:** ▪ Pre-implementation support includes: One 2-hour administrative matters meeting, one 2-hour clinical matters meeting, and one 3-hour Parent Development Interview training. ▪ One 12-week, 1.5-hour, MPG Demonstration Group (led by MPG training staff) for every three facilitator-trainees, with concurrent weekly 1.5-hour group supervision call. ▪ Upon completion of MPG Demo Group, facilitator-trainees commence leading an18-week, 1.5-hour MPG, with concurrent weekly 1.5 hour group supervision call. ▪ For MPG Level 2 training, it is recommended that agencies plan to commence an MPG for 4-6 parents and infants between 8-14 months of age, allowing Level 2 training to encompass work with both pre-mobile infants and mobile toddlers. ▪ MPG facilitator-trainees are each responsible for presenting 1) one process-recording during the 12-week MPG Demo Group supervision, 2) one process recording and one videotaped session during the 18-week facilitator-trainee-led MPG group supervision, and 3) one case formulation on attachment process and parenting styles of two parent-child couples during the last month of Level 2 training. Facilitator-trainees must attend at least 26 of 30 supervision sessions. ▪ Average length of time to complete MPG Level 2 Facilitator training is 8-10 months. ▪ Trainee receives Certificate of Completion upon successful fulfillment of MPG Level 2 training protocols. ▪ Additional consultation available upon request.
Supervisor Training Required?	NO. ▪ **Optional MPG Level 3 Supervisor Training protocol (highly recommended for program sustainability):** ▪ Successful completion of MPG Level 1 and 2 trainings. ▪ Pre-implementation support: One 1-hour administrative meeting. ▪ MPG supervisor-trainees replicate full MPG Level 2 facilitator training protocol within agency, but under supervision of the MPG supervisor-trainee. ▪ MPG supervisor-trainees participate in 16 one-hour supervising-the-supervisor calls, alternating weekly through the MPG Demo Group and the facilitator-trainee-led MPG. ▪ MPG supervisor-in-training is responsible for presenting four videotapes: two of their MPG Demo Group, and two of the facilitator-trainee-led MPG. ▪ There will also be four listen-in calls on the MPG supervisor-in-training's supervisions: two during the MPG Demo Group and two during their supervision of the facilitator-trainee- led MPG.
Certification or Accreditation Required?	YES. ▪ MPG Facilitators must successfully complete MPG Level 1 and 2 facilitator trainings. ▪ MPG Supervisors must successfully complete MPG Level 2 and 2 facilitator trainings plus MPG Level 3 supervisor training. ▪ Certificates of completion are provided upon successful fulfillment of MPG Level 1, Level 2, and Level 3 training protocols.

20. MINDFUL PARENTING GROUPS (MP) (CONTUNED)	
Train-the-Trainer Allowed?	NO. Note: This is a modified Train-the-Trainer model. ▪ All MPG Level 1 and Level 3 trainings must be conducted by Center for Reflective Parenting and affiliated MPG training staff. Trained MPG Level 3 supervisors may replicate MPG Level 2 Facilitator trainings and supervise MPG Level 2 facilitator-trainees.
Minimum Training Required Before Claiming Allowed	MPG Level 1 protocol (2-day fundamentals) plus commencement of MPG Level 2 protocol.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $27,950-$45,450 (Level 1 Cohort of 24; Level 2 Cohort of 3-6; Level 3 Cohort of 1-3) Cost per Individual: $5,045-$12,570
Comments	Center for Reflective Parenting and affiliated MPG training staff are the sole providers of MPG Level 1 and 3. www.reflectiveparenting.org

21. MULTIDIMENSIONAL FAMILY THERAPY (MDFT)	
Authorized Ages	12 – 18 years old
Required Training Protocols	▪ 4-day training. ▪ Implementation of MDFT with at least one new case. ▪ Weekly consultation calls. ▪ 2 additional site visits on months 2 and 4. ▪ Trainees submit 2 DVDs to be rated for adherence, and 1 additional DVD to be reviewed for competence. ▪ Written examinations are administered during months 3 and 6. ▪ Approximately 6 months to complete the training and be certified as an MDFT therapist. ▪ Training for MDFT is available in Spanish. ▪ Additional trainings and consultation are available if requested. ▪ MDFT therapist must have a Master's Degree in Social Work, Counseling, or related discipline.
Supervisor Training Required?	YES. <u>MDFT Supervisors Protocol:</u> ▪ Must be previously certified as an MDFT therapist. ▪ 2-day Intro to MDFT Supervision. ▪ Implement MDFT system of supervision with at least one MDFT therapist or trainee. ▪ Submit 2-4 DVDs of their case reviews and supervision work. ▪ One supervision training site visit. Annual MDFT Supervisor re-certification required.
Certification or Accreditation Required?	YES. ▪ Therapists are certified after completion of required training protocol. ▪ Therapists are certified for 1 year. ▪ Annual booster training consisting of case review, DVD review, and live supervision is required in order to maintain MDFT certification. MDFT supervisors and trainers must re-certify annually.
Train-the-Trainer Allowed?	YES. <u>Train-the-Trainer Protocol</u>: ▪ Must be previously certified as an MDFT Supervisor. ▪ Intensive analysis of recorded supervision and training sessions. ▪ Shadow a certified trainer in training a new group and carries out specific assignments. ▪ Trainers are able to train new therapists within their agency, and, under special assignment, within their region, state, or country. ▪ MDFT trainers must re-certify annually through yearly booster trainings, including case review, DVD review, and live supervision.
Minimum Training Required Before Claiming Allowed	Upon completion of Initial 4-day training.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $35,000 (Cohort of 8) Cost per Individual: $4,375

22. MULTISYSTEMIC THERAPY (MST)	
Authorized Ages	12 – 17 years old
Required Training Protocols	▪ Prior to the MST Orientation training, an MST Program Developer will visit the site to provide an overview presentation and meet with community stakeholders to assure the buy-in needed for program success after start-up. ▪ Next, staff recruitment assistance is provided including sample job descriptions, review of hiring advertisements, and interviewing and selecting staff most qualified to implement MST successfully. ▪ All selected initial staff will complete the following protocol: ▪ 5-day MST Orientation Training. ▪ Weekly telephone MST consultation for each treatment team (clinicians and supervisor) aimed at monitoring treatment fidelity and adherence to the MST treatment model. ▪ MST supervisor receives training on how to implement a manualized MST supervisory protocol and promote ongoing clinical development of team members. ▪ Quarterly on-site booster trainings (1.5-days each). ▪ 1.5 day MST-SA Training (usually given at one of the quarterly booster trainings). ▪ Ongoing organizational assistance and quality assurance support. ▪ Families are administered TAM-R (Therapist Adherence Measure-Revised) monthly. ▪ Therapist completes the SAM (Supervisor Adherence Measure) every 2 months.
Supervisor Training Required?	YES. ▪ Complete the initial required training protocol as the rest of the treatment team. ▪ Optional 2-day Supervisor Orientation Training for new MST supervisors, typically attended during the first six months on the job as MST supervisor. ▪ Supervisors are required to participate in any training or guidance established by their MST Expert. ▪ Optional Advanced Supervisor workshop is held once a year. Designed for MST clinical supervisors from licensed MST programs who have been in the MST supervisor position for six (6) months or more.
Certification or Accreditation Required?	YES. ▪ Because MST requires 24-hour, 7-day access to treatment by clients, sites are licensed (not individuals) and a team is required for operation. Because of the complexity of this treatment protocol, training is not offered to individuals without their membership in a licensed MST treatment program. Sites are licensed through MST Services, Inc. (www.mstservices.com). ▪ Site licensure indicates an agreement to implement the Multisystemic Therapy (MST) model with full fidelity in order to achieve positive outcomes for youth and families. ▪ Ongoing weekly consultation calls and quarterly booster trainings are required to maintain site-certification.
Train-the-Trainer Allowed?	NO. ▪ MST does not use a Train-the-Trainer model. However, MST Services does license MST Network Partner organizations that can provide training, consultation, and program support to MST teams. ▪ MST Network Partners have the capacity to provide the above services with their agency's site or sites (if multiple locations), and with other agencies as well. ▪ Only organizations with a strong record of starting and implementing MST programs with MST Services can become Network Partners.

22. MULTISYSTEMIC THERAPY (MST) (CONTINUED)	
Minimum Training Required Before Claiming Allowed	Upon completion of 5-day MST orientation training.
Who Retains Certification?	Agency is site-certified.
Fidelity Measure?	NO.
Estimated Training Cost	Cost per Cohort: $70,000 (Cohort of Single Team up to 5 people) Cost per Individual: $14,000

23. PARENT-CHILD INTERACTION THERAPY (PCIT)	
Authorized Ages	2 – 7 years olds at intake
Required Training Protocols	▪ 10-hour web course (http://pcit.ucdavis.edu/pcit-web-course/). ▪ Post-web course skill-building (on-site or tele-health). ▪ 100 hours of training and consultation. ▪ Successfully complete 2 PCIT cases.
Supervisor Training Required?	YES. ▪ Therapists trained in PCIT are considered trainers within their agency and capable of providing training to other PCIT trainees. ▪ Therapist must successfully complete 4 PCIT cases to become a Train-the-Trainer.
Certification or Accreditation Required?	YES. ▪ Trainees must complete training requirements, which includes 2 successfully completed PCIT cases approved by UC Davis to be considered a PCIT therapist. Clinicians are required to obtain a certificate as a PCIT therapist through UC Davis even if they are not directly trained by UC Davis.
Train-the-Trainer Allowed?	YES. ▪ Train-the-Trainer process is incorporated within the required PCIT training protocol. ▪ Must complete at least 4 PCIT cases in consultation with a PCIT trainer. ▪ Must be observed by PCIT trainer during at least one CDI and one PDI session. ▪ New PCIT trainers may provide training and supervision within their agency.
Minimum Training Required Before Claiming Allowed	▪ 10-hour web course (http://pcit.ucdavis.edu/pcit-web-course/). ▪ Current participation in a training program with the developer and/or training program with agency Train-the-Trainer.
Who Retains Certification?	▪ Practitioner retains records of approved completed 2 PCIT cases. ▪ Train-the-Trainer retains records of completed 4 PCIT cases and may train within their agency. All clinicians retain their own records of completed PCIT cases and certificates.
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $28,633 (Capital needs cost is per agency) Cost per Individual trainee: $3,633
Comments	Please note differences when claiming to First 5 LA PCIT versus MHSA PEI: • When claiming First 5 LA clients should be 2 to 5 years old at intake • Measures for First 5 LA PCIT include: o ECBI o SESBI if the child is in daycare/school o PSI (short form) o TSCYC if there is the presence of trauma Please go to: http://dmh.lacounty.gov/First5LAPCIT to find more information on First 5 LA PCIT.

24. PROBLEM SOLVING THERAPY (PST) Older Adult Providers Only		
Authorized Ages	60+ years old	
Required Training Protocols	**Option 1:** Basic Level (initial training): Options: ▪ Participants may complete one of the following to fulfill this requirement: PEARLS or MHIP-PST. See details of PEARLS or MHIP-PST. ▪ Certificate of completion is provided upon completion of the required training protocol.	**Option 2:** 1-day training.
Supervisor Training Required?	NO. There is no separate Supervisor Training, but supervisors are strongly recommended to attend at least the basic training.	NO PST Certification available through MHIP-PST.
Certification or Accreditation Required?	NO. PST certification is not required, but recommended by DMH.	NO. PST Certification available through MHIP-PST.
Train-the-Trainer Allowed?	NO. Not offered at this time.	
Minimum Training Required Before Claiming Allowed	PST-standalone: 1-day training.	
Who Retains Certification?	Practitioner	
Fidelity Measure?	YES.	
Estimated Training Cost	Cost per Cohort: $5,000 (Cohort of 30) Cost per Individual: $167	
Comments	Only Older Adult contract agencies are authorized to provide PST.	National PST Network Trainer: http://pstnetwork.ucsf.edu/who-we-are/pst-clinicians-trainers-researchers-region

25. PROLONGED EXPOSURE FOR POST-TRAUMATIC STRESS DISORDER (PE-PTSD) DMH DIRECTLY-OPERATED CLINICS ONLY	
Authorized Ages	18 – 70+ years old
Required Training Protocols	▪ 4-day PE workshop conducted by CTSA. ▪ Workshop offered to licensed mental health professionals. ▪ Certificate of completion is awarded after workshop. ▪ Booster training and consultation is available upon request, but not required.
Supervisor Training Required?	NO. <u>Optional Supervisor training protocol:</u> ▪ Complete PE Therapist certification protocol. ▪ Complete 5-day supervisor workshop. ▪ Certified as a "PE Supervisor" after completion of above protocol. ▪ Certified PE Supervisors can provide consultation to therapists who completed the 4-day PE workshop and can approve them to be certified as a PE therapist with CTSA after adequately completing 2 supervised PE cases.
Certification or Accreditation Required?	NO. Optional PE Therapist certification protocol: ▪ Complete initial required training protocol. ▪ Completion of 2 supervised PE cases under individual consultation with a PE expert. ▪ Weekly consultation telephone calls with PE expert. ▪ Videotape and review of all therapy sessions for the 2 PE cases. ▪ Each PE case is expected to last approximately 10 sessions. ▪ Certification by CTSA is lifetime.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Completion of the 4-day PE workshop.
Who Retains Certification?	Practitioner
Fidelity Measure?	NO.
Estimated Training Cost	Cost per Cohort: $16,300 (Cohort of 20) Cost per Individual: $815
Comments	PE-PTSD is a demanding intervention for both clinicians and consumers; therefore, careful screening of potential candidates for this practice is advised.

26. PROGRAM TO ENCOURAGE ACTIVE AND REWARDING LIVES FOR SENIORS (PEARLS)	
Authorized Ages	60+ years old
Required Training Protocols	Basic Level: ▪ 2-day training. ▪ Certificate of Attendance is provided upon completion of protocol.
Supervisor Training Required?	NO. There is no separate Supervisor Training. Supervisors are recommended to attend the Basic Level training.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	2-day training.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $38,500 (Cohort of 30) Cost per Individual: $1,467
Comments	For more information please refer to following website: • http://www.trainingxchange.org/our-programs/pearls

27. PROVIDING ALTERNATIVE THINKING STRATEGIES (PATHS)	
Authorized Ages	5 – 12 years old

Required Training Protocols	▪ Agency must demonstrate adequate commitment of resources and time to implement program.
	▪ Initial Training: 2-day initial training (or 1-day booster for previously trained staff) by PATHS certified trainer(s). The TOT process requires that there are two trainers on the first day, one of whom has already been trained.
	▪ Attend a 1-day (6-hours) booster training (needs to occur within one year of the initial training, but after the group has begun to provide PATHS services).
	▪ Observation and Supervision: Live observation or submission of videotaped sessions to PATHS certified trainers.
	▪ Competency Review and Certification: A minimum of 2 observations (live observation or submission of videotaped sessions) to PATHS certified trainers consisting of the following:
	  ▪ Written feedback with ratings on demonstration of PATHS core competencies.
	  ▪ Feedback (to clinician and clinic's PATHS lead) will be provided within 2 weeks of receipt of each observation.
	  ▪ If after 2 observations staff demonstrates proficiency in PATHS core competencies, then staff is awarded clinical certification.
	  ▪ If after 2 observations staff does not demonstrate proficiency in PATHS core competencies, further observation and review will be necessary.

Supervisor Training Required?	NO. Supervisor training is not required.
Certification or Accreditation Required?	YES. A group leader must be certified within 18 months following the first workshop training. A Group Leader Certification is valid for a two-year period. To be re-certified a group leader will need to meet the following requirements: 1. Provide evidence of regular (at least monthly) use of the PATHS® model in their work (this will be verified through communication from the clinician's supervisor). 2. Attend a one-day advanced-users workshop (paid by agency). 3. Demonstrate competence either through submission of a video or a case write-up of group treatment process.
Train-the-Trainer Allowed?	YES. Train-the-Trainer is available through the PATHS Affiliate Trainer (AT) Program. See separate PATHS Affiliate Trainer Program protocol at http://file.lacounty.gov/dmh/cms1_198941.pdf.
Minimum Training Required Before Claiming Allowed	2-day initial training.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $44,000 (Cohort of 30) Cost per Individual: $1,467

28. REFLECTIVE PARENTING PROGRAM (RPP)	
Authorized Ages	0 – 12 years old
Required Training Protocols	▪ 2-level training to be an RPP Group Facilitator. Level 1 protocol: ▪ 2-day (12-hours) RPP fundamentals training (lecture, discussion, video). Level 2 protocol: ▪ Pre-implementation support includes: One 2-hour administrative matters meeting, one 2-hour clinical matters meeting, and one 3-hour Parent Development Interview training. ▪ Level 2 trainees must co-facilitate a 10-week Reflective Parenting Workshop, using a curriculum for parents of children 0-2 years, 2-5 years, or 6-12 years. ▪ Eleven 90-minute supervision calls concurrent with commencement of Reflective Parenting Workshop. Trainees must attend at least 9 of 11 supervision calls. Trainees also receive feedback on process recording and case formulation. ▪ Required: 1) one written process recording exploring group dynamics and 2) one written case formulation on attachment process and parenting styles of 3 to 4 parents. ▪ Average length of time to complete RPP Group facilitator training is four (4) months. ▪ Trainee receives Certificate of Completion upon successful fulfillment of RPP Level 2 training protocols. ▪ Additional consultation available upon request.
Supervisor Training Required?	NO. Optional Supervisor Training (Level 3) protocol (highly recommended for program sustainability): ▪ Successful completion of RPP Level 1 and 2 trainings. ▪ Pre-implementation support: One 1-hour administrative meeting. ▪ RPP supervisor-trainee replicates full RPP Level 2 training protocol within agency, but under supervision of RPP supervisor-trainee. ▪ RPP Level 3 supervisor-trainees participate in 11 one-hour group supervision calls, concurrent with commencement of supervisor-trainee-led RPP Level 2 supervision group. Supervisor-trainees must attend at least 9 of 11 supervision calls. ▪ Additional 1-hour individual supervision call. ▪ Submission of supervisor-trainee notes on the RPP Level 2 trainees' process recordings and case formulations. ▪ Supervisor-trainee receives certificate of completion upon successful fulfillment of Level 3 training protocols. ▪ Note: Trained RPP Level 3 supervisors can replicate RPP Level 2 and supervise and train RPP Level 2 trainees. However, Center for Reflective Parenting and affiliated RPP training staff are the sole providers of RPP Level 1 and Level 3 trainings.
Certification or Accreditation Required?	YES. ▪ RPP Facilitators must successfully complete RPP Level 1 and 2 facilitator trainings. ▪ RPP Supervisors must successfully complete RPP Level 1 and 2 facilitator trainings plus RPP Level 3 supervisor training. ▪ Certificates of completion are provided upon successful fulfillment of RPP Level 1, Level 2, and Level 3 training protocols.

28. REFLECTIVE PARENTING PROGRAM (RPP) (CONTINUED)	
Train-the-Trainer Allowed?	NO. Note: This is a modified Train-the-Trainer model. ▪ All RPP Level 1 and Level 3 trainings must be conducted by Center for Reflective Parenting and affiliated RPP training staff. ▪ Trained RPP Level 3 supervisors may replicate RPP Level 2 and supervise and train RPP Level 2 facilitator-trainees.
Minimum Training Required Before Claiming Allowed	RPP Level 1 Protocol (2-day fundamentals) plus commencement of RPP Level 2 protocol.
Who Retains Certification?	Practitioner
Fidelity Measure	YES.
Estimated Training Cost	Cost per Cohort: $18,650-$23,900 (Level 1 Cohort of 24; Level 2 Cohort of 3-5; Level 3 Cohort of 1-3) Cost per Individual: $4,515-$6,145
Comments	Center for Reflective Parenting and affiliated RPP training staff are the sole providers of RPP Level 1 and 3. www.reflectiveparenting.org

29. SEEKING SAFETY (SS)	
Authorized Ages	13+ years old
Required Training Protocols	A. Initial Training by Developer-Approved Trainer 1. Conducted by developer-approved trainer (minimum of 6 hours). 2. Access to SS manual during and after training. 3. Developer highly recommends participation in Theme Based Calls (TBCs). 4. Read SS website's Frequently Asked Questions (FAQs) at www.SeekingSafety.org. 5. Read DMH PEI SS FAQs at http://dmh.lacounty.gov/wps/portal/dmh/about_dmh/mhsa. 6. Accreditation with LAC-DMH as competent to practice. OR B. Initial Training by Developer-Certified Adherence Rater and Supervisor (SS Champion) 1. Conducted by SS Champion for only internal agency staff. 2. Access to SS Manual, Training DVDs, and Website. 3. Complete SS Training Verification Form. a. To be completed during a 6-month period ("b" through "g"). b. Trainee will read and become familiar with SS Manual. c. Trainee will watch SS Training DVDs. 1. DVD #1: Overview of Seeking Safety. 2. DVD #2: Example of a Session. 3. DVD #3: Client's Story/Grounding. d. Trainee will read SS Website's FAQs. e. Trainee will submit a minimum of one (1) audio/video recorded session(s) to SS Champion. 1. SS Champion will rate recordings using SS Adherence Scale and SS Adherence Scale Score Sheet. 2. SS Champion will provide feedback to trainee utilizing the SS Supervision Format. 3. More adherence ratings may be needed until SS Champion determines trainee is consistently demonstrating strong adherence (score of 2.0 or better on each section) to the model. f. Trainee will demonstrate working knowledge of all the above with the SS Champion. g. SS Champion will submit completed SS Training Verification Form to SS Practice Lead at seekingsafety@dmh.lacounty.gov. 4. Developer highly recommends participation in TBCs. 5. Trainee will read LAC-DMH PEI SS FAQs. 6. Accreditation with LAC-DMH as competent to practice. Highly Recommended by SS Developer: A. Theme Based Calls (telephone consultation calls) B. Seeking Safety Champion to allow for sustainability by: 1. Training of internal agency staff. 2. Ongoing model fidelity.
Supervisor Training Required?	At minimum, SS supervisor to have completed the SS Initial Training. SS Champion is highly recommended and would exceed the minimum requirement.

29. SEEKING SAFETY (SS) (CONTINUED)	
Certification or Accreditation Required?	Initial Trainings ▪ Accreditation with LAC-DMH as competent to practice. Adherence Rater and Supervisor Training (SS Champion) ▪ Certification in accordance with Developer's requirements.
Train-the-Trainer Allowed?	YES. Please see the Seeking Safety Guidelines for SS Champion training requirements and parameters.
Minimum Training Required Before Claiming Allowed	Completion of SS Initial Training by Developer-Approved Trainer or SS Champion in Required Training Protocols section.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $36,950 (Initial Training Cohort of 100; Champion Training Cohort of 40; TBC Cohort of 15) Cost per Individual: $875
Comments	Please see most current version of the SS Guidelines for detailed information at http://file.lacounty.gov/dmh/cms1_201830.pdf. For additional questions, please contact SS Practice Lead at SeekingSafety@dmh.lacounty.gov.

30. STRENGTHENING FAMILIES (SF)	
Authorized Ages	3 – 16 years old
Required Training Protocols	▪ 2-day Group Leader training. ▪ Quality Assurance/Process Evaluation site visits are recommended. ▪ Standardized Evaluation Contracts are recommended.
Supervisor Training Required?	NO. Supervisors are strongly recommended to attend the same staff-required SF training protocol.
Certification or Accreditation Required?	YES. Lifetime Group leader certification after completion of 2-day training.
Train-the-Trainer Allowed?	YES. 4-step process: ▪ Complete 2-day group leader training. ▪ Deliver SF protocol for at least 2 group cycles. ▪ Co-train a group leader training with a certified trainer, delivering selected elements. ▪ Co-train a group leader training with a certified trainer, delivering substantial elements. ▪ Trainers are authorized to train in-house. Trainers can train externally only as sub-contracted by Lutra Group.
Minimum Training Required Before Claiming Allowed	Completion of the 2-day group leader training should occur before claiming can begin.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $3,900 (Cohort of 35) Cost per Individual: $111
Comments	Authorized trainers are contracted with the Lutra Group.

31. TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

Authorized Ages	3 – 18 years old
Required Training Protocols	**Establishing an Initial TF-CBT Team: Team must be trained by a certified TF-CBT trainer as follows:** ▪ Complete 10-hour TF-CBT online Training (http://tfcbt.musc.edu). ▪ Attend an Initial TF-CBT Training (2-days for clinicians and an extra ½ day for TF-CBT supervisors). ▪ Participate, as part of a TF-CBT team, in a minimum of 12 Consultation Calls. Each team not to exceed 8 to 10 therapists including a TF-CBT supervisor. ▪ Attend a Booster Training (1-day for clinicians and an extra ½ day for TF-CBT supervisors). The booster training to occur about 6 months after the initial training. ▪ Complete and submit up to 2 audio taped sessions to certified trainer for review, per the audio tape protocol. A minimum of 1 audio tape must be rated as "*satisfactory*" on all domains. ▪ Training must be completed within one year from initial training date. **Expanding an Established Team:** ▪ An agency must have one (or more) fully established TF-CBT teams, with a fully trained TF-CBT Supervisor who conducts regular TF-CBT group supervision. Fully trained entails completing all training components and obtaining a certificate of proficiency. TF-CBT Supervisors need to be trained as part of a team within their agency, and need to complete all training elements, conducted by national trainers, as described under "Establishing a Program." ▪ Complete the TF-CBT Online Training (http://tfcbt.musc.edu). ▪ Attend a 2-day initial TF-CBT training by a certified TF-CBT trainer. ▪ Recommended (but not required) to attend a 1-day booster training. ▪ For the duration of no less than 6 months, participate in regular ongoing supervision with a fully trained TF-CBT supervisor. (The TF-CBT supervisor must have a certificate of proficiency attesting to their completion of the full protocol.) Group supervision is ideally conducted weekly, but not less than every other week. Each supervision group not to exceed 8 therapists. ▪ Routinely use all program performance evaluation measures. ▪ Complete three TF-CBT cases, of which at least one case needs to include cognitive reprocessing of the Trauma Narrative. ▪ Complete and submit up to two audio taped sessions to certified trainer for review, per the audio tape protocol, to a certified TF-CBT trainer. A minimum of one audio tape must be rated as "*satisfactory*" on all domains.
Supervisor Training Required?	YES. TF-CBT Supervisor Training protocol: ▪ Complete TF-CBT online Training (http://tfcbt.musc.edu). ▪ 2.5-day Initial TF-CBT training. ▪ Participate in a minimum of 12 group consultation calls. ▪ 1.5-day booster training. Occurs about 6 months after initial training. ▪ Submit up to two audio taped sessions for review, with one rated satisfactory on all domains.
Certification or Accreditation Required?	YES. Certificates of Proficiency are required after completion of training protocol. In alternative, an application to DMH with proof of completion of entire training protocol may satisfy this requirement.

31. TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT) (CONTINUED)	
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer model allowed at this time. Trained TF-CBT Supervisors cannot provide the initial 2-day TF-CBT training to their staff and cannot provide booster trainings, or audio reviews.
Minimum Training Required Before Claiming Allowed	Permanent staff may begin implementing/claiming TF-CBT treatment after completing the webinar and initial 2-day training. Permanent staff must complete the full DMH TF-CBT training protocol within one year of their participation in the initial 2-day training. Students and interns are allowed to have provisional authorization to claim. They may begin to claim after viewing the online webinar. They are required to attend the 2-day training within six months of viewing the webinar. In order for an agency to qualify for this opportunity, there must be a sustained team with a TF-CBT certified supervisor, to whom the intern reports. It is expected that the interns will be fully trained and certified in the protocol within one year of viewing the webinar.
Who Retains Certification?	Practitioner
Fidelity Measure?	YES.
Estimated Training Cost	Cost per Cohort: $16,000 (Cohort of 7) Cost per Individual: $2,286

32. TRIPLE P POSITIVE PARENTING PROGRAM (TRIPLE P) -- LEVELS 4 AND 5	
Authorized Ages	0 – 18 years old

Required Training Protocols	▪ Complete both training and accreditation requirements for each program level of Triple P implemented.
	▪ Training ranges from 1 to 3 days, depending on program level.
	  ▪ Level 4: Standard Triple P – 3-day initial training
	  ▪ Level 4: Standard Teen – 3-day initial training
	  ▪ Level 4: Group Triple P – 3-day initial training
	  ▪ Level 4: Group Teen Triple P – 3-day initial training
	  ▪ Level 5: Enhanced Triple P – 2-day initial training
	  ▪ Level 5: Pathways Triple P – 2-day initial training
	▪ Accreditation ranges from ½ day to 1 day, depending on program level.
	▪ 1-day Pre-accreditation Consultation, conducted between training and accreditation is optional, but strongly recommended.
	▪ No ongoing requirement after accreditation is obtained.
	▪ Clinical consultation calls and post-accreditation Clinical Support Days are available upon request.

Supervisor Training Required?	NO. However, supervisors are strongly recommended to be trained in the implemented Triple P program(s) to better assist practitioners.
Certification or Accreditation Required?	YES. ▪ Accreditation is required in the Triple P program level being implemented. ▪ Occurs 6 to 12 weeks post training. ▪ After accreditation is obtained, no re-accreditation is required.
Train-the-Trainer Allowed?	NO. There is no Train-the-Trainer allowed at this time.
Minimum Training Required Before Claiming Allowed	Claiming can commence once the initial training has been completed. Accreditation is not needed in order for staff to start claiming to Triple P.
Who Retains Certification?	Practitioner
Fidelity Measure?	NO.
Estimated Training Cost	Cost per Cohort: $27,430 per level/group (Cohort of 20) Cost per Individual: $2,170-$9,104 (4 levels/group)
Comments	These training protocols apply only to the following: ▪ Level 4: Standard Triple P and Group Triple P, Teen ▪ Level 5: Enhanced Triple P Levels 1, 2 and 3 are prevention-only practices which are not billable by PEI Legal Entity providers.

33. UCLA TIES TRANSITION MODEL (TTM)	
Authorized Ages	0 – 8 years old
Required Training Protocols	▪ 2-day (16-hours) on-site TTM training. ▪ 3-day (9-hours) training on the TIES parent preparation/psycho-education classes in downtown LA. ▪ 6 follow-up on-site training (3 hours each) a year on this population and TTM. ▪ Weekly 1-hour phone consultation for one year.
Supervisor Training Required?	NO. Supervisor training is not required.
Certification or Accreditation Required?	NO. Certification is not required.
Train-the-Trainer Allowed?	YES. ▪ Train-the-Trainer allowed for consultation and shorter initial training. ▪ New clinicians still have to attend the 3-day (9-hours) training on the TIES parent preparation/psychoeducation classes in LA. ▪ However, new clinicians attend only a 1-day (8-hours) TTM orientation training and can receive consultation through clinicians already trained in TTM at their agency.
Minimum Training Required Before Claiming Allowed	The practitioner is able to implement the TTM after the 2-day training. The 9-hour training comes later and is based on when it is scheduled through DCFS.
Who Retains Certification?	Practitioner
Fidelity Measure?	
Estimated Training Cost	Cost per Cohort: $82,500 (Cohort of 8) Cost per Individual: $10,313

ATTACHMENT A

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT (MHSA)
Program Support Bureau (PSB)
PREVENTION AND EARLY INTERVENTION (PEI) ADMINISTRATION

EBP TRAINING VERIFICATION CONTACT REQUEST

DATE _____

AGENCY NAME _____

LEGAL ENTITY # _____ PROVIDER # _____

MAILING ADDRESS _____

_____

_____

FAX NUMBER _____

EXECUTIVE DIRECTOR NAME _____

EMAIL ADDRESS _____

PHONE NUMBER _____

LICENSED EBP/TRAINING COORDINATOR NAME _____

TITLE & LICENSE # _____

EMAIL ADDERESS _____

PHONE NUMBER _____

ATTESTATION By signing this form, I verify that all staff members, listed on the PEI Staff Registry Training Verification form, have successfully completed or are in the process of completing the training protocol items as endorsed on the form. I also acknowledge that our agency will maintain records for staff trainings and that these records are subject to audit at any time.

PRINT NAME _____ **SIGN NAME** _____
(Licensed person authorized to attest to staff training verifications at your agency)

Please email to: **MHSAPEI@dmh.lacounty.gov**

ATTACHMENT B

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Provider Request to Add/Drop PEI Practice

Agency: Click here to enter agency name.

LE Number: Click here. Provider Number(s): Click here to enter PN(s).

Contact Name: Click here to enter contact person regarding this form.

Phone Number: Click here. E-mail: Click here to enter e-mail.

Providers requesting to add or drop a Practice must complete this add/drop form (including cases of updating information in the Provider PEI Practice List).

INSTRUCTIONS:

1. Fill out the table below by selecting the Practice and the requested action from the drop-down lists. For Practices to be added, mark the check boxes for the age group(s) to be served, and if outcome measure and/or outcome measure trainings are needed.
2. Complete the Add/Drop form Attachment to identify the clinicians who were trained or currently in-training for the Practice to be added. There must be one Attachment for every Practice to be added for every Provider Number listed above.
3. All completed forms and attachments must be forwarded to the lead District Chief for approval and signature. The District Chief's analyst (staff) will e-mail the approved documents to PEI Administration at mhsapei@dmh.lacounty.gov.

PEI Practice	Action	Age Group to be Served	Outcome Measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure
Click here to select a Practice.	Choose an Action.	☐ Child (0-15 y/o) ☐ TAY (16-25 y/o) ☐ Adult (26-59 y/o) ☐ Older Adult (60+ y/o)	☐ Need outcome measure ☐ Need training in the measure

*DBT and PE-PTSD are currently applicable to DMH directly-operated clinics only.

Approve the Request: ☐ Yes ☐ No

Lead District Chief: Click here to enter district chief.

Signature: ______________________ Date: ______________

Email mhsapei@dmh.lacounty.gov for any questions or if you find trouble completing this form. Version 03/2015

ATTACHMENT B

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Trained Clinicians

Agency:	Click here to enter agency name.
Provider Number:	Click here to enter PN.
PEI Practice to Add:	Click here to select a Practice.

This attachment must be filled out for every Practice that the agency is requesting to add, there must be ONE Attachment per Practice for each Provider Number stated in the Add/Drop form. *PEI Administration will officially approve the new Practice after verifying the information on this Attachment.*

INSTRUCTIONS:

Table 1 – Clinicians who are currently attending a training

1. Enter the name of the Trainer, and the training start and end dates. If the end date is still undetermined due to the different training protocols, enter the estimated completion date and click the appropriate box.
2. List all clinicians that are currently in the process of completing their training, with their corresponding Rendering Provider Numbers (RPN) and NPI Numbers. Add as many rows as needed. If there is more than one training going on, please email mhsapei@dmh.lacounty.gov to request the appropriate form.

Table 2 – Clinicians who already completed their training protocol

3. List all clinicians who successfully completed the training protocol with their corresponding RPN and NPI Numbers. Enter Yes or No in the last column to state whether the clinicians completed their trainings while in your agency. Add as many rows as needed.

For Tables 1 and 2, list only clinicians that are going to provide this Practice in this Provider Number.

By completing this Attachment, your agency certifies that the listed clinicians are currently in training and/or have completed the entire training protocol to provide and claim for the Practice being added. Clinicians who have not completed the entire training protocol within the specified time will be required to stop providing and claiming under this Practice.
This Attachment is not meant to replace the EBP Training verification form that is submitted every six months for updates on new trainings and/or to report newly hired trained staff.

Table 1 – Clinicians currently in-training

Trainer:	Click here to enter trainer name.
Training Location:	Click here to enter location(s) of training.
Training Start Date:	Click here to select a date.
Training End Date:	Click here to select a date. Is this an estimated date only? ☐Yes ☐No

Last Name	First Name	Rendering Provider Number	NPI Number

Email mhsapei@dmh.lacounty.gov for any questions or if you find trouble completing this form.
Version 03/2015

ATTACHMENT B

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
PREVENTION AND EARLY INTERVENTION ADMINISTRATION

Trained Clinicians

Table 2 – Clinicians who completed the entire training protocol

Last Name	First Name	Rendering Provider Number	NPI Number	Did the clinician complete the training protocol while employed at your agency? (Yes or No)

Email mhsapei@dmh.lacounty.gov for any questions or if you find trouble completing this form.
Version 03/2015

ATTACHMENT C

PEI PRACTICE LEADS						
EVIDENCE-BASED PROGRAMS, PROMISING PRACTICES, COMMUNITY-DEFINED EVIDENCE PRACTICES, & PILOTS			**Age Group***	**Age Range**	**Practice Lead**	**Email Address**
1	ART	Aggression Replacement Training Aggression Replacement Training-**Skillstreaming**	C, T	12-17 5-12	Sermed Alkass	SAlkass@dmh.lacounty.gov
2	AF-CBT	Alternatives for Families Cognitive Behavioral Therapy	C	5-17	Michael Alba	MAlba@dmh.lacounty.gov
3	BSFT	Brief Strategic Family Therapy	C,T	10-18	Mike Alba	MAlba@dmh.lacounty.gov
4	CFOF	Caring for Our Families	C	5-11	Michael Alba	MAlba@dmh.lacounty.gov
5	CAPPS	Center for the Assessment & Prevention of Prodromal States	T	16-25	Sermed Alkass	SAlkass@dmh.lacounty.gov
6	CPP	Child-Parent Psychotherapy	C	0-6	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
7	CBITS	Cognitive Behavioral Intervention for Trauma in Schools	C,T	10-15	Michael Alba	MAlba@dmh.lacounty.gov
8	CORS	Crisis Oriented Recovery Services	C,T, A, OA	3+	Adriana Armenta	AArmenta@dmh.lacounty.gov
9	DBT	Dialectical Behavior Therapy	A	18+	Urmi Patel Lynn McFarr	UPatel@dmh.lacounty.gov L.McFarr@ucla.edu
10	DTQI	Depression Treatment Quality Improvement	C	12-20	Michael Alba	MAlba@dmh.lacounty.gov
11	FOCUS	Families OverComing Under Stress	C,T, A, OA	5+	Carl McKnight	CMcknight@dmh.lacounty.gov
12	FFT	Functional Family Therapy	C,T	10-18	Sermed Alkass	SAlkass@dmh.lacounty.gov
13	Group CBT	Group Cognitive Behavioral Therapy for Major Depression	A	18+	Urmi Patel	UPatel@dmh.lacounty.gov
14	IY	Incredible Years	C	0-12	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
15	Ind CBT	Individual Cognitive Behavioral Therapy	A	18+	Urmi Patel	UPatel@dmh.lacounty.gov
16	IPT	Interpersonal Psychotherapy for Depression	C, T, A, OA	12-60+	Keri Pesanti Rosalie Finer	KPesanti@dmh.lacounty.gov RFiner@dmh.lacounty.gov
17	LIFE	Loving Intervention Family Enrichment Program	C,T	4-19	Michael Alba	MAlba@dmh.lacounty.gov
18	MPAP	Make Parenting A Pleasure **RFI (Prevention)**	A	0-8	Edward Washington	EdWashington@dmh.lacounty.gov
19	MAP	Managing and Adapting Practice **Age Range Varies by Treatment Focus**	C,T	2-21	Michael Alba	MAlba@dmh.lacounty.gov
20	MP	Mindful Parenting	C, T	0-3	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
21	MDFT	Multidimensional Family Therapy	C, T	11-18	Yivette Odell	YOdell@dmh.lacounty.gov
22	MST	Multisystemic Therapy	T	11-17	Yivette Odell	YOdell@dmh.lacounty.gov
23	NFP	Nurse-Family Partnership	C,T	11-35	Kimberly Ronan	KRonan@dmh.lacounty.gov
24	OBPP	Olweus Bullying Prevention Program **(Prevention)**	C	6-17	Edward Washington	EdWashington@dmh.lacounty.gov
25	OE	Outreach and Education **RFI (Prevention)**	C, T, A, OA	0-18	Lillian Bando	LBando@dmh.lacounty.gov
26	PATHS	Promoting Alternative Thinking Strategies	C	5-12	Michael Alba	MAlba@dmh.lacounty.gov
27	PST	Problem-Solving Therapy	OA	60+	Liam Zaidel	LZaidel@dmh.lacounty.gov
28	PCIT	Parent-Child Interaction Therapy	C	2-7	Amber Cardenas	AmCardenas@dmh.lacounty.gov
29	PEARLS	Program to Encourage Active and Rewarding Lives for Seniors	OA	60+	Liam Zaidel	LZaidel@dmh.lacounty.gov
30	PE	Prolonged Exposure Therapy for Post Traumatic Stress Disorder	A	18-70+	Carl McKnight	CMcknight@dmh.lacounty.gov
31	RPP	Reflective Parenting Program	C	0-12	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
32	SS	Seeking Safety	C,T, A, OA	13+	Sermed Alkass	SAlkass@dmh.lacounty.gov
33	SF	Strengthening Families	C	3-16	Michael Alba	MAlba@dmh.lacounty.gov
34	TF-CBT	Trauma Focused Cognitive Behavioral Therapy	C,T	3-18	Michael Alba	MAlba@dmh.lacounty.gov
35	Triple P	Triple P - Positive Parenting Program Triple P-Level 2-3 **RFI (Prevention)**	C,T	0-18	Michael Alba Edward Washington	MAlba@dmh.lacounty.gov EdWashington@dmh.lacounty.gov
36	UCLA TTM	UCLA Ties Transition Model	C,T	0-9	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
Group Key: C = Child (0-15), T = Transition-Age Youth (16-25), A = Adult (26-59), OA = Older Adult (60+)						

Section 8

Training Funds

8.1 Purpose of One-Time Training Funds

All EBPs, PPs, and CDEs, include the requirement of training, evaluation and outcomes. DMH has worked with developers and trainers to identify required training, training materials and claimable items for reimbursement. Training is an essential component of successful implementation of EBPs. Training funds are intended to assist agencies to obtain the necessary training for staff in the practices being implemented by their agency. However, when selecting a particular PEI practice, it is the responsibility of each agency to ensure that adequate plans, including funding for training, are available not only at the outset of the practice, but for ongoing sustainability as staff turnover and booster trainings may necessitate additional training. Indeed, the need for training in a particular EBP/PP/CDE is considered a "forever" cost.

In FY 2010-2011, the DMH allocated PEI one-time training funds that its contracted agencies could utilize to purchase outside, non-DMH sponsored training, and invoice for staff time spent in the training sessions. These funds were marked as "one-time funds" because the money came from unspent dollars due to the initial slow implementation of the PEI Plan. In succeeding years, the one-time training funds have been reduced substantially from the prior years' allocations. Agencies are not allowed to carry over unused training funds from one fiscal year to the next fiscal year. Accordingly, agencies are advised to plan their training in light of their current PEI training fund allocation, as well as any other agency funding available. Additional information on PEI one-time training funds is contained in the FAQs - PEI Training Funds for FY 15-16 attached at the end of this Section 8.

8.2 Reimbursable Training Expenditures

Training funds are available for agencies to use only for approved PEI practices at their agency. Agencies can use these funds for reimbursement of training required for each EBP training protocol. Reimbursement of training will be allowed only for the specific age group, modality (individual, group and family), and only for the approved training and services. Agencies are also expected to complete the entire training protocol required in the PEI Training Protocols. PEI training reimbursement requests will not be approved without proof of an agency's plan to complete the entire training protocol for staff. That is, training purchased piecemeal with PEI funds (e.g., just the initial in-person training without the accompanying consultation calls, booster trainings, audio/videotape reviews, etc.) will not be approved. When negotiating

training, agencies should make sure that all the components are being provided by the same training source/trainer. The following charts depict the reimbursable training expenditures.

REIMBURSABLE TRAINING EXPENDITURES	
Trainer Fees	These fees may include developer/trainer fees and other training-related expenses.
Training Materials	Required training materials identified in the PEI Training Protocols are reimbursable. Only curricula authorized, acknowledged and deemed "required" by the EBP developer (or individual or corporate entity holding copyrights and/or intellectual property rights for the EBP, PP, or CDE) are considered valid training content. This includes all forms of electronic or print content and primary teaching exercises, strategies, and other educational techniques. Refer to the EBP training protocol to identify the required training manuals, educational materials, etc., for each EBP, CDE, or PP to ensure reimbursement request forms include appropriate information.
Venue/Room Rental	The cost of a venue/room rental must be reasonably priced and provided in the contract between the developer/trainer and contractor/agency. If the venue is not included, then DMH requires prior approval from PEI Administration Division before a commitment is made to determine if it is payable or not. To avoid delays and/or possible non-payment, it is recommended that agencies seek prior approval from PEI Administration Division for a venue to conduct training or include it in the contract. DMH requires a full description of line item charges itemizing each cost that adds up to the grand total cost of the venue, i.e., audio visual costs, tax, set-up costs, etc. Food and beverages are not reimbursable costs and will be denied if listed on the copy of the venue's receipt/invoice or if the cost of the venue infers additional non-reimbursable expenses such as food and beverages.
Trainer's Travel Expenses	DMH reimburses for travel expenses of the contracted trainer if it is reasonably priced and provided in the contract between the developer/trainer and contractor/agency. DMH requires a full description of line item charges itemizing each cost that adds up to the grand total cost of the travel expenses.
Outcome Measures	Contact the DMH MHSA Implementation and Outcomes Unit, PEIOutcomes@dmh.lacounty.gov, to obtain outcome measures. If the outcome measure is related to an approved EBP that the agency is implementing, DMH will cover the cost. The PEI Administration Division may reimburse for outcome measures not supplied by the DMH MHSA Implementation and Outcomes Unit AND upon their approval.
Community Outreach Activities and Training	Certain community outreach, education, and training activities may be eligible for reimbursement based on the explanation of activities. The community outreach, education, or training must be done face to face to an individual or group.

8.3 Non-Reimbursable Expenses

The items listed below are examples of items that are not reimbursable PEI training expenses:

- Culturally Modified TFCBT trainings
- EBP developer/trainer recommended training materials; only required training materials are reimbursable
- Electronic equipment
- Fees paid to internal or in-house trainers
- Food/drinks provided during a training
- Food/drinks provided to staff and other attendees
- Food/drinks purchased by staff
- General office supplies
- MAP MATCH book
- General toys
- Group prizes or snacks
- ICARE training
- Mileage and parking fees incurred by staff
- PCIT trainings under First 5 LA
- Reading and research time
- Room modifications or construction
- Staff driving time to and from training
- Time spent on assessment is not reimbursable; however, these services should be billed in the IS/IBHIS
- Translation costs of EBP materials not authorized by the developer
- Triple P materials: TAPS-3 and CELF-4 materials

The list above is not exhaustive. If an expense is deemed not to fall within the PEI Training Funds Guidelines, then the request for reimbursement will be denied.

8.4 Interns, Students, and Trainees

Agencies that intend to use their training funds to train interns, students, or trainees must submit an Intern/Trainee Training Plan at the beginning of the fiscal year to PEI Administration Division for approval. The Intern/Trainee Training Plan must be approved prior to initiating any training of these interns, students, or trainees. The agency will be responsible to ensure that these interns, students or trainees complete the EBP training protocol before the intern, student, or trainee leaves their internship or commitment with the agency and follow the timeline for completing the EBP training protocol, whichever is sooner. For example, the agency will have to decide whether it makes sense to train an intern in CPP when the intern is only scheduled for a one year internship and the CPP training can take up to 18 months. The Intern/Trainee Training Plan must be submitted on the agency's letterhead and include the following information:

- Name of Agency
- Dates of internship (start and ending dates)
- Provider number (student)

- Name of EBP/PP/CDE training
- Date of completed 2 day initial training
- Date of completed booster training
- Date of completed consultation calls
- Date of completed audio reviews
- Date of expected completion of entire training protocol
- Name of trainer or organization that will provide training

The completion dates for each component of the EBP training protocol can be added or deleted based on the requirements of the EBP training protocol. For example, the CORS training protocol only requires a one-day training which means it is not necessary to include completion dates for the booster, consult calls and audio review. Once PEI Administration Division approves the Intern/Trainee Training Plan, then the agency will be notified and can start training their interns, students or trainees. This requirement does not apply to agencies that have full-time staff that are also MFTIs.

8.5 Considerations When Contracting for EBP/PP/CDE Training

DMH recommends that agencies schedule EBP/PP/CDE trainings within a single fiscal year and require approved EBP developers/trainers to invoice the agency on a monthly basis so that the agency can request reimbursement on a monthly basis and within the same fiscal year. Agencies that fail to separate training dates and billing into one fiscal year, and instead bundle training dates across fiscal years (into one paid vendor agreement), risk being denied reimbursement for trainings rendered in multiple fiscal years. PEI training reimbursement funds are not permanent, and agencies may not receive funding in future fiscal years.

Contract for the Entire Practice Protocol

It is highly recommended that agencies make arrangements and contract for the entire training protocol with the same authorized trainer. Agencies should contract with a trainer for the entire protocol, set an exact or at least an approximate timeline for each component of the specific EBP training protocol and agree to pay for each training component as it is completed by the trainer and staff each month. It is not recommended that agencies pay trainers up front in a lump sum. The County reimburses only when services have actually been rendered. If the training spans two or more fiscal years, the agency must ensure that funds are available to pay for the training, with or without a DMH one-time training allocation. The County does not reimburse for training that will occur in the next fiscal year or any time in the future.

In some instances, a trainer may indicate they only do the initial in-person training but decline to do so, or subsequently are unable to do the rest of the protocol, especially the consultation calls and/or audio/videotape reviews. This has caused a problem for some agencies because subsequent trainers will not take on the responsibility of completing the rest of the training protocol, citing lack of information on the quality of training provided by the first training and unfamiliarity with the ability of the staff trained to provide such services. Trainers should invoice agencies for each training component that is completed per month. Agencies can then

pay the trainer and use the verification documents to request reimbursement from PEI based on the agency's training allocation and the funds available at the time of the request. If a trainer is not available to train per the training protocol, DMH recommends that the agency seek assistance from the DMH practice lead and get recommendations of other authorized trainers for that EBP.

Agencies are responsible for the training of their staff in EBP/PP/CDEs. Staff must meet all EBP training requirements as stipulated in the PEI Training Protocols. Agencies must ensure that trainers provide the certificates of attendance or sign-in sheets on the day the training was completed or the last day of the training. This requirement should be clearly stipulated in the contract with the trainer. Certificates of attendance must be signed by the authorized trainer providing the training. Certificates signed by an agency's representative or a representative from a training entity are not valid certificates of attendance.

Trainer Must Be Certified and/or Authorized

Trainers must be certified and/or authorized to provide training in the specific EBP/PP/CDEs. It is recommended that agencies check with the DMH practice lead and/or PEI Administration Division for a list of approved EBP trainers. Once the agency has identified an authorized trainer, then the agency must ensure that the trainer can and will provide the entire training protocol as indicated in the PEI Training Protocols. Although a trainer may be authorized to train, they may have a history of not completing the training protocol or of only providing portions of the training protocol. Agencies should plan accordingly and consider that the expected completion of the training protocol varies from EBP to EBP. For example, the TFCBT training protocol allows for one year for staff to complete the entire training protocol. The CPP training protocol may take up to 18 months for a staff to complete the entire training protocol.

Some agencies have encountered various delays in training due to some of the problems mentioned earlier. Since the agency is responsible for the completion of the training protocol, the agency must still find another authorized trainer to finish the training protocol. Unfortunately, some agencies have encountered scenarios where the second trainer does not want to pick up the training where the first trainer left off, because they are unsure of the quality of the training or the retention of the material by the staff. In this scenario, staff has been forced to repeat the same training in order to comply with the requirements of the second trainer. Agencies must then pay for training twice without any guarantee that they will receive reimbursement for either training.

8.6 Guide to Manual Reimbursement Requests

The purpose of the PEI Training Reimbursement Manual Claiming Guidelines (see copy attached at the end of this section) is to define and standardize billing procedures for all contracted agencies submitting claims for PEI approved EBP/PP/CDEs related training. Standardized training reimbursement guidelines provide clear direction and facilitate timely processing of reimbursement of PEI EBP-related training expenses. The guidelines are also intended to assist in the successful completion and timely manual submission of the PEI training reimbursement request forms, including PEI Training Reimbursement Request Forms B-1, B-2, B-3, and B-3A. Since July 1, 2014, DMH has not reimbursed for the staff time related to any training. Therefore,

Form B-1 has not been utilized after July 1, 2014. Refer to the PEI Training Reimbursement Manual Claiming Guidelines at the end of this section to see the reimbursement request forms.

The guidelines apply to all contracted agencies that were awarded DMH PEI training allocations to train their staff in the approved EBPs, PPs, or CDEs funded by the MHSA PEI, provided that PEI training funds are available. Agency training coordinators and billing staff should refer to these guidelines to determine if they are meeting PEI training reimbursement standards, timelines, and requirements for the required verification documents. When arranging for training through a non DMH-sponsored source, agencies should check first with the PEI Training Protocols to confirm that the proposed training complies with and includes all of the requirements. Agencies failing to comply with the required PEI Training Protocols and the standards may have their claims denied or be deemed ineligible to receive reimbursement for the EBP, PP, or CDE training expenses until they are in full compliance.

DMH will cross reference any request for training reimbursement with the PEI staff registry. Reimbursement requests are processed and approved based on the training records in the staff registry. The new reimbursement request forms for FY 15-16 require the NPI (National Provider Identifier) number for each staff listed on the reimbursement request forms. Each clinician should have an NPI number. DMH requires contracted agencies to submit the EBP Training Verification form on a quarterly basis. If DMH is unable to verify the staff member in the PEI Staff Registry for the specific EBP, then the agency will be asked to complete the EBP Training Verification form to indicate the training components that have been completed by the staff for that particular EBP. If the staff training records are missing in the staff registry, the agency will be required to submit an updated EBP Training Verification form before processing and approving any reimbursement requests. DMH recommends that agencies keep their training records up to date. Although the EBP Training Verification form is due quarterly, updated EBP Training Verification forms are accepted at any time.

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA)
PSB - PREVENTION AND EARLY INTERVENTION
PEI ADMINISTRATION DIVISION

Mental Health Services Act PREVENTION AND EARLY INTERVENTION Training Reimbursement Manual Claiming Guidelines

July, 2015

THESE GUIDELINES ARE APPLICABLE TO ALL PEI PROVIDERS

CONTENTS

PREVENTION AND EARLY INTERVENTION
Training Reimbursement
Manual Claiming Guidelines

1. PURPOSE AND SCOPE OF GUIDELINES

After an extensive stakeholder planning process, the County of Los Angeles Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) Plan was approved by the Mental Health Services Act (MHSA) Mental Health Services Oversight and Accountability Committee in August 2009. The Department proceeded with the implementation of the PEI Plan through a transformation process starting in Spring 2010. The new PEI Programs included Evidence-Based Practices (EBPs), Promising Practices (PP), and Community-Defined Evidence (CDE) Programs, all of which include evaluation and outcomes. The term "EBP" includes Evidence-Based Practices, Promising Practices, and Community-Defined Evidence Practices. The Department has worked with developers and trainers to identify required PEI training materials and claimable items for reimbursement (see the *MHSA PEI Training Protocols for Prevention and Early Intervention*).

The purpose of the PEI Training Reimbursement Manual Claiming Guidelines (Guidelines) is to define and standardize billing procedures for all contract staff submitting claims for PEI approved EBP related training. Standardized training reimbursement guidelines provide clear direction and facilitate timely processing of reimbursement of MHSA PEI EBP-related training expenses. The Guidelines are also intended to assist in the successful completion and timely manual submission of the PEI training reimbursement request forms, including PEI Training Reimbursement Request Forms B-2, B-3, and B-3A.

The Guidelines apply to all contract agencies that were awarded DMH PEI training allocations to train their staff in the approved PEI EBP, PP, or CDE models for Fiscal Years (FY) 2015-2016 and thereafter, provided that PEI training funds are available. Agency training coordinators and billing staff should refer to these Guidelines to determine if they are meeting PEI training reimbursement standards, timelines, and requirements for proof of purchase and verification documentation. When arranging for training through a non DMH-sponsored source, agencies should check first with the DMH *MHSA PEI Training Protocols for Prevention and Early Intervention* to confirm that the proposed training complies with and includes all of the requirements listed. Agencies failing to comply with the required PEI training protocols and the following standards may have their claims denied or be deemed ineligible to receive reimbursement for PEI EBP, PP, and CDE training expenses until they are in full compliance.

2. PEI TRAINING FUNDS

a. Purpose of Training Funds

Training is an essential component of successful implementation of an evidence-based program. Training funds are intended to assist agencies to obtain the necessary training for staff in the practices being implemented by the agency. However, when selecting a particular PEI practice, it is the responsibility of each agency to ensure that adequate plans, including funding for training, are available not only at the outset of the practice, but for ongoing sustainability as staff turnover and booster trainings may necessitate additional training. Indeed, the need for training in a particular EBP, PP, or CDE is considered a "forever" cost.

In FY 2010-11, the Department allocated PEI one-time training funds that its contracted agencies could utilize to purchase outside, i.e., non-DMH sponsored training, and invoice for staff time spent in the training sessions. These funds were marked as "one-time funds" inasmuch as the monies came from unspent dollars due to the initial slow implementation of the PEI funds. In FY

15-16, these one-time training funds have been reduced substantially from the prior years' allocations.

b. Carryover of Funds and Prepayment of Training

Training funds may be used to cover the cost of agency approved EBP trainings conducted only during the current fiscal year beginning July 1, 2015 through June 30, 2016. Agencies are not allowed to carry over unused training funds from one fiscal year to the next fiscal year. Accordingly, agencies are advised to plan their training in light of their PEI training fund allocation. Further, agencies may not prepay for training that will occur in the next fiscal year, i.e., using current fiscal year funds to pay for the following fiscal year training expenses.

c. Agency-Sponsored Trainings Crossing Multiple Fiscal Years

It is strongly recommended that agencies schedule approved EBP trainings within a single fiscal year and require approved EBP developers/trainers to request agency reimbursement on a monthly basis and within the same fiscal year. Agencies that fail to separate training dates and billing into one fiscal year, and instead bundle training dates across fiscal years into one paid contract agreement, risk being denied reimbursement for trainings rendered in a fiscal year. PEI training reimbursement funds are not permanent, and agencies may not receive funding in future fiscal years.

3. REIMBURSABLE TRAINING EXPENSES

a. Reimbursable Training Expenses

Requests for PEI training reimbursements will not be approved without proof of an agency's plans to complete the entire training protocols for staff. That is, training purchased piecemeal with PEI funds -- e.g., just the initial in-person training without the accompanying consultation calls, booster trainings, audio/videotape reviews, etc. – will not be approved. When negotiating training, agencies should be sure that all components are being provided by the same training source and authorized trainer.

The following are examples of expenses reimbursable with PEI training funds:

- Trainer Fees – These may include developer/trainer fees and other training-related expenses – see "Section 5. Trainer Fees" for more information.
- Training Materials – Required training materials identified in the DMH PEI EBP, PP, and CDE training protocols are reimbursable. Only curricula authorized, acknowledged and deemed "required" by the EBP, PP, and CDE developer (or individual or corporate entity holding copyrights and/or intellectual property rights for the EBP, PP, or CDE) are considered valid training content under the scope of these training guidelines. This includes all forms of electronic or print content and primary teaching exercises, strategies, and other educational techniques. Refer to the training protocol to identify the required training manuals, educational materials, etc., for each EBP to ensure request forms include appropriate information listed for reimbursement.
- Venue/Room Rental - DMH reimburses for the cost of a venue if it is reasonably priced and provided in the contract between the developer/trainer and contractor/provider. If the venue is not included, then DMH requires prior approval from PEI Administration Division before a commitment is made to determine if it is payable or not. To avoid delays and/or possible non-payment, it is recommended that agencies seek prior approval from the PEI Administration Division for a venue to conduct training or include it in the contract. DMH requires a full description of line item charges itemizing each cost that adds up to the grand total cost of the venue, i.e., audio visual costs, tax, set-up costs, etc. Food and beverages are not reimbursable costs and will be denied if listed on the copy of the

venue's receipt/invoice or if the cost of the venue infers additional non-reimbursable expenses such as food and beverages.

- Outcome Measures – Contact the DMH MHSA Implementation and Outcomes Unit, PEIOutcomes@dmh.lacounty.gov to obtain outcome measures. If the outcome measure is related to an approved EBP that the agency is implementing, DMH will cover the cost. The PEI Administration Division may reimburse for outcome measures not supplied by the Outcomes Unit AND upon their approval.
- Implementation Materials – Required implementation materials identified in the EBP training protocols are reimbursable. DMH does not reimburse for food, group prizes or incentives provided to groups or individuals receiving PEI services. DMH will not reimburse for any electronic equipment including audio recorders, video recorders, DVD players, cameras, etc.
- Community Outreach, Education, and Training – Certain community outreach, education, and training activities may be eligible for reimbursement based on the explanation of activities. See "Section 6. Community Outreach, Education, and Training" for more information.

b. Non-Reimbursable Training Expenses

Examples of expenses specifically excluded from reimbursement through PEI training funds include:

- Food and drinks provided to staff and other attendees
- Food and drinks purchased by staff
- Mileage and parking fees incurred by staff
- Staff driving time to and from training
- EBP, PP, or CDE developer/trainer recommended training materials; only required training materials are reimbursable
- Reading and research time
- Time spent on assessment is not reimbursable with PEI training funds; however, these services should be billed in the Integrated System (IS)
- General office supplies
- Electronic equipment
- Group prizes
- Room modifications or construction
- General toys
- Translation costs of EBP materials not authorized by the developer

Note that this is not an exhaustive list, and the Department may determine that other expenses do or do not qualify for reimbursement on a case-by-case basis.

c. Duplicate Reimbursement Requests

Agencies that sponsor and coordinate EBP training that other agencies and individuals may attend must select one of the two options below for reimbursement. Agencies may either charge agencies fees to attend the training OR request reimbursement from DMH for their training costs, but they cannot do both. An agency may not charge attendees fees to attend training and then request reimbursement for training fees from DMH as this would be considered double billing.

OPTION 1: FEES ARE CHARGED

1) Fees Charged to other Agencies Do Not Exceed Trainer's Fees: If Agency A charged fees to Agency B, other agencies and other individuals, then Agency A can only request trainer fees from DMH minus the amount Agency A received as payment for the training from Agency B, other agencies and staff attending the training.

   Example: Agency A charged Agency B $200 per person to attend training, 5 staff from Agency B paid Agency A to attend training, costing Agency B $1,000 to attend the training. Agency A paid the trainer $3,000 to provide the training. Agency A had 15 of their staff attend the training without charging them a fee. Agency A would deduct $3000-$1000, allowing Agency A to request reimbursement of $2000 of the trainer fees.

   Agency A Trainer Fees:……$3,000
   Agency A Staff (5) Enrolment Fees……..…$ -0-
   Agency B Staff (5) Enrolment Fees: - $1,000 (5 staff x $200)
   Trainer Fees $2,000 (no profit)

   Agency A authorized reimbursement: Trainer Fees - $2,000

   OR

   Example: Agency A charged Agency B $200 per person to attend training, 5 staff from Agency B paid Agency A to attend training, costing Agency B $1,000 to attend the training. Agency B can request reimbursement for $1,000. DMH will deduct the $1000 from the $3000, if Agency A has requested reimbursement of $3000 for the trainer fees.

   Agency A authorized reimbursement: Trainer Fees - $2,000
   Agency B authorized reimbursement: Trainer Fees - $1,000

2) Fees Charged to other Agencies Exceed Trainer's Fees: If the fees Agency A charged Agency B, other agencies and staff, exceed the amount Agency A received as payment for the training, then Agency A does not qualify for reimbursement for trainer fees.

   Example: Agency A charged Agency B $350 per person to attend training, 10 staff from Agency B paid Agency A to attend training, costing Agency B $3500 to attend the training. Agency A paid the trainer $3000 to provide the training, in which case Agency A is making a profit of $500.

   Agency A Trainer Fees:……. $3,000
   Agency B Staff (10) Enrolment Fees: - $3,500 (10 staff x $350)
   Trainer Fees…….....$ -0- ($500 profit)

   Agency A authorized reimbursement: Trainer Fees - $ 0
   Agency B authorized reimbursement: Training Fees - $3,500

3) If the fees Agency A collected from Agency B, other agencies and staff, exceed the actual contract training fees, then Agency A may NOT submit a reimbursement request to DMH for trainer fees.

   Example: Agency A charged Agency B $500 per person to attend training, 20 staff from Agency B paid Agency A to attend training, costing Agency B $10,000 to attend the training. Agency A paid the trainer $6,000 to provide the training, in which case Agency A is making a profit of $4,000. Agency A would not qualify for reimbursement for trainer fees. Agency A would be making an excessive profit.

   Agency A Trainer Fees:…… $6,000
   Agency B Staff (20) Enrolment Fees: - $10,000 (20 staff x $500)
   Trainer Fees……...$ -0- ($4000 [profit])

   Agency A authorized reimbursement: Trainer Fees - $ 0
   Agency B authorized reimbursement: Training Fees - $10,000

OPTION 2: NO FEES CHARGED

If Agency A does not charge any fees to Agency B or other agencies and individuals to attend the training, the Agency A may submit a B-2 form requesting reimbursement for trainer's fees.

Agency A Trainer Fees:……..$3,000
Agency A Staff (10) Enrolment Fees:…….$ -0-
Agency B Staff (10) Enrolment Fees: - $ -0-
Trainer Fees:…..…$3,000

Agency A authorized reimbursement: Trainer Fees - $3,000
Agency B authorized reimbursement: Training Fees - $ 0

4. STAFF TRAINING EXPENSES

a. Staff Stipend Amount

DMH will not reimburse for the staff time of individuals that have completed DMH sponsored or agency sponsored training. DMH will reimburse for the staff time of the staff providing community outreach activities. The hourly rate of compensation for staff time is $36.33 per hour regardless of discipline or payroll title. The staff stipend is based on the hourly rate for a Psychiatric Social Worker II, step 5, staff position. This is multiplied by the number of hours of the community outreach activity. The same staff stipend will be paid to all trainees, regardless of their actual staff position in an agency. The staff stipend is not intended to replace the salary, wages, and benefits paid to an agency's staff. Reimbursement is payable to the agency and not to individual staff.

b. Attendance at DMH-Sponsored Training

In an effort to expedite PEI training, DMH has entered into contracts with various developers and trainers to provide EBP training. DMH coordinates the EBP training protocol which includes the initial training, booster trainings, and consultation calls. These training opportunities as well as the required training materials are offered free of charge to PEI contract agencies and directly-operated clinical staff. DMH's expectation is that the agency staff will comply with the following:

- Participants must arrive during the registration period. Registration begins 30 minutes prior to the training time. Individuals who are more than 15 minutes late will not be allowed to participate in the training and will be required to return to their worksite without receiving credit. The agency is not allowed to submit claims in the Integrated System for services rendered in that EBP by the staff until the staff completes the training.
- Participants must stay for the entire duration of the training and sign in all required areas of the sign-in sheet each day for all EBP trainings. The agency will be notified by DMH if a participant arrives late, leaves early, takes longer for lunch than the allotted time, or is otherwise absent for significant amounts of time during the training. Staff will not receive partial credit for incomplete or partial attendance.
- On the sign-in sheet, individuals will have to sign in each morning, sign out for lunch, sign in when they return from lunch and sign out at the end of the day. If the training is conducted on multiple days, the attendees will have to sign-in as indicated above every day. Individuals who fail to sign-in each day of training or in all required areas of the sign-in sheet will not receive credit for attending the training.

- Participants are expected to treat each other, the instructor, and registration staff in a professional manner throughout the duration of the training or risk expulsion from the training without credit for attendance. Agency training coordinators, executive directors, as well as DMH supervisors and managers will be notified of participants' inappropriate behaviour, late arrivals and all other reasons for expulsion from EBP trainings. The agency will not be allowed to submit claims in the IS for services rendered in the EBP by the staff until the staff completes the training.
- Walk-ins are not allowed for DMH-sponsored training. Non-registered individuals who show up at a DMH-sponsored training will not receive credit for attending the training.

c. Students, Internees, and Trainees

If an agency utilizes students, interns, or trainees to provide PEI services, it is the agency's obligation to ensure that these individuals complete the full EBP training protocol before leaving the agency. Consequently, all plans for training the students, interns or trainees must include completion of the full training protocol for whichever EBP they are utilizing. Agencies must submit the training plans to the PEI Administration Division for their students, interns or trainees at the beginning of each fiscal year if they intend to request reimbursement of training funds. The contract agency's training plan must be approved by DMH prior to starting any training; otherwise the students, interns or trainees may not qualify for reimbursement.

d. Provisional Authorization to Claim

In 2010, "provisional authorization to claim" training protocols were approved for three practices where the developer allowed such minimal initial training. At this time, provisional authorization to claim is no longer an option for any of the EBPs.

5. TRAINER FEES

a. Approved Trainers

In order to be reimbursed with PEI training funds, an agency must utilize a trainer who is certified and/or approved by the developer AND approved by DMH. It is highly recommended that agencies check first with DMH to determine whether a proposed trainer has been approved by DMH. Note that there is no recommended list, only a list of trainers that both the developer and DMH have approved. Often these trainers have been paid previously by DMH. If the proposed trainer is not on the list, then the agency must provide satisfactory documentation that he or she is developer-approved trainer. Caveat: Some agencies have not been reimbursed because it turned out the trainer was not an approved trainer by the developer.

The proposed trainers should complete the entire and required EBP training protocol and not just one part of the protocol. The trainer must be able to certify that staff is fully trained in the EBP. No splitting training between trainers or piecemeal purchase of the training protocol.

b. Contracts with Developers and/or Trainers

Agencies requesting reimbursement for outside trainers must submit supporting documents with their request forms. It is not sufficient to submit just a copy of the raining contract. Further, the contract must specifically spell out in sufficient detail the date and services to be provided, among other things. Requests for training costs must be stated by line items. Examples of reimbursable trainer expenses include:

- Trainer's fees provided the fees are reasonable. DMH has a list of fees charged by various trainers, so a wide variance by a specific trainer may be questioned.

- Travel costs, including airfare, shuttle costs to and from the airport to the hotel or training site and return, and airport parking costs, provided such costs are included in the contract. However, the travel time cannot be for dates outside the training date, e.g., extra days before and after the actual training event. Travel time outside the training dates is not reimbursable and the airplane ticket costs must not include these extra travel costs.
- The trainer's meals are reimbursable only if the meals take place during the trainer's training dates and meals are included in the contract. The maximum meal expenses must conform to the county's meal guidelines and reimbursement cannot exceed the County allowable amount.
- Reasonable hotel costs may be claimed, but cannot exceed the County rates. Moreover, hotel dates cannot be for dates outside the training date, e.g., extra days before and after the actual training event. Hotel dates outside the training date are not reimbursable.
- Venue/Room Rental - DMH reimburses for the cost of a venue if it is reasonably priced and provided in the contract between the developer/trainer and contractor/provider. If the venue is not included in the contract, then DMH requires prior approval before a commitment is made to determine if it is payable or not. It is recommended, to avoid delays and/or non-payment, that agencies seek prior approval (send a quote from the venue to PEI Administration Division) from DMH for a venue to conduct an EBP or include it in the contract. DMH requires a full description of line item charges itemizing each cost that adds up to the grand total cost of the venue, i.e., audio visual costs, set-up costs, tax, etc. Food and beverages are not reimbursable costs and will be denied if listed on the copy of the venue's receipt/invoice.
- Training manuals that are required for the practice provided these are clearly required as part of the training protocol or are included in the contract.

Examples of trainer expenses specifically excluded from reimbursement through PEI training funds include:

- Rental cars
- Food and drinks provided to staff and other attendees
- Food and drinks purchased by staff
- Mileage and parking fees incurred by staff
- Staff driving time to and from training
- EBP developer/trainer recommended training materials; only required training materials are reimbursable
- Reading and research time
- Time spent on assessment is not reimbursable with PEI training funds
- General office supplies
- Electronic equipment including recorders, DVD players, or TVs
- Group prizes
- Room modifications or construction
- General toys
- Office supplies purchased by an agency for use at the training
- Translation costs of EBP materials not authorized by the developer
- Administrative support, implementation support, or technical assistance
- Learning Collaboratives

Note that this is not an exhaustive list, and the Department may determine that other expenses do or do not qualify for reimbursement on a case-by-case basis.

c. In-House Trainer Fees

When submitting an invoice for in-house/internal trainer staff time, the agency must provide documents that the in-house/internal trainer is approved to provide training (trainer certificate for the Train-the-Trainer model). In some cases, DMH has a list of approved in-house trainers for some EBPs, i.e., MAP and Seeking Safety via DMH Practice Leads.

Preparation time is allowed to prepare for trainings and must not exceed the total number of hours of the training. Agencies can request reimbursement of the internal trainer's preparation time for up to 1 hour per training day. Preparation time for consultation calls is not reimbursable because the trainer is not presenting new material and is expected to answer questions and provide guidance on issues mentioned by the trainee while on the consultation call. PEI Administration Division may contact the agency's internal trainer or administrator about the preparation time details.

DMH will not reimburse agencies for contracts with their employees/internal trainer to provide training to their own agency staff, e.g., for staff salaries, internal trainer fees or additional income.

6. REIMBURSMENT REQUESTS - REQUIRED FORMS AND DOCUMENTATION

PEI contract agencies with training allocations must submit manual reimbursement request forms to request reimbursement for expenses incurred for EBP training. Providers must submit request forms using the appropriate Forms B-2, B-3 and B3A as well as supporting documents such as registration forms, receipts, copies of contracts, cancelled checks, training invoice, etc. based on the applicable categories listed below: DMH requires a full description of the line item charges for costs incurred.

a. **Form B-1: DMH-Sponsored Training – Staff Time – PEI Reimbursement Request Form**

Form B-1 will not be utilized this fiscal year because we will not reimburse for staff time.

b. **Form B-2: Agency-Sponsored Training – Fees – PEI Training Reimbursement Request Form**

Form B-2 is to be used to request reimbursement of the agency training expenses, such as registration fees, trainer fees, consultation calls, training materials, train-the-trainer staff time, and train-the-trainer preparation time for PEI approved EBP training that the agency directly coordinated with the developer/trainer, paid fees, and trained their staff. Form B-2 consists of the Reimbursement Request Form, information on eligible reimbursements costs, and instructions.

- Complete all columns, lines, and spaces requesting information on the Form B-2 and attach required verification documentation as indicated in the instructions.
- Form B-2 includes a worksheet that contains a legend explaining the required information to enter in each item listed on the Form B-2.
- Submit a separate Form B-2 for each provider number, age group, and EBP.
- Mail the completed original signed Form B-2 to the Provider Reimbursement Section (550 S. Vermont Avenue, 8th Floor, Los Angeles, CA 90020) within 60-days after the month in which the training expenditures occurred.
- Form B-2 is updated each year with the current fiscal year and/or changes, as needed. Do not combine charges from one fiscal year onto forms from a prior fiscal year. Electronic copies of the Form B-2 are emailed to all PEI providers and training coordinators at the beginning of each fiscal year. Agencies that do not have the correct

form for the current fiscal year should email MHSAPEI@dmh.lacounty.gov to obtain the correct version of Form B-2.

- Failure to complete the Form B-2 correctly, neglect to list any part of the required information on the form, submit the required verification documentation, use incorrect forms or submit late request forms will result in a delay in payment or non-payment of charges incurred.

A list of the reimbursable training activities, expenses and required documents are listed in the chart below:

Form B-2 Agency Sponsored Training		
Training Activity or Expense		**Required Verification Documents**
1.	Registration Fees	1. Registration form with a description of the training fees; AND
		2. Copies of cancelled checks, redacted bank or credit card statement showing the payment; AND
		3. Proof of attendance - sign in sheets or certificates of attendance signed by the authorized trainer.
2.	Trainer's Fees	1. Contract with authorized trainer indicating the trainer's services, fees (including facility/venue fees if applicable), costs covered, and dates of training; or trainer/vendor invoice (itemized list of costs) AND
		2. Proof of attendance - sign in sheets or certificates of attendance signed by the authorized trainer AND
		3. Copies of cancelled checks, redacted bank or credit card statement showing the payment.
3.	Consultation Call Fees	1. Contract with consultant/trainer or trainer/vendor invoice indicating services, fees, costs covered, and dates of consultation calls; OR
		2. Written verification on letterhead from the consultant verifying the consultation calls that were provided, AND
		3. Copies of cancelled check, redacted bank or credit card statement showing the payment.
4.	Training Materials	1. Vendor invoice or other document indicating a description of the training materials and costs; AND
		2. Copies of cancelled checks, redacted bank or credit card statement showing the payment.

c. **Form B-3: Community Outreach Activities/Training and Implementation Materials – PEI Training Reimbursement Request Form**

The Form B-3 (Community Outreach Activities/Training (COAT) and Implementation Materials – PEI Training Reimbursement Request Form) and Form B-3A (Attachment to Request Reimbursement of PEI Community Outreach/Training and Implementation Activities) must be completed and submitted when requesting reimbursement of community outreach/training implementation materials. The Forms B-3 and B-3A are to be used to recover the cost of agencies' expenses incurred from, 1) purchasing outcome measures, outcome instruments, outcome training manual and other implementation materials required to utilize the outcome measures, 2) community outreach activities/training (COAT) at community sites to inform the public about the DMH approved EBPs under the PEI plan, and, 3) implementation materials. Community outreach activities/training (COAT) should not exceed more than 10% of an agency's training allocation. Implementation materials include outcome measures and translation of PEI

outreach educational materials, but not EBP tools or documents without the expressed written approval from the developer.

- Complete all columns, lines, and spaces requesting information on the Form B-3 and attach required verification documentation as indicated on the attachment of the electronic version of the Form B-3.
- Form B-3 includes a worksheet that contains a legend explaining the required information to enter in each item listed on the Form B-3.
- Submit a separate Form B-3 for each provider number, age group, and EBP.
- Mail the completed original signed Form B-3 Form to the Provider Reimbursement Section (550 S. Vermont Avenue, 8th Floor, Los Angeles, CA 90020) on time (within 60-days after the month in which the expenditures occurred).
- Forms B-3 and B3A are updated each year with the current fiscal year and/or changes, as needed. Do not combine charges from one fiscal year onto forms from a prior fiscal year. Electronic copies of Forms B-3 and B-3A are emailed to all PEI providers and training coordinators at the beginning of each fiscal year. Agencies that do not have the correct form for the current fiscal year must email mhsapei@dmh.lacounty.gov to obtain the correct electronic copies of Forms B-3 and B-3A.
- Failure to complete Forms B-3 and B-3A correctly, neglect to supply any part of the required information on the form, fail to attach the required verification documentation, use incorrect forms or submit late request forms will result in a delay in payment or non-payment of charges incurred.

A list of the reimbursable community outreach/training activities, implementation materials, and required documentation are listed in the chart below:

Form B-3 & B-3A Community Outreach/Training and Implementation Materials		
Community Outreach Activities/ Training, Implementation Activities and Materials		**Required Verification Documents**
1.	Outcome measures required for a PEI program, including the outcome instruments, training manual, and other training or materials required to utilize the outcome measures.	1. Vendor invoice or other written description of outcome measures, date of purchase and costs; AND 2. Copies of cancelled checks, credit card statement showing payment or other proof of payment.
2.	Community outreach activities and training at community sites to inform the public about the EBPs being implemented at a particular agency.	1. Completed B-3A Form: Description of community outreach / training activities, including names of staff providing the training or outreach activity, dates and time, community participants, site addresses or description, staff hourly rates, number of hours involved, and the specific EBP being presented. Do not include participants' names or addresses.
3.	Implementation Materials	1. Vendor invoice or other written description of materials, date of purchase and costs; AND 2. Copies of cancelled checks, credit card statement showing payment or other proof of payment.

7. SUBMISSION OF REIMBURSMENT REQUEST FORMS

a. Due Date of Reimbursement Request Forms

Forms B-2, B-3, and B-3A are due within 60-days after the month expenses were incurred (or the training was completed), and as referenced in agency agreements. Agencies will receive payment 30 days after PEI Administration Division's approval of a complete and accurate invoice that includes all required verification documentation subject to the limitations and conditions specified in the contract, DMH policies, and procedures. Failure to submit the completed Forms B-2, B-3, and B-3A **on time** will result in non-payment, no exceptions. Agencies failure to receive required verification documentation from vendors/trainers timely does not prevent the agency from mailing the completed, signed forms **on time.** The lack of timely receipt or invoice from vendors/trainers will not be acceptable justification to overturn the decision of non-payment resulting from late submission. In the event agencies fail to receive required verification documentation from vendors/trainers timely, DO NOT hold the Forms B-2, B-3 and B-3A until you receive the information from the vendors/trainers. List the charge on the invoice and submit the forms on time to PRS (Provider Reimbursement Section, 550 S. Vermont Avenue, 8th Floor, Los Angeles, CA 90020) and PEI Administration Division will hold the reimbursement request forms until the agency submits the required verification documentation for the charge. PEI Administration will work with the agency until the required verification documents have been submitted. Once the verification documentation is received by the agency, they should promptly email or fax it to their PEI Administration Division liaison directly (DO NOT email initial, signed original Forms B-2, B-3 or B-3A to PEI Administration Division staff, as they must be mailed to PRS). The Department will not pay in advance for the expenses listed on Forms B-2, B-3 and B-3A until all required verification documentation is submitted AND the forms have been reviewed and approved. A schedule of invoice due dates are provided below for your convenience:

b. Where to Submit Reimbursement Forms

Mail completed original signed Forms B-2, B-3, and B-3A to County of Los Angeles, Department of Mental Health, Provider Reimbursement Section, 550 S. Vermont Avenue, 8th Floor, Los Angeles, CA 90020, within 60-days after the month in which the training expenditures occurred.

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
Month of Service	July 1-31, 2015	Aug. 1-31, 2015	Sept. 1-30, 2015	Oct. 1-31, 2015	Nov. 1-30, 2015	Dec. 1-31, 2015	Jan. 1-31, 2016	Feb. 1-29, 2016	Mar. 1-31, 2016	Apr. 1-30, 2016	May 1-31, 2016	June 1-30, 2016
Due Date	Sept. 30, 2015	Oct. 30, 2015	Nov. 30, 2015	Dec. 31, 2015	Jan. 29, 2016	Feb. 29, 2016	Mar. 31, 2016	April 29, 2016	May 31, 2016	June 30, 2016	July 29, 2016	Aug. 31, 2016

c. One-on-One PEI Reimbursement Training

Please send an email to mhsapei@dmh.lacounty.gov requesting to schedule a one-on-one training regarding the PEI Reimbursement process for contract agency staff that will actually be completing Forms B-2, B-3 or B-3A or contact your PEI Administration Division Liaison at (213) 251-6712.

d. Reimbursement Timeline

On a daily basis, PRS retrieves reimbursement request forms from the DMH centralized mail room. PRS date stamps all request forms and forward those that are timely for processing, deny those that are not in compliance with timeliness rules per provider contracts. Upon receipt from PRS, PEI Administration Division reviews request forms for appropriateness of charges per approved EBP, PP, or CDE, determines whether verification documentation is submitted and

checks for overall completeness of the request ensuring all required information is listed and/or included. PEI Administration Division's review of request forms from approximately 100 providers may take between one to fifteen days before it is forwarded to PRS for processing. Agencies will be contacted if information is missing, which will cause delays until such time PEI receives all required information from providers. Request forms that are accurate and have all the required verification documents will have their request forms submitted to PRS for payment much sooner than those that are incomplete. PRS will submit payments to providers within 30 days of receipt of a complete and accurate invoice from PEI Administration Division.

PRS notifies PEI Administration Division of the denials via memo for those reimbursement requests that are submitted late. PEI Administration Division will then contact the provider advising them of the late request forms that were denied. Refer to Section 8, Appeal Process for Denied Claims.

PEI reimbursements follow the same timeline as other items paid by the Department's Provider Reimbursement Section (PRS). When in doubt about a check issued for PEI training reimbursement, please contact your PRS liaison.

8. APPEAL PROCESS FOR DENIED CLAIMS

PEI providers are encouraged to become familiar with the appeal process review stage, steps in review, approval, and the comments provided in the chart listed below:

Review Stage	Steps in Review and Approval	Comments
Invoice Received on Time	• PRS stamps the date when invoice is received • PRS forwards timely invoice to PEI for review and approval processing • PEI reviews the invoice, and if appropriate approves the invoice	Agencies need to set up internal billing procedures to ensure invoices are consistently submitted on time.
Late Invoice	• PRS stamps the date when invoice(s) is received • PRS notifies PEI the invoice was late and forwards the denied memo and invoice(s) to PEI • PEI notifies agency the invoice was late due to non-compliance to timeliness rules per provider contract • Agency is given the option to use their one time exemption as a form of appeal in order to receive reimbursement for the late invoice • If the agency decides to use their one time exemption, then agency is added to list of agencies that have received the one time exemption/appeal. PEI reviews the invoice, and if appropriate approves the invoice • If the agency decides NOT to use their one time exemption, then the agency will receive notification that invoice has been denied	All providers may be entitled to receive approval of an appeal only once during the lifetime of their contractual agreement including the renewal/amendment of an initial Agreement (not once per fiscal year). Providers are also free to check with PEI or PRS to determine whether their names appear on the list. If an agency has previously filed an appeal and subsequently files another appeal, there is greater scrutiny of program management. The agency may be asked to suspend its program until a corrective action plan is shown to be in place and staff is in adherence.

9. FURTHER ASSISTANCE:

Contact mhsapei@dmh.lacounty.gov to request electronic copies of the Forms B-2, B-3 and B-3A.

If you have any questions, need additional information or require one-on-one training on PEI Reimbursement request forms, please contact PEI Administration Division at (213) 251-6712 or via email at mhsapei@dmh.lacounty.gov.

ATTACHMENT B

FORM B-2

AGENCY SPONSORED TRAINING – FEES –
PEI TRAINING REIMBURSEMENT REQUEST FORM

Fiscal Year 2015-2016

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH - PSB - PEI ADMINISTRATION DIVISION
FORM B-2. AGENCY SPONSORED TRAINING - FEES - PEI TRAINING REIMBURSEMENT REQUEST FORM
Fiscal Year 2015-2016

Legal Entity Number :		**Date :**	
Legal Entity Name :		**Authorized Contact Name :**	
Provider Number :		**Contact Phone Number :**	
Age Group :		**EBP :**	
(Indicate Only One Age Group: Child, TAY, Adults or Older Adults)		**(Indicate Only One EBP Per Form)**	

Name of Staff (First and Last Name)	Position/Title	NPI #	EBP Training Attended (Indicate Consultant's Name for Consultation Calls if Applicable)	Date(s) of Training	Number of Hours	Requested Amount	Supervisor Indicate Yes or No
						Subtotal:	

Note: Verification documents must be attached for all claims. Submit one form per month; do not combine months on one form.

Print Name/Signature of Authorized Staff

Title

Date

REQUEST FORM DUE WITHIN 60 DAYS OF SERVICES RENDERED

MAIL or DELIVER REQUEST FORM TO:

County of Los Angeles - Department of Mental Health
Accounting Division
Provider Reimbursement Section
550 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90020

DMH/PEI Approval:

Approved By:

Date:

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PSB - PEI ADMINISTRATION DIVISION

Checklist of Training Costs Eligible for PEI Training Funds Reimbursement
Fiscal Year 2015-2016

The activities listed below qualify for reimbursement under the PEI Training Funds. Please contact the EBP practice lead or PEI administration to verify whether a trainer is authorized to train for an EBP, list of authorized trainers, and for any specific questions about an EBP and the training protocols.

PEI administration can reimburse for the activities listed below based on the requirements of the EBP's training protocol but DOES NOT reimburse for the following: staff time, audio recorders, food, technical assistance, administrative support or administrative fees, learning collaboratives, staff travel expenses, parking or implementation support.

When submitting a qualifying claim, the required verification documentation must be submitted together with the request form, including original receipts to support payment invoice. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained should be retained.

If you are missing verification documents when the request forms are due, please submit the request form before its due date and coordinate with PEI administration the submission of the missing verification documents.

If you have contracted with a trainer for an EBP training, for a specific time frame and have paid the trainer a lump sum upfront, then you must break down the lump sum per month and request reimbursement each month after the training has been completed each month. Providers are expected to submit the request form before its due date each month. We do not reimburse for training fees at the end of the year, but will reimburse the fees monthly.

Providers that expect to spend more than their training allocation and would like to request additional training funds in order to cover those expenses, must complete the Plan for Expenditures FY 15-16 before they incur those expenses. There is no guarantee that you will receive additional training funds after you have maximized your training allocation.

	Training Activity or Expense	Required Verification Documents
1	Registration Fees	1. Registration form with a description of the training fees; AND
		2. Copies of cancelled checks, redacted bank or credit card statement showing the payment; AND
		3. Proof of attendance - sign in sheets or certificates of attendance signed by the authorized trainer.
2	Trainer's Fees	1. Contract with authorized trainer indicating the trainer's services, fees (including facility fees if applicable), costs covered, and dates of training; or trainer/vendor invoice AND
		2. Proof of attendance - sign in sheets or certificates of attendance signed by the authorized trainer AND
		3. Copies of cancelled checks, redacted bank or credit card statement showing the payment.
3	Consultation Call Fees	1. Contract with consultant/trainer or trainer/vendor invoice indicating services, fees, costs covered, and dates of consultation calls; OR
		2. Written verification on letterhead from the consultant verifying the consultation calls that were provided, AND
		3. Cancelled check, redacted bank or credit card statement as proof of payment for consultation calls, if applicable.
4	Training materials	1. Vendor invoice or other document indicating a description of the training materials and costs; AND
		2. Copies of cancelled checks, redacted bank or credit card statement showing the payment.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PSB - PEI ADMINISTRATION DIVISION

Fiscal Year 2015-2016

INSTRUCTIONS

PEI Training Reimbursement Request Forms must be received by PRS within sixty (60) days from the month in which the expenditure occurred.

PEI administration can reimburse only for the training requirements listed in the EBP's training protocol but DOES NOT reimburse for the following: staff time, audio recorders, food, technical assistance, administrative support or fees, learning collaboratives, staff travel expenses, parking or implementation support.

When submitting a qualifying claim, the verification documentation must be submitted together with the request form, including original receipts to support payment invoice. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained should be retained.

If you are missing verification documents when the request forms are due, please submit the request forms by their due date and coordinate with PEI administration the submission of the missing verification documents.

#	Description	Explanation
1	Legal Entity Number:	Indicate agency's legal entity number.
2	Legal Entity Name:	Indicate agency's legal entity name.
3	Provider Number:	Indicate provider number.
4	Age Group:	Indicate only one of the following: Child, TAY, Adults, Older Adults.
5	Date:	Indicate the date when the form is completed.
6	Authorized Contact Name:	Indicate the authorized person that will be able to answer questions about the request form and provide verification documents.
7	Contact Phone Number:	Indicate the phone number of the authorized person.
8	EBP:	Indicate only one EBP per form. Do not combine months on one form.
9	Name of Staff (First and Last Name):	Indicate the first and last name of the staff that attended the training.
10	Position/Title:	Indicate the position/title of the staff that attended the training.
11	NPI #:	Indicate the staff person's National Provider Identifier number.
12	EBP Training Attended:	Indicate the title of the training, consultation call, training materials (include the name of the consultant that provided the consultation calls, if applicable).
13	Date(s) of Training:	Indicate the date(s) of the training, consultation call, or webinar.
14	Number of Hours:	Indicate the number of hours of the training. We will not reimburse for the lunch hour and two 15 minute breaks. (For example, we will deduct 1.5 hrs from an 8 hr. day of training and reimburse for 6.5 hrs).
15	Amount:	Indicate the amount based on the registration fees or trainer fees per the trainer invoice or contract.
16	Supervisor (Indicate Yes/No):	Indicate Yes or No whether the staff is a supervisor or not.
17	Subtotal:	Indicate the subtotal for this form only.
18	Print Name/Signature of Authorized Staff:	Print the name of the Authorized Staff. Indicate signature of Authorized Staff.
19	Title:	Indicate the title of the Authorized Staff.
20	Date:	Indicate the date of when the Authorized Staff signed the form.
21	Submit Request Form:	Mail or deliver the completed forms and verification documentation to LA County DMH, PRS, 550 S. Vermont Ave., 8th Floor, Los Angeles, CA 90020.

FY 2015-2016
Due Dates

	1	2	3	4	5	6	7	8	9	10	11	12
Month of Service	July 1-31, 2015	Aug. 1-31, 2015	Sept. 1-30, 2015	Oct. 1-31, 2015	Nov. 1-30, 2015	Dec. 1-31, 2015	Jan. 1-31, 2016	Feb. 1-29, 2016	Mar. 1-31, 2016	Apr. 1-30, 2016	May 1-31, 2016	June 1-30, 2016
Due Date	Sept. 30, 2015	Oct. 30, 2015	Nov. 30, 2015	Dec. 31, 2015	Jan. 29, 2016	Feb. 29, 2016	Mar. 31, 2016	Apr. 29, 2016	May. 31, 2016	Jun. 30, 2016	Jul. 29, 2016	Aug. 31, 2016

ATTACHMENT C

FORM B-3

COMMUNITY OUTREACH/TRAINING AND IMPLEMENTATION MATERIALS - PEI TRAINING REIMBURSEMENT REQUEST FORM

Fiscal Year 2015-2016

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH - PSB - PEI ADMINISTRATION DIVISION

FORM B-3. COMMUNITY OUTREACH / TRAINING AND IMPLEMENTATION MATERIALS - PEI TRAINING REIMBURSEMENT REQUEST FORM

Fiscal Year 2015-2016

Legal Entity Number : _____ **Date :** _____

Legal Entity Name : _____ **Authorized Contact Name :** _____

Provider Number : _____ **Contact Phone Number :** _____

Age Group : _____ **EBP :** _____

(Indicate Only One Age Group: Child, TAY, Adults or Older Adults) **(Indicate One EBP Per Form)**

Name of Staff (First and Last Name)	Position/Title	NPI #	Description of Community Outreach, Implementation Activities or Materials	Date(s) of Service	Hourly Rate or Unit Cost	No. of Hours or No. of Materials	Total Cost
						Subtotal:	

Note: Verification documents must be attached for all claims.
Form B-3A must be attached for each community outreach activity.

REQUEST FORM DUE WITHIN 60 DAYS OF SERVICES RENDERED

Print Name/Signature of Authorized Staff

Title

Date

MAIL or DELIVER REQUEST FORM TO:

County of Los Angeles - Department of Mental Health
Accounting Division
Provider Reimbursement Section
550 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90020

DMH/PEI Approval:

Approved By:

Date:

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PSB - PEI ADMINISTRATION DIVISION

Checklist of Community Outreach / Training, Implementation Activities, and Implementation Materials Eligible for PEI Training Funds Reimbursement
Fiscal Year 2015-2016

The activities listed below qualify for reimbursement under the PEI Training Funds.
Please contact PEI administration for any specific questions about reimbursement.

PEI administration can reimburse for the activities listed below based on the requirements of the EBP's training protocol, including approved manuals or books, and other equipment required for the implementation of an EBP. Although there may be many materials that are recommended, PEI administration DOES NOT reimburse for the following: audio recorders, general toys, general office supplies, electronic equipment, group prizes, food, parking, room modifications or construction.

When submitting a qualifying claim, the required verification documentation must be submitted together with the request form, including original receipts to support payment invoice. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained should be retained.

If you are missing verification documents by the submission deadline, please submit the request form before its due date and coordinate with PEI administration the receipt of the missing verification documents.

Providers that expect to spend more than their training allocation and would like to request additional training funds in order to cover their training expenses, must complete the Plan for Expenditures FY 15-16 before they incur those expenses. There is no guarantee that providers will receive additional training funds after they have maximized their training allocation.

	Community Outreach / Training, Implementation Activities and Training Materials	Required Verification Documents
1.	Outcome measures required for a PEI program, including the outcome instruments, training manual, and other training or materials required to utilize the outcome measures.	1. Vendor invoice or other written description of outcome measures, date of purchase and costs; AND
		2. Copies of cancelled checks, credit card statement showing payment or other proof of payment.
2.	Community outreach and training activities at community sites to inform the public about the EBP's being implemented at a particular agency.	1. Completed B-3A Form: Description of community outreach / training activities, including names of staff providing the training or outreach activity, dates and time, community participants, site addresses or description, staff hourly rates, number of hours involved, and the specific EBP being presented. Do not include participants' names or addresses.
3.	Implementation Materials	1. Vendor invoice or other written description of materials, date of purchase and costs; AND
		2. Copies of cancelled checks, credit card statement showing payment or other proof of payment.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PSB - PEI ADMINISTRATION DIVISION
Fiscal Year 2015-2016

INSTRUCTIONS

PEI Training Reimbursement Request Forms must be received by PRS within sixty (60) days from the month in which the expenditure occurred.

When submitting a qualifying claim, the required verification documentation must be submitted together with the request form, including original receipts to support payment invoice. If an original receipt is not obtainable, a copy of the receipt or justification as to why the receipt was not obtained should be retained.

If you are missing verification documents by the submission deadline, please submit the claim before its due date and coordinate with PEI administration the receipt of the missing verification documents.

#	Description	Explanation
1	Legal Entity Number:	Indicate agency's legal entity number.
2	Legal Entity Name:	Indicate agency's legal entity name.
3	Provider Number:	Indicate provider number.
4	Age Group:	Indicate only one of the following: Child, TAY, Adults, Older Adults.
5	Date:	Indicate the date the form is completed.
6	Authorized Contact Name:	Indicate the authorized person that will be able to answer questions about the request form and provide verification documents.
7	Contact Phone Number:	Indicate the phone number of the authorized person.
8	EBP:	Indicate only one EBP per form. Do not combine months on one form.
9	Name of Staff (First and Last Name):	Indicate the first and last name of the staff that purchased the materials, outcome measure or provided the community outreach/training.
10	Position/Title:	Indicate the position/title of the staff.
11	NPI #:	Indicate the staff person's National Provider Identifier number.
12	Description of Community Outreach, Implementation Activities or Materials:	Indicate the title of the community outreach activity/training or description of implementation materials. You must submit the completed B-3A form for each related community outreach activity. If the community outreach activity includes multiple EBPs, then you must divide the amount requested by the number of EBPs and complete a separate B-3 form for each EBP.
13	Date(s) of Training:	Indicate the date(s) of the community outreach activity/training or purchase of materials/outcome measures.
14	Hourly Rate or Unit Cost:	Indicate the hourly rate or unit cost based on the itemized list on the vendor invoice.
15	Number of Hours or Number of Materials:	Indicate the number of hours or number of materials as indicated on the vendor invoice.
16	Total Cost:	Indicate the total cost as indicated on the vendor invoice for each line item.
17	Subtotal:	Indicate the subtotal for this form only.
18	Print Name/Signature of Authorized Staff:	Print the name of the Authorized Staff. Indicate signature of Authorized Staff.
19	Title:	Indicate the title of the Authorized Staff.
20	Date:	Indicate the date of when the Authorized Staff signed the form.
21	Submit Request Form:	Mail or deliver the completed forms and verification documentation to LA County DMH, PRS, 550 S. Vermont Ave., 8th Floor, Los Angeles, CA 90020.

FY 2015-2016

Due Dates

	1	2	3	4	5	6	7	8	9	10	11	12
Month of Service	July 1-31, 2015	Aug. 1-31, 2015	Sept. 1-30, 2015	Oct. 1-31, 2015	Nov. 1-30, 2015	Dec. 1-31, 2015	Jan. 1-31, 2016	Feb. 1-29, 2016	Mar. 1-31, 2016	Apr. 1-30, 2016	May 1-31, 2016	June 1-30, 2016
Due Date	Sept. 30, 2015	Oct. 30, 2015	Nov. 30, 2015	Dec. 31, 2015	Jan. 29, 2016	Feb. 29, 2016	Mar. 31, 2016	Apr. 29, 2016	May. 31, 2016	Jun. 30, 2016	Jul. 29, 2016	Aug. 31, 2016

ATTACHMENT D

FORM B3A

ATTACHMENT TO REQUEST REIMBURSEMENT OF PEI COMMUNITY OUTREACH / TRAINING AND IMPLEMENTATION ACTIVITIES

Fiscal Year 2015-2016

Attachment III

FORM B-3A - ATTACHMENT TO REQUEST REIMBURSEMENT OF PEI COMMUNITY OUTREACH / TRAINING AND IMPLEMENTATION ACTIVITIES

Fiscal Year 2015-2016

A. WHO PROVIDED SERVICES

(Please provide the following information regarding the community outreach / training and implementation activities your staff provided for your agency's PEI programs).

AGENCY NAME	**PROVIDER NUMBER**
STAFF NAME (First, Last Name)	**STAFF TITLE/POSITION**
PHONE NUMBER	**EMAIL ADDRESS**

B. WHEN WERE SERVICES DELIVERED

(Please indicate date and time frame. Must complete a separate form for each community outreach activity.)

C. WHERE WERE SERVICES DELIVERED

(Please describe the community settings where services were delivered.)

D. WHO RECEIVED SERVICES

(Please describe target group.)

1. Name of Agency _____
2. Age Group(s) _____
3. Ethnic Group(s) served _____
4. Language(s) spoken (other than English) _____

***** Please note that this form MUST be signed at the bottom of the document.**

E. WHAT SERVICES WERE DELIVERED

(Describe community outreach/training activity. Please specify the EBPs, content of presentation, process, outcomes, etc.)

Describe any special problems or successful techniques which might be helpful in future community outreach or training activity.

F. CERTIFICATION:

I certify that the above community outreach / training and implementation activities were provided as documented.

AUTHORIZED STAFF NAME	TITLE
AUTHORIZED STAFF SIGNATURE	DATE
PHONE NUMBER	EMAIL ADDRESS

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT - PSB
PREVENTION AND EARLY INTERVENTION

PEI Training Funds for Fiscal Year 2015-2016

FREQUENTLY ASKED QUESTIONS
July 2015

TRAINING FUNDS ALLOCATION

1. Are agencies allowed to carry over funds from the previous fiscal year?
   No. Funds must be used during the current fiscal year the funds were issued.

2. What if agencies need more funds than what was allocated for the fiscal year?
   Agencies that would like to get additional training funds must use at least 70% of their allocation before they can be considered for additional funding. The Plan for Expenditures FY 15-16 form should be completed (request must be received by PEI Administration Division before March 1, 2016). This plan must clearly indicate how the agency intends to use the funds and should always be for the entire EBP training protocol. We recommend that agencies attach the training contract or invoice that explains how and when the entire EBP training protocol will be completed in one year (unless otherwise indicated in the EBP training protocol).

3. Can agencies receive reimbursements for costs incurred last fiscal year?
   It depends. Reimbursement will be based on the dates the costs were incurred and taken out of the allocation of that fiscal year. Reimbursement is based on the training date, consult call date, or purchase date. An agency must have sufficient PEI training funds remaining in the respective fiscal year to cover the amounts requested. Also, an agency must have submitted their reimbursement requests by the due date, as late reimbursement requests will be denied.

4. What is the timeline for utilizing training funds?
   Funds may be utilized to cover all approved evidence-based practice (EBP) training conducted during the respective fiscal year beginning July 1 to June 30 and only for the duration DMH plans to include PEI training dollars in provider allocations.

COMPENSATION

1. What is the hourly rate of compensation?
   It is $36.33 per hour regardless of discipline or payroll title. Reimbursement of training fees will be based on the proof of payment and proof of attendance.

2. How is the staff stipend calculated?
   The staff stipend is based on the hourly rate for a Psychiatric Social Worker II, step 5, staff position. The same staff stipend will be paid to all training participants, regardless of their actual staff position in an agency.

3. Can agencies receive reimbursement for staff time spent in training?
   No. DMH will not reimburse for staff time during this fiscal year. DMH will reimburse for the time spent by staff providing community outreach activities/training (COAT) by submitting the B-3 and B-3a form.

4. Do students, trainees and interns qualify for reimbursement of training expenditures?
   It depends. If the individual is authorized to bill DMH for PEI services and has been fully trained in the specific EBP model, then the training fees can be reimbursed. Agencies that want to train their interns, students, trainees in any EBP must submit and obtain prior DMH approval for its training plan for such students/interns to start EBP training. Agencies must ensure that their students/interns complete the EBP training protocol before such students/interns leave the agency and within the required one-year time limit.

5. What are the categories that qualify for PEI reimbursement? And what forms does DMH require agencies to use to receive reimbursement?

   There are three forms that can be used to request reimbursement:

   Form B-2: Agency-Sponsored Training – Fees – PEI Training Reimbursement Request Form

   Agencies can use the Form B-2 to request reimbursement for the following:
   1. Registration Fees
   2. Trainer's Fees
   3. Consultation Call Fees
   4. Required Training Materials

   Submit the completed Form B-2 with the required verification documents, as identified in the Instructions (third worksheet) of the electronic Form B-2. Agencies may only submit reimbursement requests for those EBPs, PPs, and/or CDEs that they were approved to implement. In addition, agencies must attach copies of the required verification documents, as identified on the Eligible Reimbursement Costs form (second worksheet) of the electronic Form B-2. (**Note: The agency**

coordinates and establishes the EBP training contract and payment directly with the developer/trainer and agency staff participate in training).

Form B-3: Community Outreach/Training and Implementation Materials – PEI Training Reimbursement Request Form

Agencies can use the Form B-3 to request reimbursement for the following:

1. Community Outreach Activities/Training (COAT)
2. Required Implementation Materials
3. Outcome Measures

Submit the completed Form B-3 with the required information as identified on the Instructions (third worksheet) of the electronic Form B-3. In addition, agencies must attach copies of the required verification documents, as identified on the Eligible Reimbursement Costs form (second worksheet) of the electronic Form B-3. The recommended amount for community outreach activities/training (COAT) is 10% of an agency's training allocation. Qualifying activities include providing information face to face at community sites to inform the public about PEI programs. Implementation materials include outcome measures and translation of PEI outreach educational materials, but not EBP tools or documents without the expressed written approval from the developer.

Form B-3A: Attachment to Request Reimbursement of PEI Community Outreach/Training and Implementation Activities

A description of the community outreach activity/training must also be completed and attached to Form B-3. Form B-3 will not be processed without an attached Form B-3A.

6. We paid for training that covers two fiscal years, and our agreement and receipt includes both years. Can we submit a request for reimbursement?

   Agencies may not use current training funds to pay for trainings in future fiscal years. It is strongly recommended that agencies require approved EBP developers/trainers to invoice the agency on a monthly basis following each consecutive month's set of trainings to assist agencies in submitting reimbursement requests to DMH on time and within the current fiscal year. Agencies must submit monthly reimbursement requests for trainings after the trainings/services have been rendered within the current fiscal year and attach the required verification documents. However, agencies that fail to separate training dates and billing into one fiscal year and instead bundle it into one agreement for trainings to be held in two fiscal years (have one cancelled check to cover it all) take on a huge risk of being denied reimbursement for trainings rendered in a future fiscal year. PEI training reimbursement funds are not permanent and agencies may not receive the funding in a future fiscal year; therefore, the agency may be denied reimbursement because the funding is not included in their allocation. Agencies are required to submit their monthly reimbursement requests within 60 days after the service month.

7. We paid a lump sum for the entire EBP training protocol (1 year of training). Can we receive reimbursement for the entire training protocol? When do we request reimbursement for these training fees?

It is strongly recommended that agencies do not pay for an entire year of training up front. We recommend that agencies contract with approved EBP developers/trainers for the entire EBP training protocol, but pay for each training component as it is completed each month. Agencies must request reimbursement on a monthly basis for trainings after they have been rendered within the current fiscal year. Agencies will be required to submit the Form B-2, attach copies of the contract agreement, cancelled checks, certificates of attendance or sign in sheets, and/or receipt(s). Agencies will also be required to complete the EBP Training Verification Form in order to receive reimbursement. Please do not wait until all the training components have been completed to request reimbursement of the lump sum paid for the entire training protocol because there may be a possibility that some of the months may be denied reimbursement for being submitted late.

DUE DATE

1. When is the reimbursement request form (Form B-2, B-3 and B3A) due?
   Reimbursement requests shall be mailed and/or hand delivered to the Provider Reimbursement Section within 60 calendar days of the end of the month in which eligible expenses were incurred. Agencies will receive payment within 30 days after PEI Administration's approval of a complete and accurate invoice, subject to the limitations and conditions specified in the contract, policies, and procedures. Failure to submit reimbursement requests on-time may result in non-payment, no exceptions. A schedule of the due dates is provided below for your convenience:

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
Month of Service	July 1-31, 2015	Aug. 1-31, 2015	Sept. 1-30, 2015	Oct. 1-31, 2015	Nov. 1-30, 2015	Dec. 1-31, 2015	Jan. 1-31, 2016	Feb. 1-29, 2016	Mar. 1-31, 2016	Apr. 1-30, 2016	May 1-31, 2016	June 1-30, 2016
Due Date	Sept. 30, 2015	Oct. 30, 2015	Nov. 30, 2015	Dec. 31, 2015	Jan. 29, 2016	Feb. 29, 2016	Mar. 31, 2016	April 29, 2016	May 31, 2016	June 30, 2016	July 29, 2016	Aug. 31, 2016

2. What happens if the reimbursement request is not submitted on time?
   Failure to submit reimbursement requests on time may result in non-payment, no exceptions.

3. What should an agency do if they want to appeal a denied invoice?
   Appeal Procedures - Refer to chart below:

Review Stage	Steps in Review and Approval	Comments
Invoice Received on Time	• PRS stamps the date when reimbursement request is received • PRS forwards timely request to PEI Administration for review and approval processing • PEI reviews the request, and if appropriate approves the request	Agencies need to set up internal billing procedures to ensure reimbursement requests are consistently submitted before their due date.
Late Invoice	• PRS stamps the date when request(s) is received • PRS notifies PEI the invoice was late and forwards the denied memo and request(s) to PEI • PEI notifies agency the invoice was late due to non-compliance to timeliness rules per provider contract • Agency is given the option to use their one time exemption as a form of appeal in order to receive reimbursement for the late	All agencies may be entitled to receive approval of an appeal only once during the lifetime of their Agreement including the renewal/amendment of an initial Agreement (not once per fiscal year).

	request • If the agency decides to use their one time exemption, then agency is added to list of agencies that have received the one time exemption/appeal. PEI reviews the invoice, and if appropriate approves the request • If the agency decides NOT to use their one time exemption, then the agency will receive notification that invoice has been denied	Agencies are also free to check with PEI or PRS to determine whether their names appear on the list. If an agency has previously filed an appeal and subsequently files another appeal, there is greater scrutiny of program management. The agency may be asked to suspend its program until a corrective action plan is shown to be in place and staff is in adherence.

4. What should an agency do if they are missing the required verification documents?
   If an agency is missing any of the required verification documents, then they should still submit the request form before its deadline to avoid being late. PEI Administration Division will request any missing verification documents and work with the agency to submit these documents.

SUBMISSION OF REIMBURSEMENT REQUESTS

1. How do I submit my requests for training reimbursement?
   Complete the required Form B-2, B-3, B-3A and the required verification documents. Each type of reimbursable expense requires a unique DMH form to be completed by each agency: Form B-2 is for agency sponsored training fees, Form B-3 is for community outreach activity/training (COAT) and implementation materials, and Form B-3A must be completed when requesting reimbursement for any community outreach/training activity. The Department will now cross reference any reimbursement with the PEI Staff Registry. Reimbursement requests are processed and approved based on the training records in the staff registry. The new reimbursement request forms for FY 15-16 require the NPI (National Provider Identifier) number for each staff listed on the reimbursement request forms. DMH requires contracted agencies to submit the EBP Training Verification form on a quarterly basis. If DMH is unable to verify the staff member in the PEI Staff Registry for the specific EBP, then the agency will be asked to complete the EBP Training Verification form to indicate the training components that have been completed by the staff for that particular EBP.

2. The electronic format of the Forms B-2, B-3 and B-3A were emailed to all PEI providers in July of each fiscal year. However, agencies may also obtain these forms by request through email to MHSAPEI@dmh.lacounty.gov.

3. Where should reimbursement requests be mailed or hand delivered?
   Submit all reimbursement requests (Form B-2, B-3 and B-3A) with original signatures and all required verification documentation to the address below:

   County of Los Angeles, Department of Mental Health
   Provider Reimbursement Section
   550 S. Vermont Avenue, **8th Floor**
   Los Angeles, CA 90020

4. There is an error on the original invoice that was already submitted to PRS. Does DMH want the revised reimbursement requests delivered to PEI Administration Division?

   REVISIONS of original reimbursement requests that were initially submitted on time to PRS must be emailed or faxed (213) 252-8749 to PEI administration, but initial **ORIGINAL signed reimbursement requests must be mailed or delivered to Provider Reimbursement Section, 550 S. Vermont Ave., 8th Floor, LA, CA, 90020**. Please do NOT mail revisions to PRS as this creates confusion to their tracking system of the reimbursement requests already received.

5. Our agency does not know where all of our receipts are – do we have to submit original receipts? Can we just submit the invoice?

   Original receipts should be maintained at the agency. However, failure to submit any of the requested information may result in non-payment of agency expenses. Copies are acceptable.

6. Why must we send in canceled checks or other proof of payment? Can't a bill from the trainer/developer suffice?

   Cancelled check/credit card/statement/bank statement is required for auditing purposes to confirm actual expenses paid. Failure to provide proof of payment may result in non-payment of the entire invoice or disallowances for unconfirmed expenses.

7. Our agency has multiple sites; can we combine them on one form?

   Depending on the policies and procedures, some agencies prefer to use one form for all provider numbers. It is important that entries are separated by age group and by EBP. Please do not combine multiple EBPs or age groups on one form.

REIMBURSABLE EXPENSES

1. Is travel time to and from the training covered?

   No, travel time by staff is not a reimbursable expense. However, if the travel expenses of a developer/trainer are included in the agency's contract, then it is covered.

2. Are travel expenses reimbursable (i.e. mileage, air fare, parking, etc.)?

   Travel expenses are a reimbursable cost only if it is a part of the agency's contract with a developer/trainer. Otherwise, travel expenses incurred by staff are not reimbursable.

3. Are meals reimbursable?

   Staff meals are not a reimbursable cost. However, if meals are part of the agency's contract with a developer/trainer (i.e., per diem for the trainer), then these meals are covered.

4. Are the fees paid for consultation calls reimbursable through these training funds? If yes, what documents are required?

   Yes, fees for consultation calls are reimbursable if it is a required component of the EBP's training protocol.

Complete Form B-2 – Submit trainer/consultant contract/invoice, cancelled check or credit card statement showing the payment. Verification will be conducted by DMH prior to reimbursement for consultation calls.

5. Do reimbursable expenses include costs of consultation calls, audio tape reviews, recordings, and booster trainings?
   Yes, if it is a required component of the training protocol approved by DMH.

6. Can agencies send students/interns to be trained in EBPs and receive reimbursement through the invoicing process?
   If the individual is authorized to bill DMH for PEI services and has been fully trained in the specific EBP model, then the training fees can be reimbursed. Agencies that want to train their interns, students, trainees in any EBP must submit and obtain prior DMH approval for its training plan for such students/interns to start EBP training. Agencies must ensure that their students/interns complete the EBP training protocol before such students/interns leave the agency and within the required one-year time limit.

7. Is the time spent on assessment reimbursable through these training funds?
   No. These are services that should be billed to the IS/IBHIS.

8. Will the training funds cover the cost of outcome measures?
   Contact the PEI Outcomes Unit via their email address at PEIOutcomes@dmh.lacounty.gov to obtain outcome measures. If the outcome measure is related to an approved EBP that the agency is implementing, DMH will cover the cost. PEI Administration Division may reimburse for outcome measures that are not supplied by the Outcomes Unit AND upon their approval.

9. If former staff who were trained during the current fiscal year have since left our agency, can we include their training costs on our invoice for reimbursement through the PEI training funds?
   Yes, as long as the staff was trained in the current fiscal year time period while employed by the agency requesting reimbursement, payment will be authorized.

10. Can agencies be reimbursed for reading time?
    No, this is not a reimbursable expense.

11. Can an agency be reimbursed for the cost of renting a venue when hosting a DMH approved EBP training?
    Yes. DMH reimburses for the cost of a venue if it is reasonably priced and provided in the contract between the developer/trainer and provider/agency. If the venue is not included, then DMH requires prior approval before a commitment is made to determine if it is payable or not. It is recommended, to avoid delays, that agencies seek prior approval of a venue to conduct an EBP training and include it in the contract.

12. Our agency would like to use up all of our allocation this fiscal year. Can we schedule and pay for EBP trainings to occur in a future fiscal year but paid for the training in advance?
    No. Trainings must not only be planned but must occur prior to the end of the fiscal year, to be eligible for reimbursement in the current fiscal year. Reimbursement for

trainings that occur in a future fiscal year must also be planned and rendered in the same fiscal year. Providers are strongly encouraged to require developers/vendors/trainers to submit billing to them on a monthly basis and not collapse multiple months together, which may include dates crossing over into the next fiscal year. PEI funding may not be provided in a future fiscal year.

13. What does DMH require to be included on the venue receipt/invoice?
    DMH requires a full description of line item charges, itemizing each cost that adds up to the grand total cost of the venue, i.e., audio visual costs, tax, set up cost, etc. Food and beverages are not reimbursable costs and will be denied if listed on the receipt/invoice.

14. Can an agency be reimbursed for the cost of the MAP database subscriptions?
    For agency staff that was trained directly by PracticeWise, the subscriptions are a reimbursable training expense by completing the B-3 form.

NON-REIMBURSABLE COSTS

1. Can I include the cost of food and drinks that were provided at an agency-sponsored DMH approved EBP training and/or community outreach and implementation activity on a Form B-2 or B-3, respectively, and receive reimbursement?
   No. Food and drinks are not reimbursable costs; and if they are included on the invoice, then they will be denied.

2. Can agencies receive reimbursement for audio recorders or other electronic equipment?
   No.

3. If the cost of food and drinks are included on a vendor and/or venue contract, can the agency receive reimbursement for paying for those items?
   No. Food and drinks are not reimbursable costs, even if they are included on the invoice or contract. However, if travel expenses (cost of food and lodging) are included in the contract, then these costs are reimbursable only for trainers (if the trainer has come from out of state).

4. Can agencies receive reimbursement for general toys, group prizes or general office supplies?
   No. There are very limited therapeutic toys that are reimbursable under the PEI training funds.

5. Can agencies receive reimbursement for their staff time or fees related to learning collaboratives?
   No, learning collaboratives are recommended but are not required.

6. Can agencies receive reimbursement for technical assistance, administrative fees, implementation support or training coordinator fees?
   No.

7. Can agencies receive reimbursement for parking expenses?
   No.

8. Can agencies receive reimbursement for room modifications or construction?

No.

9. Can agencies receive reimbursement for the trainer's administrative or implementation support fees (typically requested for Group CBT)?
   No.

10. Can agencies receive reimbursement for parking expenses?
    No.

11. Is on-line TF-CBT webinar training reimbursable?
    No. Staff time is no longer reimbursed.

12. Will staff be able to obtain reimbursement for taking the optional Grief Online training that is offered after taking the TF-CBT Webinar Online training?
    No.

13. Is the DMH sponsored MAP symposium reimbursable under one time training funds?
    No.

14. Are the trainings for mandatory competencies for the Birth to Five populations (such as the DC 0-3 Diagnosing Infant and Early Childhood MH and Developmental Disorders) reimbursable?
    No. These trainings are not specific EBP trainings and are not a requirement of any EBP training protocol.

15. Does the MATCH book for MAP qualify for reimbursement?
    No.

16. Can we send a HWLA clinician to attend the TF-CBT training since we are seeing a lot of trauma in one of our sites? Can we use our training dollars to pay for the registration fee and staff time?
    If agencies want reimbursement of the PEI One Time training funds, the therapists must be providing PEI services. We will not reimburse for the staff time nor fees related to HWLA or any other non-PEI related services.

17. How do we request reimbursement of the outcome measure trainings sponsored by DMH?
    We do not reimburse for staff time during this fiscal year.

18. Is the staff time for the ICARE training reimbursable?
    ICARE training is recommended to use with CPP but it is not required and, therefore, it is not reimbursable.

DMH SPONSORED TRAINING (FORM B-1)

1. Our staff attended a DMH sponsored training; can we receive reimbursement for their staff time at this training?

DMH has not reimbursed for the staff time at DMH sponsored trainings since July 1, 2014. Starting with FY15-16, DMH will be offering DMH sponsored trainings in the five most commonly used EBPs. However, DMH will not reimburse for the staff time at these trainings.

AGENCY-SPONSORED TRAINING FEES (FORM B-2)

1. Can I use one form to include all of the EBPs (and staff names) that our agency was trained in?
   No. Agencies must use one form per age group and EBP (with the names of staff who were trained in that age group and EBP). Do not combine EBPs and age groups on one form.

2. Does Form B-2 apply only to trainings that an agency has hosted?
   Yes. This form can be used to receive reimbursement for agency hosted approved EBP trainings including developer/trainer costs, consultation call fees, and training materials incurred during the current fiscal year.

3. Can agencies bill for staff that have previously been trained in EBPs?
   Yes, but only if the staff's training occurred during the qualifying current fiscal year and funds are available.

4. Can agencies bill for staff that were trained by their own agency staff (internal trainer/Train-the-Trainer)?
   Yes – provided that such agency staff were certified and authorized by a DMH approved developer to conduct training in the agency. The agency must submit proof of such certification as an authorized DMH approved trainer. The hourly rate of an internal trainer's compensation is $36.33 per hour.

5. If we bought training materials, do we need to itemize them and provide the staff names for the distribution of these materials?
   Yes, the agency must identify the staff that will receive the training materials. The staff must be trained in the specific EBP in order to receive reimbursement for the training materials. It is necessary for the agency to itemize the materials and provide supporting verification documents.

6. Do we need to fill in every column, including the hourly rate or unit cost, or can we just fill in the total cost?
   Please complete the entire Form B-3. Agencies must indicate the name of the staff that have attended the training or received any services.

7. Can agencies obtain reimbursement for group consultation (i.e., if is an IPT requirement)?
   Yes, if the group consultation is listed on the DMH approved protocol for IPT and is identified as part of the training in the agency's contract, then it qualifies for reimbursement.

8. Some of my staff and I attended the IPT booster training last week with a DMH approved vendor/trainer. Do I need to complete a B-2 form for that training?

If the agency contracted directly with the vendor/trainer and paid them directly for the training, please complete the Form B-2 and attach the verification documents as indicated in the attachment of the electronic Form B-2.

9. Can an agency receive reimbursement for the MAP subscriptions?
   Yes, agencies can receive reimbursement by completing the Form B-2 and attaching the required verification documents.

10. Are the "PCIT for Traumatized Children" and "PCIT Advance Skills" webinars reimbursable?
    No, DMH will not reimburse for staff time during this fiscal year.

11. When we register our staff with an outside agency for training, do we have to submit something in writing stating that the follow up calls are included in the registration fee or is that assumed?
    No. If an agency contracted with a consultant/trainer for training that includes consultation calls, then DMH will need a copy of the contract indicating the services to be rendered or a letter from the consultant/trainer verifying the staff and dates of the consultation calls, as it is not automatic or payable if it is not in the contract. We recommend that providers contract for the entire training protocol and not by separate components.

12. Can I put all consult calls for a month on the same B-2 even if they are different calls?
    Yes, as long as the calls are for the same EBP and the same age group. If the calls are for a different EBP and age group, then agencies must use separate B-2 forms.

13. An EBP training is 20% Child and 80% TAY, how do I indicate this on the reimbursement Forms?
    Agencies must choose one age group for each EBP training. If agencies choose to use both age groups, then they must break down the amount per age group so that it adds up to the amount being requested (i.e. 1 day training fee, $500, would be divided by each age group, $100 (20%) for Child and $400 (80%) for TAY).

14. How do we request for reimbursement of training fees, $8000, for a 1 year contract?
    Since DMH can only reimburse for trainings that have been completed, agencies must break down the fees per month, for 12 months. Agencies must request reimbursement of these fees per month by submitting the Form B-2 along with the same contract, certificates of attendance (signed by trainer) or sign in sheets, and proof of payment. For example, an agency would request $666.66 per month if they have paid $8000 for a 1 year of trainings. DMH will not pay in advance for trainings that have not been completed.

15. Can we request reimbursement of the CPP consult groups which are facilitated by our CPP Supervisor? They completed the CPP Supervisors' Training a while back and has been providing CPP now for over 2 years. Can we claim this time on a B-2 Form?

No, we do not reimburse for supervision of staff. Consultation must be provided by an authorized trainer of the specific EBP.

16. One of our staff who has been trained as a MAP trainer is now leading a training for some staff. I have completed the Form B-2 to get reimbursed for it. Is this the correct form and do I need anything else?

    Yes, it is the correct form, but agencies must also submit the trainer's certificate, sign-in sheets and timed agenda for each day of training.

17. For reimbursement of agency-sponsored training, can sending staff to the EBP Symposium by CIMH for ART and TF-CBT count as booster trainings? If yes, can it count even if they've had a booster training in the past?

    No, the trainings have to be specific to an EBP and part of the training protocol. We do not typically reimburse for symposiums. The only possibility would be if the symposium is listed as part of the training protocol.

18. Can funds be used to cover extra staff time to set up and clean up for a training?

    No.

19. Can we get reimbursement of technology products and infrastructure to support EBP implementation? Specifically, the purchase of recorders so staff can tape their sessions as part of the EBP certification/credentialing process?

    No, we do not reimburse for any electronic equipment or products.

20. Can we get reimbursement of the cost of T-1 internet connection to allow for videoconferencing about our EBP implementation across our multiple sites?

    No, we do not reimburse for the cost of T-1 internet connection.

21. Can we get reimbursement for the coordination of PEI training funds and EBP certification (i.e. the time spent on the submission of the reimbursement requests, management of an internal database to track EBP trainings and the status of staff EBP certification)?

    No.

22. Our MAP internal trainer/supervisor provided a 5-day initial training for our staff. Is the MAP internal trainer/supervisor's time conducting the training and preparation time reimbursable?

    Yes, the agency may request reimbursement by using the Form B-2 and attach all of the required verification documents. The preparation time for a 5-day training may not exceed more than 1 hour per day of training.

23. Will we be able to submit requests for reimbursement of cost of training for Triple P Level 3? Once our staff is trained in Triple P Level 3, can we submit requests for reimbursement for the services they deliver on the Community Training Form?

    No. Triple P Level 3 is not reimbursable under Early Intervention. Triple P Level 3 is only for Prevention Only Programs.

24. We paid for our MAP training in April, but the training will take place in June. I have the training contract/agreement and proof of payment made in April. Should I submit the request for reimbursement for April or June?

    The request must be submitted with the June reimbursement requests because that is when the training will be completed. DMH will only reimburse for trainings that have been completed.

25. What is the hourly rate of reimbursement for the internal trainer's time?

    Reimbursement would be at $36.33 per hour.

26. Do we need to contract with the same trainer for an entire training protocol?

    Yes, staff must complete the entire training protocol with the same trainer. Providers requesting reimbursement for training will be required to submit the contract or agreement with trainer that will indicate the timeline of completing the entire training protocol with the same trainer in order to receive reimbursement of the initial training.

27. Can an in-house TF-CBT supervisor provide consultation calls if there is an established TF-CBT team already in place?

    Yes, but the 2 day initial training, booster training and audio reviews must be provided by an authorized TF-CBT trainer. Reimbursement will only be approved for fees paid to an authorized TFCBT trainer.

28. Our DVD recorder is broken, so we had to have it fixed – is that expense reimbursable since some EBP's require that the sessions be recorded?

    No.

COMMUNITY OUTREACH ACTIVITY/TRAINING AND IMPLEMENTATION MATERIALS (FORM B-3 & B-3A)

1. Can we request reimbursement for printing materials about our PEI programs that we distributed to the community?

    Yes. These costs are reimbursable, but copies of relevant verification documentation such as cancelled checks, redacted bank or credit card statements, and descriptions of materials should be attached to the invoice when submitted.

2. We translated our community education materials. Can we get reimbursed for the translation costs?

    These costs are reimbursable as long as these are for community education materials about the agency's PEI programs.

3. Some materials prepared by developers have not been translated into the languages that many of our clients need. Can we get reimbursed for the cost of translating these materials, including workbooks?

    Yes, agencies must first obtain the written authorization by the developer to translate the materials. All training materials are the property of the developer and require written approval prior to being translated.

4. Can agencies obtain reimbursement for the time it takes staff to create their educational brochures?

   DMH will reimburse agencies for a reasonable amount of time it takes to create a brochure about the agency's PEI programs. This will be monitored on a case-by-case basis.

5. What is the hourly rate of compensation for staff who engages in community outreach activities/training (COAT)?

   The hourly rate of compensation is $36.33 per hour.

6. How do we report our community training and implementation activities?

   A description of the activities must be submitted on Form B-3A, as an attachment to the Community Training and Implementation Activities, Form B-3.

7. What if we go over the 10% limit of our training funds that is allowable for community outreach activities/training (COAT)?

   The 10% rate is not an absolute maximum rate, and requests will be reviewed on a case-by-case basis.

8. Are presentations to parents or teachers in small groups, at a faculty meeting, at a PTA meeting, back-to-school night, etc., to educate about trauma, depression, anxiety, etc. and to explain our agency's EBP programs covered?

   Yes. Such presentations qualify as community training if EBP programs are covered.

9. Could we purchase books for TF-CBT and request reimbursement for these materials?

   Yes, agencies can request reimbursement of the TF-CBT manual (Treating Trauma and Traumatic Grief in Children and Adolescents by Cohen*).*

10. We've purchased incentives/prizes for children that attend and participate in our groups. Would this purchase qualify for reimbursement?

    No, DMH does not reimburse for food or prizes.

11. Is the outcome measure, Ages & Stages Questionnaire, required to use for CPP?

    No.

12. If an EBP provider goes to a conference to specifically talk about their services, would this count as marketing? The conference is out of state.

    We can only reimburse for the time spent presenting on the specific EBPs approved for the agency. DMH does not reimburse for the staff member's travel expenses or attendance of a training or conference.

13. Can we request reimbursement of the time spent, one-on-one, with an individual informing them about PEI services?

    Yes. Submit requests for reimbursement using the Forms B-3 and B3A. Community outreach can be conducted with an individual, small group or large groups as long as staff is presenting and educating them about specific EBPs under PEI approved for the agency.

14. Which form should I complete to request reimbursement of the cost of training materials versus implementation materials?

    The Form B-2 should be used to request reimbursement for the cost of training materials required for the EBP training. The Form B-3 should be used to request reimbursement for the cost of implementation materials.

15. We have two provider numbers and two locations. We sent two staff, one from each site, to a community outreach event a few weeks ago. Would we complete one form for each staff (one provider number) and combine the time, or can we bill only once?

    Complete one Form B-3A for the community outreach activity indicating all of the provider numbers and staff if the EBP and age group are the same. Complete a Form B-3 for each provider number and staff, distinguishing the age group and EBP as applicable. If it is different EBPs and age groups, then agencies will have to submit a separate Form B-3 and B-3A as appropriate. If there are multiple pages for one community outreach activity, then the total amount being requested should be divided among each Form B-3.

MISCELLANEOUS

1. Will checks include an invoice number to assist agencies reconcile back to their respective reimbursement requests?

    DMH reimbursements will follow the same process as other items paid by the Department's Provider Reimbursement Section. When in doubt about a check issued for PEI training reimbursement, please contact your PRS liaison.

2. Who do I contact regarding MHSA PEI EBP questions?

    Please email our PEI Administration Division mailbox for all PEI EBP-related matters at MHSAPEI@dmh.lacounty.gov.

3. Who do I contact regarding questions about the reimbursement of PEI Training Funds?

    If you have any questions or need additional information regarding the reimbursement of PEI training funds, please email Olivia Sanchez-Baynham at osanchez@dmh.lacounty.gov or call (213) 251-6717.

Section

9

Program Monitoring and Technical Assistance Site Visits

PEI Administration Division provides oversight and technical assistance to the PEI funded programs in Los Angeles County. Program monitoring is required by the State of California and County of Los Angeles, as well as by State MHSA guidelines and the PEI Regulations. The primary methods of program monitoring are through site visits and analysis of PEI claiming for services.

9.1 PEI Technical Assistance Site Visits FY 12-13

In 2012, the PEI Administration Division began Technical Assistance Site Visits (TASVs) to 122 PEI funded providers, collaborating with other Department units that have responsibility for PEI programs. Over 90 staff from the Program Support Bureau, Childrens System of Care, Transition-Age Youth System of Care, Adult System of Care, Older Adults System of Care, and the MHSA Implementation and Outcomes Division Unit participated in the planning and preparation, generating data reports, attending the on-site visits, providing follow-up assistance, and writing of the final reports. The purpose of the site visits was to gain increased understanding of the PEI implementation process since transformation, as well as to provide support to the PEI providers. The TASVs were conducted in order to:

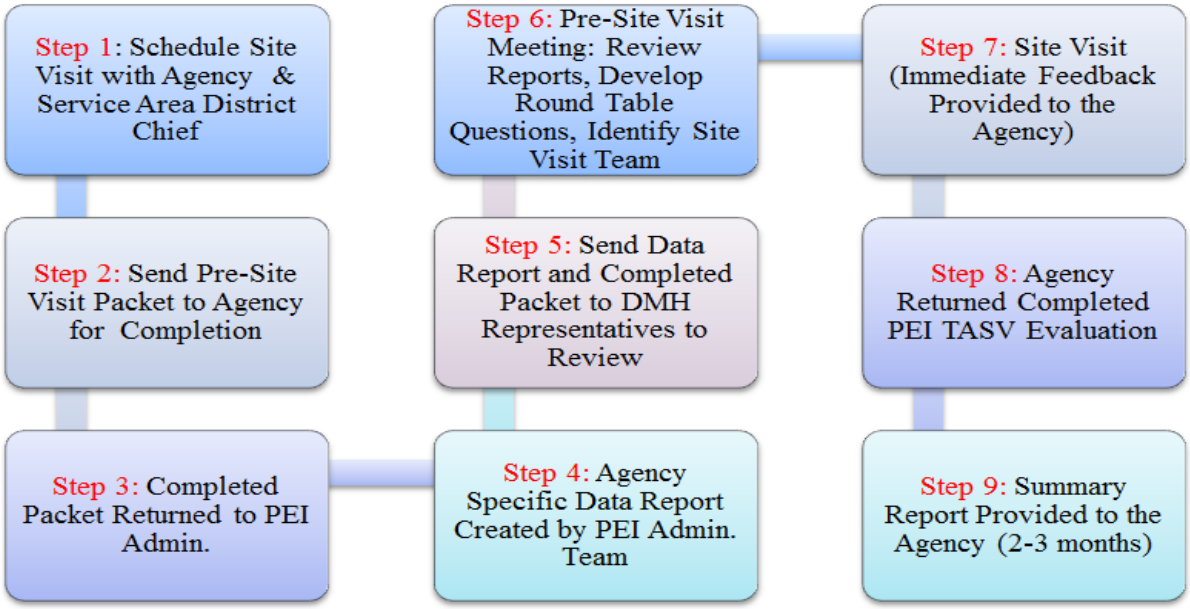
1. Ensure fidelity to PEI Program implementation;
2. Improve sustainability of PEI Practices;
3. Help agencies claim appropriately;
4. Provide information and resources;
5. Share PEI principles; and
6. Prepare agencies for future monitoring visits.

The specific objectives of the site visits were to:

1. Gather information regarding the PEI transformation process at the agency level
2. Identify agency successes and challenges
3. Collaborate with agencies to appropriately claim for services
4. Provide technical assistance including support for fidelity and sustainability

5. Identify resources to support implementation of PEI Practices

The nine-step process is depicted in the TASV Flow Chart below.



Agency specific data reports were created to provide agencies comprehensive information about their PEI Program. The data report included the following information: claiming trends, utilization of PEI allocation, allocation and claiming, client demographics, average cost per client, claiming by PEI Practices, breakdown of the clients served, claiming patterns, core vs. non-core services, practice-specific information, staffing information, and outcomes data. In addition, county-wide data charts were created and updated quarterly to provide agencies a reference to observe their progress in comparison to countywide PEI implementation.

9.2 Monitoring and Technical Assistance Site Visits FY 14-16

In the first round of TASVs, PEI Administration Division focused on learning about agency experiences and challenges in implementing PEI programs as well as providing technical assistance. Lessons learned in implementation from the 122 agencies as well as Department concerns were shared in order to improve services and be in compliance with PEI guidelines. In 2014, the second round of site visits was undertaken, with an emphasis on monitoring and program compliance, resulting in Monitoring and Technical Assistance Site Visits (MTASVs).

In addition to technical assistance, the MTASVs focus on fidelity to the EBP/PP/CDE practices and sustainability of PEI programs. Agencies progress on the following key indicators supporting effective and successful PEI programs are examined:

1. Claiming
2. Target Population
3. Quality Assurance

4. Training
5. Supervision and Staff Support
6. Agency and Administrative Support
7. Data Reporting
8. Outcome Utilization
9. Fidelity
10. Sustainability

The PEI Administration Division continues to provide agency-specific data charts, countywide data reports for comparison, roundtable questions that are incorporated during data chart review, and a site visit debrief to provide agencies the immediate feedback of the visit.

Additionally, PEI Administration Division conducts chart reviews of the PEI practices the agencies have implemented since FY 13-14. A chart review checklist indicating the items to be reviewed in each chart is provided in advance to the agency. The MTASV Fact Sheet on the following page summarizes the site visit.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
MHSA PREVENTION AND EARLY INTERVENTION (PEI)

2014-16 PEI Monitoring and Technical Assistance Site Visits
FACT SHEET

Purpose	Monitoring and Technical Assistance Site Visits (MTASVs) will be conducted with each Legal Entity (LE) and DMH Directly Operated (DO) Clinic implementing the PEI Program in order to: • Assess implementation trends along identified indicators and highlight areas in which improvement is needed. • Determine agency performance in providing PEI services in accordance with PEI Guidelines. • Work collaboratively to strengthen the implementation process, increasing the potential for sustainability of the PEI Practices and Program.	
Expected Outcomes	As a result of the MTASVs, the Department will: • Ensure our ability to continue to provide the highest level of client care and clinical outcomes. • Identify and share effective implementation strategies and information among our providers. • Increase the potential for sustainability of the PEI Practices and Program. • Expand and enhance its range of supports for PEI implementation.	
Components of Site Visit	The site visit will consist of: • Discussion of the agency's responses to the PEI Pre-Site Visit Questionnaire and PEI Practice-Specific Questionnaire. • Review of the agency's PEI Data Report and Staff Registry Report. • Verification of staff training certificates and plans for completing training. • Review of selected PEI clients' charts. • Summary discussion to share the MTASV findings and develop recommendations and strategies for the agency's PEI Program.	
Site Visit Process	Key steps in the MTASV: • DMH staff will schedule and conduct a site visit with each LE and DO, beginning with pilot sites in December 2014. • For LEs with multiple provider sites, DMH will conduct the initial MTASV at the primary site, and then may conduct subsequent MTASVs at selected provider sites. • Providers complete Pre-Site Visit Questionnaires and submit an updated Staff Verification Form, • Prior to the visit, Providers will receive roundtable questions, data reports, and a list of clients whose charts will be reviewed. • The visit will last approximately 6-hours, generally from 9:00 AM to 3:00 PM. • The MTASV Report will be distributed to the Provider, District Chiefs, and Deputy Director. • If required, a Quality Improvement Plan must be submitted to PEI Administration 15 days subsequent to the agency's receipt of the report.	
Who Attends	<u>Providers:</u> Administrators, Supervisors of PEI Practice(s), Clinicians, Finance, Data Entry Personnel	<u>DMH (4 to 6):</u> PEI Administration, Outcomes Division, Practice Lead, Age Group/Service Area Lead, Quality Assurance

9.3 Performance-Based Criteria

DMH uses performance-based criteria during the MTASVs, as required in the PEI Regulations. Data is extracted from the IS, MCA Report, OMA, and the CiMH Program Performance Dashboard Report. Data charts covering practices implemented, a demographic breakdown of the clients served, claiming patterns, core vs. non-core services, diagnostic itemization outcome measures, and average costs per client were developed with the intended goal of providing a comprehensive overview of each agency's PEI program. DMH generated county-wide data charts provide a reference for comparing individual agency progress against the countywide PEI implementation.

Section 10

Contacts, References and Resources

The Department of Mental Health has various departments and units that share an array of responsibilities to oversee the implementation of the MHSA PEI Plan throughout the County of Los Angeles. The contact information for the various DMH units are listed in this Section 10. Please note that staff assignments may change. For any questions about current staff responsibilities, please contact the PEI Administration Division at MHSAPEI@dmh.lacounty.gov.

10.1 PEI Administration Division

The PEI Administration Division has general oversight and monitoring of the implementation of the practices. The PEI Administration Division is responsible for the implementation, monitoring, and assesment of PEI programs in Los Angeles County. PEI Administration Division provides information on specific MHSA plans in order to prepare the Annual Update. This division helps define the appropriateness of claiming and approves proposals for new programs and PEI training reimbursement requests. See the list of the PEI Administration Division staff below.

PEI ADMINISTRATION DIVISION			
MHSA PEI Email:	MHSAPEI@dmh.lacounty.gov		
Main Telephone:	(213) 251-6712		
Fax:	(213) 252-8749		
NAME	**TITLE**	**PHONE**	**EMAIL**
Lillian Bando J.D., MSW	Mental Health Clinical Program Manager III	(213) 251-6710	lbando@dmh.lacounty.gov
Keri Pesanti Psy.D	Mental Health Clinical Program Head	(213) 251-6721	kpesanti@dmh.lacounty.gov
Edward Washington MSW	Health Program Analyst II MTASVs Questions	(213) 251-6727	edwashington@dmh.lacounty.gov
Olivia Sanchez Psy.D	Health Program Analyst I *Training Reimbursement Questions	(213) 251-6717	osanchez@dmh.lacounty.gov

10.2 PEI Age Group Leads

The Age Group Leads focus on the PEI programs and EBP/PP/CDEs that serve their specific age group responsibility. They address issues and concerns about their target age group population. See the list of PEI Age Group Leads below.

PEI AGE GROUP LEADS			
AGE GROUP	**LEADS**	**OFFICE #**	**EMAIL**
CSOC	Kalene Gilbert	(213) 739-5403	kgilbert@dmh.lacounty.gov
	Francisco Tan	(213) 739-5428	ftan@dmh.lacounty.gov
	Michael Alba	(213) 739-5434	malba@dmh.lacounty.gov
TAY	Sermed Alkass	(213) 738-4715	salkass@dmh.lacounty.gov
ASOC	Scott Hanada	(213) 738-6120	shanada@dmh.lacounty.gov
	Victoria Lee	(213) 738-2901	vdlee@dmh.lacounty.gov
OA	Martin Jones	(213) 639-6002	mjones@dmh.lacounty.gov
	Carol Sagusti	(213) 738-2322	csagusti@dmh.lacounty.gov
	Liam Zaidel	(213) 738-2305	lzaidel@dmh.lacounty.gov

10.3 DMH PEI Practice Leads Contact

DMH staff are designated as Practice Leads for specific EBP/PP/CDE practices that are being implemented throughout LA County. In general, every EBP/PP/CDE has a designated Practice Lead; in instances where only one agency is implementing a practice, the PEI Administration Division staff are the Practice Lead. The responsibilities of Practice Leads include the folowing:

- Be knowledgeable about the practice
- Work with the developer or trainer on the implementation of the practice
- Know the resources for the practice and the DMH requirements
- Develop FAQs
- Determine appropriateness of claiming
- Determine the core versus non-core services
- Work with developer on training protocols
- Track training issues
- Provide technical assistance to providers and respond to questions
- Provide recommendations for implementation, effectiveness and sustainability
- Write purchase orders or statements of work as needed for training funded by DMH

See the list of DMH PEI Practice Leads on the next page.

Los Angeles County - Department of Mental Health
PROGRAM SUPPORT BUREAU
Prevention and Early Intervention

PEI PRACTICE LEADS (as of 7/1/2016)

EVIDENCE-BASED PROGRAMS, PROMISING PRACTICES, COMMUNITY-DEFINED EVIDENCE PRACTICES, & PILOTS			Age Group*	Age Range	Practice Lead	Email Address
1	ART	Aggression Replacement Training Aggression Replacement Training-**Skillstreaming**	C, T	12-17 5-12	Sermed Alkass	SAlkass@dmh.lacounty.gov
2	AF-CBT	Alternatives for Families Cognitive Behavioral Therapy	C	5-17	Michael Alba	MAlba@dmh.lacounty.gov
3	BSFT	Brief Strategic Family Therapy	C,T	10-18	Mike Alba	MAlba@dmh.lacounty.gov
4	CFOF	Caring for Our Families	C	5-11	Michael Alba	MAlba@dmh.lacounty.gov
5	CAPPS	Center for the Assessment & Prevention of Prodromal States	T	16-25	Sermed Alkass	SAlkass@dmh.lacounty.gov
6	CPP	Child-Parent Psychotherapy	C	0-6	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
7	CBITS	Cognitive Behavioral Intervention for Trauma in Schools	C,T	10-15	Michael Alba	MAlba@dmh.lacounty.gov
8	CORS	Crisis Oriented Recovery Services	C,T, A, OA	3+	Adriana Armenta	AArmenta@dmh.lacounty.gov
9	DBT	Dialectical Behavior Therapy	A	18+	Urmi Patel Lynn McFarr	UPatel@dmh.lacounty.gov L.McFarr@ucla.edu
10	DTQI	Depression Treatment Quality Improvement	C	12-20	Michael Alba	MAlba@dmh.lacounty.gov
11	FOCUS	Families OverComing Under Stress	C,T, A, OA	5+	Carl McKnight	CMcknight@dmh.lacounty.gov
12	FFT	Functional Family Therapy	C,T	10-18	Sermed Alkass	SAlkass@dmh.lacounty.gov
13	Group CBT	Group Cognitive Behavioral Therapy for Major Depression	A	18+	Urmi Patel	UPatel@dmh.lacounty.gov
14	IY	Incredible Years	C	0-12	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
15	Ind CBT	Individual Cognitive Behavioral Therapy	A	18+	Urmi Patel	UPatel@dmh.lacounty.gov
16	IPT	Interpersonal Psychotherapy for Depression	C, T, A, OA	12-60+	Keri Pesanti Rosalie Finer	KPesanti@dmh.lacounty.gov RFiner@dmh.lacounty.gov
17	LIFE	Loving Intervention Family Enrichment Program	C,T	4-19	Michael Alba	MAlba@dmh.lacounty.gov
18	MPAP	Make Parenting A Pleasure **RFI (Prevention)**	A	0-8	Edward Washington	EdWashington@dmh.lacounty.gov
19	MAP	Managing and Adapting Practice **Age Range Varies by Treatment Focus**	C,T	2-21	Michael Alba	MAlba@dmh.lacounty.gov
20	MP	Mindful Parenting	C, T	0-3	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
21	MDFT	Multidimensional Family Therapy	C, T	11-18	Yivette Odell	YOdell@dmh.lacounty.gov

PEI PRACTICE LEADS (as of 7/1/2016)

EVIDENCE-BASED PROGRAMS, PROMISING PRACTICES, COMMUNITY-DEFINED EVIDENCE PRACTICES, & PILOTS			Age Group*	Age Range	Practice Lead	Email Address
22	MST	Multisystemic Therapy	T	11-17	Yivette Odell	YOdell@dmh.lacounty.gov
23	NFP	Nurse-Family Partnership	C,T	11-35	Kimberly Ronan	KRonan@dmh.lacounty.gov
24	OBPP	Olweus Bullying Prevention Program **(Prevention)**	C	6-17	Edward Washington	EdWashington@dmh.lacounty.gov
25	OE	Outreach and Education **RFI (Prevention)**	C, T, A, OA	0-18	Lillian Bando	LBando@dmh.lacounty.gov
26	PATHS	Promoting Alternative Thinking Strategies	C	5-12	Michael Alba	MAlba@dmh.lacounty.gov
27	PST	Problem-Solving Therapy	OA	60+	Liam Zaidel	LZaidel@dmh.lacounty.gov
28	PCIT	Parent-Child Interaction Therapy	C	2-7	Amber Cardenas	AmCardenas@dmh.lacounty.gov
29	PEARLS	Program to Encourage Active and Rewarding Lives for Seniors	OA	60+	Liam Zaidel	LZaidel@dmh.lacounty.gov
30	PE	Prolonged Exposure Therapy for Post Traumatic Stress Disorder	A	18-70+	Carl McKnight	CMcknight@dmh.lacounty.gov
31	RPP	Reflective Parenting Program	C	0-12	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
32	SS	Seeking Safety	C,T, A, OA	13+	Sermed Alkass	SAlkass@dmh.lacounty.gov
33	SF	Strengthening Families	C	3-16	Michael Alba	MAlba@dmh.lacounty.gov
34	TF-CBT	Trauma Focused Cognitive Behavioral Therapy	C,T	3-18	Michael Alba	MAlba@dmh.lacounty.gov
35	Triple P	Triple P - Positive Parenting Program Triple P-Level 2-3 **RFI (Prevention)**	C,T	0-18	Michael Alba Edward Washington	MAlba@dmh.lacounty.gov EdWashington@dmh.lacounty.gov
36	UCLA TTM	UCLA Ties Transition Model	C,T	0-9	Allegra Klacsmann	AKlacsmann@dmh.lacounty.gov
Group Key: C = Child (0-15), T = Transition-Age Youth (16-25), A = Adult (26-59), OA = Older Adult (60+)						

10.4 PEI Service Area Coordinators

PEI Service Area (SA) Coordinators function as a resource for providers. The PEI SA Coordinators are responsible for providing education and training (at Service Area provider meetings, Quality Improvement Committee (QICs), and in other ways) regarding EBPs and their implementation. PEI coordinators also provide technical assistance via telephone, email, review and respond to written materials and at site visits. They may assist with contract monitoring of PEI specific issues, e.g., populations being served. They must ensure that the population served is congruent with the designated population for the EBPs. In addition, these coordinators review provider data (pulled by Service Area District Chief, analyst, contract monitor, etc.) and take action, if needed, with providers regarding findings not within program expectations. PEI Coordinators attend Service Area Provider meetings, Service Area PEI Coordinators' meetings, and other Service Area community meetings to ensure there is consistency in the implementation of the PEI Plan. See the list of PEI Service Area Coordinastors below.

SA	PEI COORDINATOR			DISTRICT CHIEF
1	TBD	N/A	N/A	JoEllen Perkins (661) 223-3827 JPerkins@dmh.lacounty.gov
2	Darwin Puno	(213) 738-4999	DPuno@dmh.lacounty.gov	Eva Carrera (213) 738-3190 ECarrera@dmh.lacounty.gov
4	Kary To	(213) 738-3504	KTo@dmh.lacounty.gov	Ed Vidaurri (213) 738-3765 EVidaurri@dmh.lacounty.gov
5	Tora Miller	(310) 482-6617	TMiller@dmh.lacounty.gov	Jacquelyn Wilcoxen (310) 584-3700 JWilcoxen@dmh.lacounty.gov
6	TBD	N/A	N/A	Yolanda Whittington (323) 298-3671 YWhittington@dmh.lacounty.gov
7	Alicia Llamas	(213) 738-2978	ALlamas@dmh.lacounty.gov	Ana Suarez (213) 738-3499 ASuarez@dmh.lacounty.gov
8	Ann Lee (Interim)	(562) 435-3027	ALee@dmh.lacounty.gov	Youngsook Kim-Sasaki (562) 435-2337 YKimSasaki@dmh.lacounty.gov

10.5 MHSA Implementation and Outcomes Division Contacts

To address the DMH PEI Program evaluation, the Department designated the MHSA Implementation and Outcomes Division to oversee PEI Program evaluation. This division was charged with the development of a methodology for the collection and analysis of data across all agencies and directly operated programs within Los Angeles County. See the list of MHSA Implementation and Outcomes Division contacts below.

MHSA Implementation & Outcomes Division Contacts			
Name	**Role**	**Email**	**Phone**
Debbie Innes-Gomberg	MHSA Implementation & Outcomes District Chief	digomberg@dmh.lacounty.gov	213-251-6817
Kara Taguchi	MHSA Implementation & Outcomes OMA Program Head	ktaguchi@dmh.lacounty.gov	213-251-6818
Alejandro Silva	MHSA Implementation & Outcomes PEI Outcomes Supervisor	asilva@dmh.lacounty.gov	213-251-6812
George Eckart	MHSA Implementation & Outcomes PEI Outcomes Staff	geckart@dmh.lacounty.gov	213-251-6511
Josh Cornell	MHSA Implementation & Outcomes PEI Outcomes Staff	jocornell@dmh.lacounty.gov	213-251-6570
M. Frances Pavon	MHSA Implementation & Outcomes PEI Outcomes Staff	m.pavon@dmh.lacounty.gov	213-251-6860
Ivy Levin	MHSA Implementation & Outcomes PEI Outcomes Staff	ilevin@dmh.lacounty.gov	213-480-3630
Omar Vasquez	CIOB/Solutions Developer OMA Supervisor	ovasquez@dmh.lacounty.gov	213-251-6624

10.6 Web Resources

MHSA PEI Administration	http://dmh.lacounty.gov
MHSA OMA	www.dmhoma.pbworks.com
IS Codes Manual	http://LAC-DMH.lacounty.gov/hipaa/index.html
Organizational Provider's Manual and the Procedure Codes Manual	http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals
MHSOAC	http://www.mhsoac.ca.gov/

APPENDIX 1

Article 2. Definitions

Adopt Section 3200.245 as follows:

Section 3200.245. Prevention and Early Intervention Component.

(a) "Prevention and Early Intervention Component" means the section of the Three-Year Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code.

Adopt Section 3200.246 as follows:

Section 3200.246. Prevention and Early Intervention Fund.

(a) "Prevention and Early Intervention funds" means the Mental Health Services funds allocated for prevention and early intervention programs pursuant to Welfare and Institutions Code section 5892, subdivision (a)(3).

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5892, Welfare and Institutions Code.

Article 5. Reporting Requirements

Adopt Section 3510.010 as follows:

Section 3510.010. Prevention and Early Intervention Annual Revenue and Expenditure Report.

(a) As part of the Mental Health Services Act Annual Revenue and Expenditure Report the County shall report the following:
  (1) The total funding source dollar amounts expended during the reporting period, which is the previous fiscal year, on each Program funded with Prevention and Early Intervention funds by the following funding sources:
    (A) Prevention and Early Intervention funds
      1. The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations. If the Programs are combined, the County shall estimate the percentage of funds dedicated to each Program.

(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funding

(2) The amount of funding expended for Prevention and Early Intervention Component Administration by the following funding sources:
(A) Prevention and Early Intervention funds
(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funding

(3) The amount of funding expended for evaluation of the Prevention and Early Intervention Component by the following funding sources:
(A) Prevention and Early Intervention funds
(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funds

(4) The amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

(b) The County shall within 30 days of submitting to the state the Mental Health Services Act Annual Revenue and Expenditure Report:
(1) Post a copy on the County's website; and
(2) Provide a copy to the County's Mental Health Board

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845, 5847, and 5899, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Adopt Section 3560 as follows:

Section 3560. Prevention and Early Intervention Reports.

(a) The County shall submit to the Mental Health Services Oversight and Accountability Commission the following Prevention and Early Intervention reports:
(1) The Annual Prevention and Early Intervention Program and Evaluation report as specified in Section 3560.010.
(2) The Three- Year Program and Evaluation Report as specified in Section 3560.020.

Adopt Section 3560.010 as follows:

Section 3560.010. Annual Prevention and Early Intervention Program and Evaluation Report.

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention Program and Evaluation Report.

(1) The first Annual Prevention and Early Intervention Program and Evaluation Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2017 as part of the Annual Update or Three-Year Program and Expenditure Plan and no later than December 30th every year thereafter except for years in which the Three-Year Program and Evaluation Report is due.

(2) The Annual Prevention and Early Intervention Program and Evaluation Report shall report on the required data for the fiscal year prior to the due date.

(3) The County shall exclude from the Annual Prevention and Early Intervention Program and Evaluation Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded infor mation pursuant subdivision (3) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Annual Prevention and Early Intervention Program and Evaluation Report that contains all of the information including the information that was excluded pursuant to subdivision (3). This supplemental report shall be marked "confidential."
2. A supplement to the Annual Prevention and Early Intervention Program and Evaluation Report that contains the information that was excluded pursuant to subdivision (3). This supplement to the report shall be marked "confidential."

(b) The County shall report the following information annually as part of the Annual Update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:

(1) For each Prevention Program and each Early Intervention Program list:

(A) The Program name.

(B) Unduplicated numbers of individuals served in the preceding fiscal year

1. If a Program served both individuals at risk of a mental illness (Prevention) and individuals with early onset of a mental illness (Early Intervention), the County shall report numbers served separately for each category.
2. If a Program served families the County shall report the number of individual family members served.

(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness Program or Strategy within a Program, the County shall report:

(A) The Program name
(B) The number of potential responders
(C) The setting(s) in which the potential responders were engaged
1. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.
(D) The type(s) of potential responders engaged in each setting (e.g. nurses, principles, parents)

(3) For each Access and Linkage to Treatment Strategy or Program the County shall report:
(A) The Program name
(B) Number of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.
(C) Number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.
(D) Average duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.
(E) Average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.

(4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:
(A) The program name
(B) Identify the specific underserved populations for whom the County intended to increase timely access to services.
(C) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.
(D) Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.
(E) Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.
(F) Description of ways the County encouraged access to services and follow-through on referrals

(5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:
(A) The following age groups:
1. 0-15 (children/youth)
2. 16-25 (transition age youth)

3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

(B) Race by the following categories:
1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:
1. Hispanic or Latino as follows
   a. Caribbean
   b. Central American
   c. Mexican/Mexican-American/Chicano
   d. Puerto Rican
   e. South American
   f. Other
   g. Number of respondents who declined to answer the question
2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used listed by threshold languages for the individual county

(E) Sexual orientation,
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer

6. Another sexual orientation
7. Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness

1. Yes, report the number that apply in each domain of disability(ies)
   a. Communication domain separately by each of the following
      (i) Difficulty seeing,
      (ii) Difficulty hearing, or having speech understood
      (iii) Other (specify)
   b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
   c. Physical/mobility domain
   d. Chronic health condition (including, but not limited to, chronic pain)
   e. Other (specify)
2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,

1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender

1. Assigned sex at birth:
   a. Male
   b. Female
   c. Number of respondents who declined to answer the question
2. Current gender identity:
   a. Male
   b. Female
   c. Transgender
   d. Genderqueer
   e. Questioning or unsure of gender identity
   f. Another gender identity
   g. Number of respondents who declined to answer the question

(6) Any other data the County considers relevant, for example, data for additional demographic groups that are particularly prevalent in the County, at elevated risk of or with high rates of mental illness, unserved or underserved, and/or the focus of one or more Prevention and Early Intervention funded services.

(7) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, the County may report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

(8) For all programs and Strategies, the County may report implementation challenges, successes, lessons learned, and relevant examples.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Adopt Section 3560.020 as follows:

Section 3560.020. Three-Year Program and Evaluation Report.

(a) The County shall submit the Three-Year Program and Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of the Three-Year Program and Expenditure Plan. The Three-Year Program and Evaluation Report answers questions about the impacts of Prevention and Early Intervention Component Programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.

(1) The first Three-Year Program and Evaluation Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2018 as part of the Three-Year Program and Expenditure Plan for fiscal years 2017/18 through 2019/20. The Three-Year Program and Evaluation Report shall be due no later than December 30th every three years thereafter and shall report on the evaluation(s) for the three fiscal years prior to the due date.

(2) The County shall exclude from the Three-Year Program and Evaluation Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded information pursuant subdivision (2) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Three-Year Program and Evaluation Report that contains all of the information including the information that was excluded pursuant to subdivision (2). This supplemental report shall be marked “confidential.”
2. A supplement to the Three-Year Program and Evaluation Report that contains the information that was excluded pursuant to subdivision (2). This supplement to the report shall be marked “confidential.”

(b) The Three-Year Program and Evaluation Report shall describe the evaluation of each Prevention and Early Intervention Component Program and two Strategies: Access and Linkage to Treatment and

Improving Timely Access to Services for Underserved Populations. The Report shall include the following:

(1) The name of each Program for which the county is reporting

(2) The outcomes and indicators selected for each Prevention, Early Intervention, Stigma and Discrimination Reduction, or Suicide Prevention Program

(3) The approaches used to select the outcomes and indicators, collect data, and determine results for the evaluation of each Program and the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(4) How often the data were collected for the evaluation of each Program and for the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(c) The Three-Year Program and Evaluation Report shall provide results and analysis of results for all required evaluations set forth in Section 3750 for the three fiscal years prior to the due date.

(d) The County may also include in the Three-Year Program and Evaluation Report any additional evaluation data on selected outcomes and indicators, including evaluation results related to the impact of Prevention and Early Intervention Component Programs on mental health and related systems.

(e) The County shall include the same information for the previous fiscal year that otherwise would be reported in the Annual Prevention and Early Intervention Program and Evaluation Report in response to requirements specified in 3560.010(b).

(f) The County may report any other available evaluation results in the County's Annual Updates.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Article 7. Prevention and Early Intervention

Adopt Section 3700 as follows:

Section 3700. Rule of General Application.

(a) The use of Prevention and Early Intervention funds shall be governed by the provisions specified in this Article and Articles 1 through 5, unless otherwise specified.

Adopt Section 3701 as follows:

Section 3701. Definitions.

(a) "Prevention and Early Intervention regulations" means sections 3200.245 and 3200.246 of Article 2, sections 3510.010, 3560, 3560.010, and 3560.020 of Article 5, and Article 7.

(b) "Program" as used in the Prevention and Early Intervention regulations means a stand-alone organized and planned work, action or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at risk of serious mental illness or for the mental health system.

(c) "Strategy" as used in the Prevention and Early Intervention regulations means a planned and specified method within a Program intended to achieve a defined goal.

(d) "Mental illness" and "mental disorder" as used in the Prevention and Early Intervention regulations means, a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological or biological processes underlying mental functioning. Mental illness is usually associated with significant distress or disability in social, occupational, or other important activities. An expected or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental illness. Socially variant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental illness unless the variance or conflict results from a dysfunction in the individual, as described above.

(e) "Serious mental illness," "serious mental disorder" and "severe mental illness" as used in the Prevention and Early Intervention regulations means, a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

(f) The definition in subdivision (d) is applicable to serious emotional disturbance for individuals under the age of 18, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the individual's age according to expected developmental norms.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5600.3, 5840, Welfare and Institutions Code.

Adopt Section 3705 as follows:

Section 3705. Prevention and Early Intervention Component General Requirements.

(a) The County shall include in its Prevention and Early Intervention Component:
  (1) At least one Early Intervention Program as defined in Section 3710.
  (2) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness Program as defined in Section 3715.
  (3) At least one Prevention Program as defined in Section 3720
    (A) Small counties may opt out of the requirement to have at least one Prevention Program if:

1. The Small County obtains a declaration from the Board of Supervisors that the County cannot meet this requirement.

(B) A Small County that opts out of the requirement in (a)(3) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.

(4) At least one Access and Linkage to Treatment Program as defined in Section 3726

(5) At least one Stigma and Discrimination Reduction Program as defined in Section 3725

(6) The Strategies defined in Section 3735.

(b) The County may include in its Prevention and Early Intervention Component:

(1) One or more Suicide Prevention Programs as defined in Section 3730.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3706 as follows:

Section 3706. General Requirements for Services.

(a) The County shall serve all ages in one or more Programs of the Prevention and Early Intervention Component.

(b) At least 51 percent of the Prevention and Early Intervention Fund shall be used to serve individuals who are 25 years old or younger.

(c) Programs that serve parents, caregivers, or family members with the goal of addressing MHSA outcomes for children or youth at risk of or with early onset of a mental illness can be counted as meeting the requirements in (a) and (b) above.

(d) A Small County may opt out of the requirements in (a) and/or (b) above if:

(1) The Small County obtains a declaration from the Board of Supervisors that the County cannot meet the requirements because of specified local conditions.

(e) A Small County that opts out of the requirements in (a) and/or (b) shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5847, and 5848, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Adopt Section 3710 as follows:

Section 3710. Early Intervention Program.

(a) The County shall offer at least one Early Intervention Program as defined in this section.

(b) "Early Intervention Program" means treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.

(c) Early Intervention Program services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.

(1) For purpose of this section, "serious mental illness or emotional disturbance with psychotic features" means, schizophrenia spectrum and other psychotic disorders including schizophrenia, other psychotic disorders, disorders with psychotic features, and schizotypal (personality) disorder). These disorders include abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

(d) Early Intervention Program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.

(e) The County may combine an Early Intervention Program with a Prevention Program, as long as the requirements in Section 3710 and Section 3720 are met

(f) The County shall include all of the Strategies in each Early Intervention Program as referenced in Section 3735

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3715 as follows:
Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness.

(a) The County shall offer at least one Outreach for Increasing Recognition of Early Signs of Mental Illness Program as defined in this section.

(b) "Outreach" is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

(c) "Potential responders" include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.

(d) Outreach for Increasing Recognition of Early Signs of Mental Illness may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.

(e) In addition to offering the required Outreach for Increasing Recognition of Early Signs of Mental Illness Program, the County may also offer Outreach for Increasing Recognition of Early Signs of Mental Illness as a Strategy within a Prevention Program, a Strategy within an Early Intervention Program, a Strategy within another Program funded by Prevention and Early Intervention funds, or a combination thereof.

(f) An Outreach for Increasing Recognition of Early Signs of Mental Illness Program may be provided through other Mental Health Services Act components as long as it meets all of the requirements in this section.

(g) The County shall include all of the Strategies in each Outreach for Increasing Recognition of Early Signs of Mental Illness Program as referenced in Section 3735.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3720 as follows:

Section 3720. Prevention Program.

(a) The County shall offer at least one Prevention Program as defined in this section.

(b) "Prevention Program" means a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

(c) "Risk factors for mental illness" means conditions or experiences that are associated with a greater than average risk of developing a potentially serious mental illness. Risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.

  (1) Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, traumatic loss (e.g. complicated, multiple, prolonged, severe), having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

(d) Prevention Program services may include relapse prevention for individuals in recovery from a serious mental illness.

(e) Prevention Programs may include universal prevention if there is evidence to suggest that the universal prevention is an effective method for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average.
(f) The County may combine an Early Intervention Program with a Prevention Program, as long as the requirements in Section 3710 and Section 3720 are met.
(g) The County shall include all of the Strategies in each Prevention Program as referenced in Section 3735.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3725 as follows:

Section 3725. Stigma and Discrimination Reduction Program.

(a) The County shall offer at least one Stigma and Discrimination Reduction Program as defined in this section.
(b) "Stigma and Discrimination Reduction Program" means the County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.
    (1) Examples of Stigma and Discrimination Reduction Programs include, but are not limited to, social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services, and efforts to encourage self-acceptance for individuals with a mental illness.
    (2) Stigma and Discrimination Reduction Programs shall include approaches that are culturally congruent with the values of the populations for whom changes in attitudes, knowledge, and behavior are intended.
(c) The County shall include all of the Strategies in each Stigma and Discrimination Reduction Program as referenced in Section 3735.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3726 as follows:

Section 3726. Access and Linkage to Treatment Program.

(a) The County shall offer at least one Access and Linkage to Treatment Program as defined in this section.
(b) "Access and Linkage to Treatment Program" means a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3,

as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

(1) Examples of Access and Linkage to Treatment Programs, include but are not limited to, Programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response.

(c) In addition to offering the required Access and Linkage to Treatment Program, the County is also required to offer Access and Linkage to Treatment as a Strategy within all Prevention and Early Intervention Programs.

(d) The County shall include all of the Strategies in each Access and Linkage to Treatment Program as referenced in Section 3735.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5600.3 and 5840, Welfare and Institutions Code.

Adopt Section 3730 as follows:
Section 3730. Suicide Prevention Programs.

(a) The County may offer one or more Suicide Prevention Programs as defined in this section.

(b) Suicide Prevention Programs means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of Programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

(1) Suicide prevention activities that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a Prevention Program pursuant to Section 3720 or a focus of an Early Intervention Program pursuant to Section 3710.

(c) Suicide Prevention Programs pursuant to this section include, but are not limited to, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.

(d) The County shall include all of the Strategies in each Suicide Prevention Program as referenced in Section 3735.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3735 as follows:
Section 3735. Prevention and Early Intervention Strategies.

(a) The County shall include all of the following Strategies as part of each Program listed in Sections 3710 through 3730 of Article 7:

(1) Be designed and implemented to help create Access and Linkage to Treatment.

(A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the

onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

(2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.

(A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

(B) Services shall be provide in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, shelters, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.

(C) In addition to offering the required Improve Timely Access to Services for Underserved Populations Strategy, the County may also offer Improve Timely Access to Services for Underserved Populations as a Program.

(3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory

(A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" means promoting, designing, and implementing Programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.

(B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual orientation; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3740 as follows:

Section 3740. Effective Methods.

(a) For each Program and each Strategy in Article 7, the County shall use effective methods likely to bring about intended outcomes, based on one of the following standards, or a combination of the following standards:
  (1) Evidence-based practice standard: Evidence-based practice means activities for which there is scientific evidence consistently showing improved mental health outcomes for the intended population, including, but not limited to, scientific peer-reviewed research using randomized clinical trials.
  (2) Promising practice standard: Promising practice means Programs and activities for which there is research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes, but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.
  (3) Community and or practice-based evidence standard: Community and or practice-based evidence means a set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically. Community and or practice-defined evidence takes a number of factors into consideration, including worldview, historical, and social contexts of a given population or community, which are culturally rooted.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3745 as follows:

Section 3745. Changed Program.

(a) If the County determines a need to make a substantial change to a Program or Strategy described in the County's most recent Three-Year Program and Expenditure Plan or Annual Update that was adopted by the local county board of supervisors as referenced in Welfare and Institutions Code Section 5847, the County shall ensure that stakeholders contributed meaningfully to the planning process that resulted in the decision to make the change.
(b) "Substantial change" as used in this section means, change(s) to the essential elements of a Program or Strategy or change(s) to the intended outcomes or target population.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5848, Welfare and Institutions Code.

Adopt Section 3750 as follows:

Section 3750. Prevention and Early Intervention Component Evaluation.

(a) For each Early Intervention Program the County shall evaluate the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(b) For each Prevention Program the County shall measure the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(c) For each Early Intervention and each Prevention Program that the County designates as intended to reduce any of the other Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness, the County shall select, define, and measure appropriate indicators that the County selects that are applicable to the Program.

(d) For each Stigma and Discrimination Reduction Program referenced in Section 3725, the County shall select and use a validated method to measure one or more of the following:
  (1) Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific Program.
  (2) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific Program.

(e) If the County chooses to offer a Suicide Prevention Program referenced in Section 3730, the County shall select and use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific Program.

(f) For each Strategy or Program to provide Access and Linkage to Treatment the County shall track:
  (1) Number of referrals to treatment, and kind of treatment to which person was referred.
  (2) Number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.
    (A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.
  (3) Duration of untreated mental illness.
    (A) Duration of untreated mental illness shall be measured for persons who are referred to treatment and who have not previously received treatment as follows:

1. The time between the self-reported and/or parent-or-family-reported onset of symptoms of mental illness and entry into treatment, defined as participating at least once in treatment to which the person was referred.

(B) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(4) The interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred

(A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(g) For each Strategy or Program to Improve Timely Access to Services for Underserved Populations the County shall measure:

(1) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program, and/or treatment beyond early onset.

(2) Number of persons who followed through on the referral and engaged in services, defined as the number of individuals who participated at least once in the Program to which the person was referred.

(A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(3) Timeliness of care.

(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval between referral and engagement in services, defined as participating at least once in the service to which referred.

(h) The County shall design the evaluations to be culturally competent and shall include the perspective of diverse people with lived experience of mental illness, including their family members, as applicable.

(i) In addition, to the required evaluations listed in this section, the County may also, as relevant and applicable, define and measure the impact of Programs funded by Prevention and Early Intervention funds on the mental health and related systems, including, but not limited to education, physical healthcare, law enforcement and justice, social services, homeless shelters and other services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

(j) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, is exempt from the evaluation requirements in this section for one year from the effective date of this section.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Adopt Section 3755 as follows:

Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.

(a) The requirements set forth in this section shall apply to the Annual Update due for the fiscal year 2016-17 and each Annual Update and/or Three-Year Program and Expenditure Plan thereafter.

(b) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:

(1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300, were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component.

(2) A description of the County's plan to involve community stakeholders meaningfully in all phases of the Prevention and Early Intervention Component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

(3) A brief description, with specific examples of how each Program and/or Strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all applicable Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.

(c) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Early Intervention Program as defined in Section 3710 including, but not limited to:

(1) The Program name

(2) Identification of the target population for the specific Program including:

(A) Demographics relevant to the intended target population for the specific Program, including, but not limited to, age, race/ethnicity, gender or gender identity, primary language used, military status, and sexual orientation.

(B) The mental illness or illnesses for which there is early onset.

(C) Brief description of how each participant's early onset of a potentially serious mental illness will be determined.

(3) Identification of the type(s) of problem(s) and need(s) for which the Program will be directed and the activities to be included in the Program that are intended to bring about mental health

and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with early onset of potentially serious mental illness.

(4) The Mental Health Services Act negative outcomes as a consequence of untreated mental illness referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated mental illness, as defined in Section 3750, subdivision (a).

(A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (a).

(B) For any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness, as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.

(C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Early Intervention Program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(d) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Prevention Program including but not limited to the following information:

(1) The Program name

(2) Identification of the target population for the specific Program, including:

(A) Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness, i.e. the condition, experience, or behavior associated with greater than average risk.

(B) How the risk of a potentially serious mental illness will be defined and determined, i.e. what criteria and process the County will use to establish that the intended beneficiaries of the Program have a greater than average risk of developing a potentially severe mental illness.

(C) Demographics relevant to the intended target population for the specific Program including but not limited to age, race/ethnicity, gender or gender identity, sexual orientation, primary language used, and military status.

(3) Specify the type of problem(s) and need(s) for which the Prevention Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with greater than average risk of potentially serious mental illness.

(4) Specify any Mental Health Services Act negative outcomes as a consequence of untreated mental illness as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including reduction of prolonged suffering, as defined in Section 3750, subdivision (b).

(A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).

(B) If the County intends the Program to reduce any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.

(C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Prevention Program is likely to bring about reduction of relevant Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for the intended population by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(e) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Outreach for Increasing Recognition of Early Signs of Mental Illness Program and for any Strategy within a Program, including, but not limited to:
  (1) The Program name
  (2) Identify the types and settings of potential responders the Program intends to reach.
    (A) Describe briefly the potential responders' setting(s), as referenced in Section 3750, subdivisions (d)(3)(A), and the opportunity the potential responders will have to identify diverse individuals with signs and symptoms of potentially serious mental illness.
  (3) Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

(f) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Stigma and Discrimination Reduction Program, including, but not limited to:
  (1) The Program name
  (2) Identify whom the Program intends to influence.
  (3) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services, consistent with requirements in Section 3750, subdivision (e), including timeframes for measurement.
  (4) Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:
    (A) If the County used the evidence-based standard or promising practice standard, to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.
    (B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(g) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Suicide Prevention Program including, but not limited to:
  (1) The Program name

(2) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.
(3) Indicate how the County will measure changes in attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 3750, subdivision (f) including timeframes for measurement.
(4) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the County by providing the following information:
(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), explain how the practice's effectiveness has been demonstrated and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.
(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(h) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Access and Linkage to Treatment Program and Strategy within each Program including, but not limited to:
(1) Program name
(2) An explanation of how the Program and Strategy within each Program will create Access and Linkage to Treatment for individuals with serious mental illness as referenced in Section 3735, subdivision (a)(1)
(3) Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program.
(4) Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.
(5) Explain how the Program will follow up with the referral to support engagement in treatment.
(6) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (f) and if so, specify what outcome(s) and how will it be measured, including timeframes for measurement.

(i) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:
(1) Program name
(2) An explanation of how the Program will be implemented to help Improve Access to Services for Underserved Populations, as required in Section 3735, subdivision (a)(2)

(3) For each Program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. If the County intends to locate the Program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population.

(4) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcome(s) and how will it be measured, including timeframes for measurement.

(j) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:

(1) The Program name

(2) An explanation of how the Program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, including a description of the specific Strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes.

(k) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs the following information for the fiscal year after the plan is submitted.

(1) Estimated number of children, adults, and seniors to be served in each Prevention Program and each Early Intervention Program.

(2) The County may also include estimates of the number of individuals who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Access and Linkage to Treatment Program, Suicide Prevention Programs, and Stigma and Discrimination Reduction Programs.

(l) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include projected expenditures for each Program funded with Prevention and Early Intervention funds by fiscal year

(1) Projected expenditures by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation

(D) 1991 Realignment

(E) Behavioral Subaccount

(F) Any other funding

(2) The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, an Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations and shall estimate expected expenditures for each Program. If the Programs are combined, the County shall estimate the percentage of funds dedicated to each Program.

(A) The County shall estimate the amount of Prevention and Early Intervention funds for Administration of the Prevention and Early Intervention Component.

(m) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include the previous fiscal years' unexpended Prevention and Early Intervention funds and the amount of those funds that will be used to pay for the Programs listed in the Annual Update and/or Three-year Program and Expenditure Plan.

(n) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include an estimate of the amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5847, and 5848 Welfare and Institutions Code.

Adopt Section 3755.010 as follows:

Section 3755.010. Prevention and Early Intervention Program Change Report.

(a) If the County determines a need to make a substantial change to a Program, Strategy, or target population as described in Section 3745, the County shall in the next Three-Year Program and Expenditure Plan or Annual Update, whichever is closest in time to the planned change, include the following information:

(1) A brief summary of the Program as initially set forth in the originally adopted Three-Year Program and Expenditure Plan or Annual Update.

(2) A description of the change including the resulting changes in the intended outcomes and the planned evaluation.

(3) Explanation for the change including, stakeholder involvement in the decision and, if any, evaluation data supporting the change.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code.

APPENDIX 2

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

Program Support Bureau - Prevention and Early Intervention Administration Division

Provider PEI Practice List

AGENCY/PROVIDER NAME	Provider Number	SA	Supervisorial District (SD)		PEI Plan					ART	AF-CBT	BSFT	CFOF	CAPPS	CPP	CBITS	CORS	DTQI	DBT* (DMH DO only)	FOCUS	FFT	Group CBT	IY	Ind CBT	IPT	LIFE	MAP	MHIP	MP	MDFT	MST	PCIT	PST	PEARLS	PE* (DMH DO only)	PATHS	RPP	SS	SF	TF-CBT	TRIPLE P	UCLA TTM
			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
1736 Family Crisis Center	7111	6	2	2	X	X	X	X									X							X													X				
1736 Family Crisis Center	7348	6	2	2	X	X	X	X									X							X													X				
Alcott Center for Mental Health Services	7229	5	2	2		X											X							X													X				
Alcott Center for Mental Health Services	7229	5	2	2			X										X							X													X				
Alcott Center for Mental Health Services	7229	5	2	2				X									X							X									X	X			X				
Alma Family Services, Inc.	7019	7	1	1	X												X								X		X										X		X		
Alma Family Services, Inc.	7019	7	1	1		X											X							X	X		X										X		X		
Alma Family Services, Inc.	7019	7	1	1			X										X							X	X												X				
Alma Family Services, Inc.	7019	7	1	1				X									X							X	X												X				
Alma Family Services, Inc.	7019	7	1	1					X																			X													
Alma Family Services, Inc.	7562	7	1	1	X												X								X		X					X						X		X		
Alma Family Services, Inc.	7562	7	1	1		X											X							X	X		X										X		X		
Alma Family Services, Inc.	7562	7	1	1			X										X							X	X												X				
Alma Family Services, Inc.	7562	7	1	1				X									X							X	X												X				
Alma Family Services, Inc.	7562	7	1	1					X																			X													
Amanecer Community Counseling Services, Inc.	7104	4, 5, 6	1	1	X										X		X						X		X		X										X		X		
Amanecer Community Counseling Services, Inc.	7104	4, 5, 6	1	1		X											X					X			X		X										X		X		
Amanecer Community Counseling Services, Inc.	7104	4, 5, 6	1	1			X										X					X		X	X												X				
Amanecer Community Counseling Services, Inc.	7104	4, 5, 6	1	1				X									X					X		X	X									X			X				
American Indian Counseling Center	7421	7	DMH DO	4	X												X								X		X										X		X		
American Indian Counseling Center	7421	7	DMH DO	4		X											X							X	X		X										X		X		
American Indian Counseling Center	7421	7	DMH DO	4			X	X									X							X	X												X				
American Indian Counseling Center	7421	7	DMH DO	4					X																			X													
Antelope Valley MHS	1904	1	DMH DO	5			X	X									X							X										X							
Antelope Valley MHS	1904	1	DMH DO	5					X																			X													
Arcadia MHS	1917	3	DMH DO	5			X										X					X		X										X				X			
Arcadia MHS	1917	3	DMH DO	5					X																			X													
Asian American Drug Abuse Program, Inc. (AADAP)	7528	8	2	2	X												X																						X	X	
Asian American Drug Abuse Program, Inc. (AADAP)	7528	8	2	2		X											X																						X	X	
Asian American Drug Abuse Program, Inc. (AADAP)	7528	8	2	2			X										X																								
Augustus F Hawkins MHS	6864	6	DMH DO	2	X												X										X					X						X		X		

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
Augustus F Hawkins MHS	6864	6	DMH DO	2		X											X		X			X		X			X								X			X		X		
Augustus F Hawkins MHS	6864	6	DMH DO	2			X	X									X		X			X		X											X			X				
Augustus F Hawkins MHS	6864	6	DMH DO	2					X																			X														
Barbour & Floyd Medical Associates	7218	6	2	2			X										X							X	X													X				
Barbour & Floyd Medical Associates	7218	6	2	2				X									X							X	X								X	X				X				
Bayfront Youth & Family Services	7823	8	4	4			X										X																					X				
Bayfront Youth & Family Services	7891	8	4	4		X	X																	X																		
Behavioral Health Services, Inc.	7520	4	2	1		X																																				
Bienvenidos Children's Center, Inc.	7381	7	1	1	X										X		X										X											X		X		
Bienvenidos Children's Center, Inc.	7381	7	1	1		X											X							X			X											X		X		
Bienvenidos Children's Center, Inc.	7382	3	1	5	X										X		X										X											X		X		
Bienvenidos Children's Center, Inc.	7382	3	1	5		X											X							X			X											X		X		
Bienvenidos Children's Center, Inc.	7575	3	1	1	X										X		X										X											X		X		
Bienvenidos Children's Center, Inc.	7575	3	1	1		X											X							X			X											X		X		
Bienvenidos Children's Center, Inc.	7575	3	1	1		X											X							X			X											X		X		
Bienvenidos Children's Center, Inc.	7840	7	1	1	X												X										X											X		X		
Bienvenidos Children's Center, Inc.	7840	7	1	1		X											X							X			X											X		X		
Bienvenidos Children's Center, Inc.	7840	7	1	1					X																			X														
Braswell Rehab Institute for Dev. of Growth (dba BRIDGES)	7772	2	1	3	X	X											X																					X		X		
Braswell Rehab Institute for Dev. of Growth (dba BRIDGES)	7772	2	1	3			X																	X																		
California Hispanic Commission, Inc.	7519	4	ALL	1	X	X																					X											X		X		
California Institute of Health & Social Svc, Inc. (Alafia)	7539	1	4	5	X										X	X	X																					X		X		
California Institute of Health & Social Svc, Inc. (Alafia)	7539	1	4	5		X											X																					X		X		
California Institute of Health & Social Svc, Inc. (Alafia)	7539	1	4	5			X																	X																		
California Institute of Health & Social Svc, Inc. (Alafia)	7540	6	4	2	X										X		X																					X		X		
California Institute of Health & Social Svc, Inc. (Alafia)	7540	6	4	2		X											X																					X		X		
California Institute of Health & Social Svc, Inc. (Alafia)	7539	1	4	5			X																	X																		
California Institute of Health & Social Svc, Inc. (Alafia)	7655	6	4	2	X										X		X										X											X		X	X	
California Institute of Health & Social Svc, Inc. (Alafia)	7655	6	4	2		X											X										X											X		X	X	
California Institute of Health & Social Svc, Inc. (Alafia)	7539	1	4	5			X																	X																		
Center For Integrated Family & Health Services	7545	3	5	5	X	X				X							X							X			X													X		
Child & Family Center	7413	2	5	5	X	X											X										X											X		X	X	

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Child & Family Center	7413	2	5	5			X										X																				X				
Child & Family Center	7413	2	5	5					X																			X														
Child & Family Center	7479	2	5	5	X										X		X			X						X					X					X		X	X	
Child & Family Center	7479	2	5	5		X											X			X						X										X		X	X	
Child & Family Center	7479	2	5	5			X										X			X																X				
Child and Family Guidance Center	1975	2	3	3	X					X					X		X				X				X		X									X		X	X	
Child and Family Guidance Center	1975	2	3	3		X				X							X				X			X	X		X									X		X	X	
Child and Family Guidance Center	1975	2	3	3			X										X							X	X															
Child and Family Guidance Center	7225	1	3	5	X					X					X		X						X		X		X									X		X	X	
Child and Family Guidance Center	7225	1	3	5		X				X							X							X	X		X									X		X	X	
Child and Family Guidance Center	7225	1	3	5			X										X							X	X															
Child and Family Guidance Center	7247	2	3	3	X					X					X		X									X		X				X					X		X	X	
Child and Family Guidance Center	7247	2	3	3		X				X							X								X	X		X									X		X	X	
Child and Family Guidance Center	7247	2	3	3			X										X								X	X															
Child and Family Guidance Center	7390	2	3	3	X					X					X		X									X		X				X	X					X		X	X	
Child and Family Guidance Center	7390	2	3	3		X				X							X								X	X		X				X					X		X	X	
Child and Family Guidance Center	7390	2	3	3			X										X								X	X											X				
Childnet Youth & Family Services, Inc.	7469	8	4	4	X										X			X										X				X					X				
Childnet Youth & Family Services, Inc.	7469	8	4	4		X												X										X									X				
Childnet Youth & Family Services, Inc.	7469	8	4	4			X																		X																
Children's Bureau of Southern California	7300	4	2	2	X										X									X		X		X									X		X		
Children's Bureau of Southern California	7300	4	2	2		X																				X		X									X		X		
Children's Bureau of Southern California	7301	1	2	5	X										X									X		X		X											X		
Children's Bureau of Southern California	7301	1	2	5		X																				X		X											X		
Children's Bureau of Southern California	7302	3	2	1	X										X									X		X		X									X		X		X
Children's Bureau of Southern California	7302	3	2	1		X																				X		X									X				
Children's Bureau of Southern California	7473	1	2	5	X										X									X		X		X									X				
Children's Bureau of Southern California	7473	1	2	5		X																				X		X									X				
Children's Bureau of Southern California	7570	8	2	2	X										X									X		X		X									X			X	X
Children's Bureau of Southern California	7570	8	2	2		X																				X		X									X				
Children's Bureau of Southern California	7782	6	2	1	X										X									X		X		X									X			X	X

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
Children's Bureau of Southern California	7782	6	2	1		X																			X		X												X		
Children's Hospital Los Angeles	1989	4	3	3	X										X								X				X										X		X		
Children's Hospital Los Angeles	1989	4	3	3		X																		X			X											X		X		
Children's Hospital Los Angeles	7449	4	3	3	X																																	X		X		
Children's Hospital Los Angeles	7449	4	3	3		X																		X														X		X		
Children's Hospital Los Angeles	7586	4	3	3	X																		X																X		
Children's Hospital Los Angeles	7586	4	3	3		X																		X															X		
Children's Hospital Los Angeles	7614	4	3	2	X										X								X				X					X						X		X		
Children's Hospital Los Angeles	7614	4	3	2		X																		X				X										X		X		
Children's Institute Inc.	7275	8	2	2	X										X																	X				X		X		
Children's Institute Inc.	7275	8	2	2		X																		X	X												X		X		
Children's Institute Inc.	7275	8	2	2			X																	X	X												X				
Children's Institute Inc.	7328	4	2	2	X										X							X		X			X					X							X		
Children's Institute Inc.	7328	4	2	2		X																X			X	X	X					X						X		X		
Children's Institute Inc.	7328	4	2	2			X																		X	X											X				
Children's Institute Inc.	7625	8	2	4	X																						X												X		
Children's Institute Inc.	7625	8	2	4		X																			X	X	X											X		X		
Children's Institute Inc.	7625	8	2	4			X																		X	X											X				
Children's Institute Inc.	7736	6	2	2	X										X	X						X		X			X												X		
Children's Institute Inc.	7736	6	2	2		X																X					X											X		X		
Children's Institute Inc.	7736	6	2	2			X																				X											X				
Children's Institute Inc.	7779	8	2	4	X											X						X		X			X												X		
Children's Institute Inc.	7779	8	2	4		X																X			X	X	X											X		X		
Children's Institute Inc.	7779	8	2	4			X																		X	X											X				
Children's Institute Inc.	7780	4	2	2	X											X						X					X												X		
Children's Institute Inc.	7780	4	2	2		X																X			X	X	X											X		X		
Children's Institute Inc.	7780	4	2	2			X																		X	X											X				
Children's Institute Inc.	7817	4	2	1	X																											X					X				
Children's Institute Inc.	7817	4	2	1		X																			X	X												X				
Children's Institute Inc.	7817	4	2	1			X																		X	X												X				
Children's Institute Inc.	7845	6	2	2		X																				X																

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Children's Institute Inc.	7845	6	2	2			X																	X																		
Coastal API Family MHC	7064	8	DMH DO	2	X												X																				X		X	X	
Coastal API Family MHC	7064	8	DMH DO	2		X											X					X		X											X			X		X	X	
Coastal API Family MHC	7064	8	DMH DO	2			X	X									X					X		X											X			X				
Coastal API Family MHC	7064	8	DMH DO	2					X																		X																
Community Family Guidance Center	1977	7	4	4	X																X						X					X					X		X	X		
Community Family Guidance Center	1977	7	4	4		X															X						X											X		X	X		
Community Family Guidance Center	1977	7	4	4			X																	X																		
Community Family Guidance Center	7471	7	4	4	X																X						X										X		X	X		
Community Family Guidance Center	7471	7	4	4		X															X						X												X	X		
Compton Family MHS	1938	6	DMH DO	2	X												X								X		X										X		X			
Compton Family MHS	1938	6	DMH DO	2		X											X							X	X		X										X		X			
Compton Family MHS	1938	6	DMH DO	2			X	X									X							X	X												X					
Compton Family MHS	1938	6	DMH DO	2					X																			X														
Counseling & Research Asso. Inc., (dba Masada Homes)	7342	8	2	2	X	X				X																														X			
Counseling & Research Asso. Inc., (dba Masada Homes)	7432	8	2	2	X					X					X												X										X		X	X		
Counseling & Research Asso. Inc., (dba Masada Homes)	7432	8	2	2		X				X																	X										X		X	X		
Counseling & Research Asso. Inc., (dba Masada Homes)	7792	1	2	5	X					X					X												X					X					X		X	X		
Counseling & Research Asso. Inc., (dba Masada Homes)	7792	1	2	5		X				X																	X										X		X	X		
Counseling & Research Asso. Inc., (dba Masada Homes)	7822	6	2	2	X	X				X																																
Counselling4Kids	7483	2	5	5	X																						X					X					X		X	X		
Counselling4Kids	7483	2	5	5		X																					X										X		X	X		
Counselling4Kids	7483	2	5	5			X																														X					
Counselling4Kids	7516	8	5	4	X	X																					X										X		X	X		
Counselling4Kids	7516	8	5	4			X																														X					
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7341	3	5	5	X	X											X							X			X			X							X		X	X		
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7341	3	5	5			X										X							X													X					
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7440	3	5	5	X	X											X							X			X			X							X		X	X		
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7440	3	5	5			X										X							X													X					
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7775	3	5	5	X	X																					X			X							X		X	X		
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7872	3	5	5	X	X	X										X							X																		

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7873	3	5	5	X	X	X										X							X																		
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7874	3	5	5	X	X	X										X							X																		
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7878	3	5	5	X	X	X										X																									
D' Veal Corp. (dba D'Veal Family and Youth Svcs)	7880	3	5	5	X	X	X										X							X																		
David & Margaret Home, Inc.	7566	3	5	5	X	X																					X											X		X		
David & Margaret Home, Inc.	7566	3	5	5			X																																			
Didi Hirsch Psychiatric Service	1973	5	2	2	X												X			X					X		X											X			X	
Didi Hirsch Psychiatric Service	1973	5	2	2		X											X			X		X		X	X		X											X			X	
Didi Hirsch Psychiatric Service	1973	5	2	2			X										X			X		X		X	X													X				
Didi Hirsch Psychiatric Service	1973	5	2	2				X									X			X		X		X	X								X	X				X				
Didi Hirsch Psychiatric Service	1973	5	2	2					X																		X																
Didi Hirsch Psychiatric Service	7209	8	2	2	X										X	X	X			X					X		X											X		X	X	
Didi Hirsch Psychiatric Service	7209	8	2	2		X											X			X		X		X	X		X											X		X	X	
Didi Hirsch Psychiatric Service	7209	8	2	2			X										X			X		X		X	X													X				
Didi Hirsch Psychiatric Service	7209	8	2	2				X									X			X		X		X	X								X	X				X				
Didi Hirsch Psychiatric Service	7209	8	2	2					X																		X																
Didi Hirsch Psychiatric Service	7334	5	2	2	X										X	X	X			X							X					X						X		X	X	
Didi Hirsch Psychiatric Service	7334	5	2	2		X											X			X							X											X		X	X	
Didi Hirsch Psychiatric Service	7334	5	2	2			X	X									X			X																		X				
Didi Hirsch Psychiatric Service	7359	4	2	2	X										X	X	X			X							X											X		X	X	
Didi Hirsch Psychiatric Service	7359	4	2	2		X											X			X							X											X		X	X	
Didi Hirsch Psychiatric Service	7359	4	2	2			X	X									X			X																		X				
Didi Hirsch Psychiatric Service	7423	6	2	2	X										X	X	X			X							X											X		X	X	
Didi Hirsch Psychiatric Service	7423	6	2	2		X											X			X							X											X		X	X	
Didi Hirsch Psychiatric Service	7423	6	2	2			X	X									X			X																		X				
Didi Hirsch Psychiatric Service	7812	2	2	5	X										X		X			X					X		X											X		X	X	
Didi Hirsch Psychiatric Service	7812	2	2	5		X											X			X		X		X	X		X											X		X	X	
Didi Hirsch Psychiatric Service	7812	2	2	5			X										X			X		X		X	X													X				
Didi Hirsch Psychiatric Service	7812	2	2	5				X									X			X		X		X	X								X	X				X				
Didi Hirsch Psychiatric Service	7812	2	2	5					X																		X																
Didi Hirsch Psychiatric Service	7868	2	2	3	X										X		X			X					X													X		X	X	

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Didi Hirsch Psychiatric Service	7868	2	2	3		X											X			X		X			X											X		X	X	
Didi Hirsch Psychiatric Service	7868	2	2	3			X										X			X		X		X	X											X				
Didi Hirsch Psychiatric Service	7868	2	2	3				X									X			X		X		X	X											X				
Dignity Health (dba California Hospital Medical Center)	7590	4	1	1	X										X		X									X										X		X		X	
Dignity Health (dba California Hospital Medical Center)	7590	4	1	1			X																	X																	
DMH at Harbor-UCLA Medical Center	6859	8	DMH DO	2	X												X																				X		X	X	
DMH at Harbor-UCLA Medical Center	6859	8	DMH DO	2		X											X					X		X											X		X		X	X	
DMH at Harbor-UCLA Medical Center	6859	8	DMH DO	2			X	X									X					X		X											X		X				
DMH at Harbor-UCLA Medical Center	6859	8	DMH DO	2					X																		X														
DMH at Harbor-UCLA Medical Center Wellness	7738	8	DMH DO		X																										X									
Downtown MHC	7057	4	DMH DO	2			X										X					X		X	X											X				
Downtown MHC	7057	4	DMH DO	2					X																		X														
Drew Child Development Corporation	7535	6	2	2	X										X		X						X		X		X									X		X		
Drew Child Development Corporation	7535	6	2	2		X											X								X		X									X		X		
Drew Child Development Corporation	7721	6	2	2	X					X					X		X						X		X		X									X		X		
Drew Child Development Corporation	7721	6	2	2		X				X							X								X		X									X		X		
Edmund D Edelman W MHC Child & Family	7191	5	DMH DO	3	X	X											X										X											X	X	
Edmund D. Edelman Westside MHC	1906	5	DMH DO	3		X	X	X									X		X	X		X		X	X									X			X			
Edmund D. Edelman Westside MHC	1906	5	DMH DO	3					X																		X														
Eggleston Youth Centers, Inc.	7861	6	2		X					X							X										X					X					X		X		
Eggleston Youth Centers, Inc.	7861	6	2			X				X							X										X										X		X		
Eggleston Youth Centers, Inc.	7861	6	2				X										X							X																
El Centro De Amistad, Inc.	7050	2	3	3	X	X											X								X		X											X		X	X	
El Centro De Amistad, Inc.	7050	2	3	3			X																	X																
El Centro De Amistad, Inc.	7050	2	3	3					X																		X														
El Centro De Amistad, Inc.	7371	2	3	3	X	X											X								X		X											X		X	X	
El Centro De Amistad, Inc.	7371	2	3	3					X																		X														
El Centro Del Pueblo, Inc.	7581	4	1	1	X	X																					X											X		X		
El Centro Del Pueblo, Inc.	7581	4	1	1			X																															X				
El Dorado Community Service Centers	7838	8	2	2			X	X									X																					X				
El Dorado Community Service Centers	7894	2	3	3			X	X									X																					X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
El Dorado Community Service Centers	7897	8	2	2			X	X									X																				X				
El Dorado Community Service Centers	7899	1	1	5			X	X									X																				X				
ENKI Health and Research Systems, Inc.	7173	3	5	1	X												X							X		X										X		X	X	
ENKI Health and Research Systems, Inc.	7173	3	5	1		X											X						X	X		X										X		X	X	
ENKI Health and Research Systems, Inc.	7173	3	5	1			X										X						X	X												X				
ENKI Health and Research Systems, Inc.	7173	3	5	1				X									X						X	X								X	X			X				
ENKI Health and Research Systems, Inc.	7173	3	5	1					X																		X														
ENKI Health and Research Systems, Inc.	7253	7	5	1	X												X							X												X				
ENKI Health and Research Systems, Inc.	7253	7	5	1		X	X										X							X	X											X				
ENKI Health and Research Systems, Inc.	7253	7	5	1				X									X							X	X								X	X			X				
ENKI Health and Research Systems, Inc.	7253	7	5	1					X																		X														
ENKI Health and Research Systems, Inc.	7254	7	5	1	X												X							X												X				
ENKI Health and Research Systems, Inc.	7254	7	5	1		X	X										X							X	X											X				
ENKI Health and Research Systems, Inc.	7254	7	5	1				X									X							X	X								X	X			X				
ENKI Health and Research Systems, Inc.	7254	7	5	1					X																		X														
ENKI Health and Research Systems, Inc.	7255	4	5	1	X												X							X												X				
ENKI Health and Research Systems, Inc.	7255	4	5	1		X	X										X							X	X											X				
ENKI Health and Research Systems, Inc.	7255	4	5	1				X									X							X	X								X	X			X				
ENKI Health and Research Systems, Inc.	7255	4	5	1					X																		X														
ENKI Health and Research Systems, Inc.	7360	7	5	1	X												X								X		X						X					X	X	
ENKI Health and Research Systems, Inc.	7360	7	5	1		X											X								X		X											X	X	
ENKI Health and Research Systems, Inc.	7360	7	5	1			X	X									X								X															
ENKI Health and Research Systems, Inc.	7452	3	5	1	X	X											X								X		X											X	X	
ENKI Health and Research Systems, Inc.	7452	3	5	1			X	X									X								X															
ENKI Health and Research Systems, Inc.	7472	4	5	1	X	X											X								X		X											X	X	
ENKI Health and Research Systems, Inc.	7472	4	5	1			X	X									X								X															
Ettie Lee Homes, Inc.	7453	3	1	1	X	X				X																	X												X			
Ettie Lee Homes, Inc.	7712	3	1	5	X	X																					X													X		
Exceptional Children's Foundation	7730	5	2	2	X																						X											X		X	X	
Exceptional Children's Foundation	7730	5	2	2		X																		X			X											X		X	X	
Exceptional Children's Foundation	7730	5	2	2			X																	X														X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
FamiliesFirst, Inc.	7749	4	3	3	X										X											X					X						X		X		
FamiliesFirst, Inc.	7749	4	3	3		X																				X											X		X		
FamiliesFirst, Inc.	7749	4	3	3			X																																		
Five Acres - The Boys & Girls Aid Society of LA County	7286	3	5	5	X	X				X		X														X											X		X	X	
Five Acres - The Boys & Girls Aid Society of LA County	7337	3	5	5	X	X				X		X														X											X		X	X	
Five Acres - The Boys & Girls Aid Society of LA County	7640	3	5	1	X	X				X		X														X											X		X	X	
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7524	ALL	OUT COUNTY	OUT COUNTY	X	X																															X				
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7605	8	4	4	X	X																															X				
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7605	8	4	4			X										X																								
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7659	3	1	1	X	X																															X				
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7659	3	1	1			X										X																								
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7660	7	4	4	X	X																															X				
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7660	7	4	4			X										X																								
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7661	8	2	2	X	X																															X				
Florence Crittenton Services of Orange County, Inc. dba Crittenton Services for Children and Families	7661	8	2	2			X										X																								
Foothill Family Service	7330	3	5	5	X										X			X		X			X				X					X					X		X	X	
Foothill Family Service	7330	3	5	5		X												X		X							X										X		X	X	
Foothill Family Service	7330	3	5	5			X										X			X				X													X				
Foothill Family Service	7331	3	5	1	X										X			X		X			X				X					X					X		X	X	
Foothill Family Service	7331	3	5	1		X												X		X							X										X		X	X	
Foothill Family Service	7331	3	5	1			X										X			X				X													X				
Foothill Family Service	7407	3	5	5	X										X					X																						
Foothill Family Service	7407	3	5	5		X														X																						
Foothill Family Service	7407	3	5	5			X										X							X													X				
Foothill Family Service	7463	3	5	1	X										X	X		X		X			X				X					X					X		X	X	
Foothill Family Service	7463	3	5	1		X												X		X							X										X		X	X	
Foothill Family Service	7463	3	5	1			X										X			X				X													X				
Foothill Family Service	7755	3	5	5	X										X			X		X			X				X										X		X	X	

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
Foothill Family Service	7755	3	5	5		X												X		X						X										X		X	X	
Foothill Family Service	7755	3	5	5			X										X			X				X												X				
For The Child, Inc.	7121	8	4	4	X										X												X				X				X		X		X		
For The Child, Inc.	7121	8	4	4		X																					X								X		X				
For The Child, Inc.	7121	8	4	4			X										X							X																
For The Child, Inc.	7854	8	4	4	X																																				
For The Child, Inc.	7854	8	4	4		X																																			
For The Child, Inc.	7854	8	4	4			X										X							X																
Gateways Hospital & MHC	1982	4	1	1	X											X									X		X				X						X		X	X	
Gateways Hospital & MHC	1982	4	1	1		X																			X		X										X		X	X	
Hamburger Home (dba Aviva Center)	7268	4	3	2	X										X						X						X				X						X		X		
Hamburger Home (dba Aviva Center)	7268	4	3	2		X															X			X			X										X		X		
Hamburger Home (dba Aviva Center)	7268	4	3	2			X																	X																
Hamburger Home (dba Aviva Center)	7626	2	3	3	X																											X								
Hamburger Home (dba Aviva Center)	7889	4	3	3	X																					X										X		X		
Hamburger Home (dba Aviva Center)	7889	4	3	3		X																		X		X										X		X		
Hamburger Home (dba Aviva Center)	7889	4	3	3			X																	X																
Hathaway Sycamores Child & Family Services	7278	4	5	1	X										X								X			X					X				X		X			
Hathaway Sycamores Child & Family Services	7278	4	5	1		X																				X									X		X			
Hathaway Sycamores Child & Family Services	7557	2	5	3	X													X						X			X									X		X	X	
Hathaway Sycamores Child & Family Services	7557	2	5	3		X												X									X									X		X	X	
Hathaway Sycamores Child & Family Services	7599	3	5	5	X										X			X							X		X									X		X	X	
Hathaway Sycamores Child & Family Services	7599	3	5	5		X	X											X							X		X									X		X	X	
Hathaway Sycamores Child & Family Services	7600	2	5	3	X													X						X		X	X									X		X	X	
Hathaway Sycamores Child & Family Services	7600	2	5	3		X	X											X							X		X									X		X	X	
Hathaway Sycamores Child & Family Services	7601	3	5	5	X	X												X									X									X		X		
Hathaway Sycamores Child & Family Services	7602	3	5	5	X	X	X																		X												X				
Hathaway Sycamores Child & Family Services	7669	3	5	5	X	X	X																		X																
Hathaway Sycamores Child & Family Services	7670	7	5	1	X	X																																X			
Hathaway Sycamores Child & Family Services	7741	1	5	5	X	X	X											X							X		X									X		X	X	
Hathaway Sycamores Child & Family Services	7744	6	5	2	X	X																																X			

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Helpline Youth Counseling, Inc.	7574	7	4	4	X	X																			X												X		X	X	
Helpline Youth Counseling, Inc.	7574	7	4	4			X																	X	X																
Helpline Youth Counseling, Inc.	7849	7	4	4	X	X																					X										X		X	X	
Helpline Youth Counseling, Inc.	7849	7	4	4			X																	X	X												X				
Heritage Clinic/ Center For Aging Resources	7430	3	5	5				X										X							X								X	X			X				
Heritage Clinic/ Center For Aging Resources	7430	3	5	5					X																			X													
Heritage Clinic/ Center For Aging Resources	7648	8	5	4				X										X						X	X								X	X				X			
Heritage Clinic/ Center For Aging Resources	7648	8	5	4					X																			X													
Heritage Clinic/ Center For Aging Resources	7679	1	5	5				X										X							X								X	X			X				
Heritage Clinic/ Center For Aging Resources	7679	1	5	5					X																			X													
Heritage Clinic/ Center For Aging Resources	7785	4	5	1				X										X							X								X	X				X			
Heritage Clinic/ Center For Aging Resources	7785	4	5	1					X																			X													
Hillsides	7231	3	1	1	X										X			X						X				X										X		X	X	
Hillsides	7231	3	1	1		X												X										X										X		X	X	
Hillsides	7231	3	1	1			X											X							X																
Hillsides	7332	3	1	1	X	X				X								X										X										X		X	X	
Hillsides	7332	3	1	1			X											X							X																
Hillsides	7645	4	1	1	X	X												X										X										X		X	X	
Hillsides	7645	4	1	1			X											X							X																
Hillsides	7883	3	1	1	X										X									X				X										X		X	X	
Hillsides	7883	3	1	1		X																						X										X		X	X	
Hillview Mental Health Center, Inc.	7068	2	3	3		X												X								X		X										X				
Hillview Mental Health Center, Inc.	7068	2	3	3			X											X							X	X												X				
Hillview Mental Health Center, Inc.	7068	2	3	3				X										X							X	X								X	X			X				
Hillview Mental Health Center, Inc.	7068	2	3	3					X																				X													
Hollywood MHC	1909	4	DMH DO	3			X											X					X		X																
Hollywood MHC	1909	4	DMH DO	3					X																			X													
Institute For Multicultural Coun. & Edu. Svcs, Inc. (IMCES)	7312	4	2	2	X	X												X							X			X										X		X		
Institute For Multicultural Coun. & Edu. Svcs, Inc. (IMCES)	7312	4	2	2			X											X							X													X				
Institute For Multicultural Coun. & Edu. Svcs, Inc. (IMCES)	7312	4	2	2					X																			X													
Institute For Multicultural Coun. & Edu. Svcs, Inc. (IMCES)	7547	2	2	5	X	X												X							X			X										X		X		

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Institute For Multicultural Coun. & Edu. Svcs, Inc. (IMCES)	7547	2	2	5			X										X							X													X				
Institute For Multicultural Coun. & Edu. Svcs, Inc. (IMCES)	7547	2	2	5					X																			X														
Intercommunity Child Guidance Ctr (dba The Whole Child)	1972	7	4	4	X										X								X				X											X		X	X	
Intercommunity Child Guidance Ctr (dba The Whole Child)	1972	7	4	4		X																					X											X		X	X	
Jewish Family Service of Los Angeles	7693	4	2	3				X																X	X							X					X				
Jewish Family Service of Los Angeles	7693	4	2	3					X																			X														
Jewish Family Service of Los Angeles	7694	2	2	3				X																X	X							X					X				
Jewish Family Service of Los Angeles	7694	2	2	3					X																			X														
Juvenile Justice Transition Aftercare Services	7821		DMH DO	2						X												X	X															X		X		
JWCH Institute, Inc.	7888	ALL	4	4			X																	X																		
Kedren Community Health Center, Inc.	7080	6	2	2	X	X											X																							X	X	
Kedren Community Health Center, Inc.	7080	6	2	2			X										X																									
Kedren Community Health Center, Inc.	7577	6	2	2	X												X															X							X	X	
Kedren Community Health Center, Inc.	7577	6	2	2		X											X																							X	X	
Kedren Community Health Center, Inc.	7577	6	2	2			X										X																									
Korean American Family Services, Inc.	7825	4	3	3			X										X																						X				
Koreatown Youth & Community Center, Inc.	7103	4	2	2	X																						X													X	
Koreatown Youth & Community Center, Inc.	7103	4	2	2			X										X							X														X				
Leroy Haynes Ctr For Children & Family Svcs, Inc.	7565	3	5	5	X	X				X																	X											X		X		
Long Beach API Family MHC	7207	8	DMH DO	4	X												X								X													X		X	X	
Long Beach API Family MHC	7207	8	DMH DO	4		X											X		X			X		X	X									X				X		X	X	
Long Beach API Family MHC	7207	8	DMH DO	4			X	X									X		X			X		X	X									X				X				
Long Beach API Family MHC	7207	8	DMH DO	4					X																		X															
Long Beach Child & Adol Clinic	1926	8	DMH DO	4	X																X		X				X											X		X		
Long Beach Child & Adol Clinic	1926	8	DMH DO	4		X															X			X			X											X		X		
Long Beach MHS Adult Clinic	1927	8	DMH DO	4		X	X	X									X		X	X		X		X	X									X				X				
Long Beach MHS Adult Clinic	1927	8	DMH DO	4					X																		X															
Los Angeles Child Guidance Clinic	6870	6	2	2	X										X												X											X		X	X	
Los Angeles Child Guidance Clinic	6870	6	2	2		X																					X											X		X	X	
Los Angeles Child Guidance Clinic	6870	6	2	2			X										X							X														X				
Los Angeles Child Guidance Clinic	7265	6	2	2	X										X							X					X											X		X	X	

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
Los Angeles Child Guidance Clinic	7265	6	2	2		X															X					X												X	X	
Los Angeles Child Guidance Clinic	7265	6	2	2			X																X																		
Los Angeles Child Guidance Clinic	7276	6	2	2	X																					X												X			
Los Angeles Child Guidance Clinic	7276	6	2	2		X																				X												X			
Los Angeles Child Guidance Clinic	7276	6	2	2			X																	X														X			
Los Angeles Unified School District	7211	6	1	2	X											X				X						X												X	X	
Los Angeles Unified School District	7211	6	1	2		X														X						X												X	X	
Maryvale	7474	3	1	1	X																																	X			
Maryvale	7474	3	1	1		X																																X			
Maryvale	7815	3	1	5	X																					X						X						X			
Maryvale	7815	3	1	5		X											X									X												X			
Maryvale	7815	3	1	5			X										X																								
McKinley Children's Center, Inc.	7436	3	5	5	X																					X												X			
McKinley Children's Center, Inc.	7436	3	5	5		X																			X		X												X			
McKinley Children's Center, Inc.	7436	3	5	5			X																		X	X												X			
McKinley Children's Center, Inc.	7436	3	5	5				X																	X																
Mental Health America of Los Angeles	7204	1	4	5		X	X																															X				
Mental Health America of Los Angeles	7576	8	4	4		X	X										X								X												X				
New Directions for Veterans	7515	5	3	3		X	X	X																	X												X				
New Directions for Veterans	7900	5	3	3		X	X	X																	X																
Northeast MHC	1914	4	DMH DO	1		X											X					X		X											X		X		X		
Northeast MHC	1914	4	DMH DO	1			X	X									X					X		X											X		X				
Northeast MHC	1914	4	DMH DO	1					X																		X														
Olive Crest	7534	7, 8	4	4			X										X								X	X												X				
Optimist Boys' Home & Ranch Inc.	7344	4	1	1	X	X																					X											X				
Optimist Boys' Home & Ranch Inc.	7444	4	1	4	X																						X											X		X	X	
Optimist Boys' Home & Ranch Inc.	7444	4	1	4		X																				X	X											X		X	X	
Optimist Boys' Home & Ranch Inc.	7444	4	1	4			X										X								X																
Optimist Boys' Home & Ranch Inc.	7541	1	1	5	X																																	X				
Optimist Boys' Home & Ranch Inc.	7541	1	1	5			X										X																								
Pacific Asian Counseling Services	7272	5	2	2	X								X		X												X									X	X		X			

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
Pacific Asian Counseling Services	7378	2	2	3	X								X		X											X										X	X		X		
Pacific Asian Counseling Services	7426	8	2	4	X								X		X											X					X					X	X		X		
Pacific Clinics	1974	3	5	5	X					X							X							X		X				X						X		X	X	
Pacific Clinics	1974	3	5	5		X				X							X							X		X										X		X	X	
Pacific Clinics	1974	3	5	5			X										X							X												X				
Pacific Clinics	1974	3	5	5				X									X						X	X												X				
Pacific Clinics	1979	3	5	5	X					X							X							X		X					X					X		X	X	
Pacific Clinics	1979	3	5	5		X				X							X							X		X										X		X	X	
Pacific Clinics	1979	3	5	5			X	X									X							X												X				
Pacific Clinics	7101	3	5	1	X	X				X							X									X										X		X	X	
Pacific Clinics	7101	3	5	1			X	X									X																			X				
Pacific Clinics	7194	3	5	1	X	X	X	X																	X											X				
Pacific Clinics	7224	3	5	1	X	X	X	X																	X											X				
Pacific Clinics	7227	3	5	1, 5	X	X				X							X								X		X									X		X	X	
Pacific Clinics	7227	3	5	1, 5			X	X									X								X											X				
Pacific Clinics	7284	3	5	1	X	X	X	X																												X				
Pacific Clinics	7380	3	5	5	X					X							X								X		X					X					X		X	X	
Pacific Clinics	7380	3	5	5		X				X							X								X		X										X		X	X	
Pacific Clinics	7380	3	5	5			X	X									X								X											X				
Pacific Clinics	7401	3	5	5	X					X							X								X		X					X					X		X	X	
Pacific Clinics	7401	3	5	5		X				X							X								X		X										X		X	X	
Pacific Clinics	7401	3	5	5			X	X									X								X											X				
Pacific Clinics	7418	3	5	5	X										X		X						X		X		X					X			X		X		X	X	
Pacific Clinics	7418	3	5	5		X											X								X		X										X		X	X	
Pacific Clinics	7418	3	5	5			X	X									X								X											X				
Pacific Clinics	7439	3	5	5	X					X							X								X		X					X					X		X	X	
Pacific Clinics	7439	3	5	5		X				X							X								X		X										X		X	X	
Pacific Clinics	7439	3	5	5			X	X									X								X											X				
Pacific Clinics	7441	3	5	1	X					X							X								X		X					X			X		X		X	X	
Pacific Clinics	7441	3	5	1		X				X							X								X		X										X		X	X	
Pacific Clinics	7441	3	5	1			X	X									X								X											X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Pacific Clinics	7447	3	5	5	X	X	X	X																														X				
Pacific Clinics	7495	1	5	1, 4	X					X								X				X		X		X		X										X		X	X	
Pacific Clinics	7495	1	5	1, 4		X				X								X				X				X		X										X		X	X	
Pacific Clinics	7495	1	5	1, 4			X	X										X								X												X				
Pacific Clinics	7502	5	5	5	X										X			X						X		X		X			X					X		X		X	X	
Pacific Clinics	7502	5	5	5		X												X								X		X										X		X	X	
Pacific Clinics	7502	5	5	5			X	X										X								X												X				
Pacific Clinics	7561	3	5	1	X					X								X								X		X				X						X		X	X	
Pacific Clinics	7561	3	5	1		X				X								X								X		X										X		X	X	
Pacific Clinics	7561	3	5	1			X	X										X								X												X				
Pacific Clinics	7677	4	5	1		X								X																												
Pacific Clinics	7678	1	5	1	X		X																			X																
Pacific Clinics	7678	4	5	1		X																				X																
Pacific Clinics	7678	1	5	1				X																	X	X																
Pacific Clinics	7690	6	5	2	X	X	X																			X												X				
Pacific Clinics	7690	6	5	2				X																	X	X												X				
Pacific Clinics	7748	3	5	1		X								X																												
Pacific Lodge Youth Service	7551	2	3	3	X	X				X																	X											X		X		
Palmdale MHC	7386	1	DMH DO	5		X	X	X										X					X		X									X			X				
Palmdale MHC	7386	1	DMH DO	5					X																		X															
Para Los Ninos	7546	4	1	1	X										X											X		X				X										
Para Los Ninos	7546	4	1	1		X																				X																
Pasadena Unified School District	7567	3	5	5	X	X				X																X		X										X		X		
Pasadena Unified School District	7567	3	5	5			X																		X	X																
Pediatric & Family Medical Center (dba Eisner)	7829	4	1	1	X																						X											X		X	X	
Pediatric & Family Medical Center (dba Eisner)	7829	4	1	1			X																		X	X																
Pediatric & Family Medical Center (Dba Eisner)	7829	4	1	1					X																			X															
Penny Lane Centers	6863	2	3	3	X	X				X					X								X				X											X		X	X	
Penny Lane Centers	7455	1	3	5	X					X										X	X					X												X		X	X	
Penny Lane Centers	7455	1	3	5		X				X				X						X	X					X												X		X	X	
Penny Lane Centers	7455	1	3	5			X																		X													X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Penny Lane Centers	7511	7	3	1	X					X											X						X											X		X	X	
Penny Lane Centers	7511	7	3	1		X				X											X						X											X		X	X	
Penny Lane Centers	7511	7	3	1			X																																			
Penny Lane Centers	7855	2	3	3	X										X												X											X		X	X	
Penny Lane Centers	7855	2	3	3		X																					X											X		X		
Penny Lane Centers	7855	2	3	3			X																		X																	
Personal Involvement Center, Inc.	7542	6	2	2	X												X							X													X		X	X	
Phoenix Houses of Los Angeles, Inc.	7356	2	3	3	X	X				X																	X											X	X	X		
Prototypes	7370	3	1	5	X										X									X		X	X										X		X		
Prototypes	7370	3	1	5		X																			X		X											X		X		
Prototypes	7370	3	1	5			X																		X	X												X				
Prototypes	7568	3	1	1	X										X									X			X											X		X		
Prototypes	7568	3	1	1		X																					X											X		X		
Prototypes	7568	3	1	1			X																															X				
Prototypes	7569	3	1	1	X										X									X		X	X										X		X		
Prototypes	7569	3	1	1		X																				X	X										X		X		
Prototypes	7569	3	1	1			X																		X	X												X				
Providence Community Services, LLC	7572	7	N/A	4	X										X									X			X													X		
Providence Community Services, LLC	7572	7	N/A	4		X																					X											X		X		
Providence Community Services, LLC	7572	7	N/A	4			X																															X				
Providence Community Services, LLC	7751	1	N/A	5	X																												X									
Providence Saint John's Health Center	6773	5	3	3	X										X		X								X		X					X							X		X	X	
Providence Saint John's Health Center	6773	5	3	3		X											X							X	X		X											X		X	X	
Providence Saint John's Health Center	6773	5	3	3			X																	X	X													X				
Rio Hondo Community MHC	1930	7	DMH DO	4			X	X									X					X		X											X						
Rio Hondo Community MHC	1930	7	DMH DO	4					X																			X															
Rosemary Children's Services	7374	3	5	5	X	X																					X											X		X		
Rosemary Children's Services	7374	3	5	5			X																																			
Rosemary Children's Services	7816	3	5	5	X	X																					X											X		X		
Rosemary Children's Services	7816	3	5	5			X																																			
Roybal Family MHS	6857	7	DMH DO	1	X	X									X		X										X													X	X	

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Roybal Family MHS	6857	7	DMH DO	1	X	X											X									X													X	X	
Roybal School Based Program	7584	7	DMH DO	1	X	X																				X													X		
San Antonio MHC	7468	7	DMH DO	1	X												X									X					X								X		
San Antonio MHC	7468	7	DMH DO	1		X											X									X													X		
San Fernando MHS	6840	2	DMH DO	3, 5	X												X									X												X				
San Fernando MHS	6840	2	DMH DO	3, 5		X											X							X			X									X			X			
San Fernando MHS	6840	2	DMH DO	3, 5			X	X									X							X											X			X				
San Fernando MHS	6840	2	DMH DO	3, 5					X																		X																
San Fernando Valley Community MHC, Inc.	6853	2	3	3	X	X																				X												X		X	X	
San Fernando Valley Community MHC, Inc.	6853	2	3	3			X	X																														X				
San Fernando Valley Community MHC, Inc.	7100	2	3	3	X												X								X													X				
San Fernando Valley Community MHC, Inc.	7100	2	3	3		X											X					X			X													X		X		
San Fernando Valley Community MHC, Inc.	7100	2	3	3			X	X									X					X			X													X				
San Fernando Valley Community MHC, Inc.	7100	2	3	3					X																		X																
San Fernando Valley Community MHC, Inc.	7177	2	3	3	X	X											X								X													X		X		
San Fernando Valley Community MHC, Inc.	7177	2	3	3			X	X									X								X													X				
San Fernando Valley Community MHC, Inc.	7177	2	3	3					X																		X													X				
San Fernando Valley Community MHC, Inc.	7174	2	3	3	X	X																																	X		X		
San Fernando Valley Community MHC, Inc.	7174	2	3	3			X	X																															X				
San Fernando Valley Community MHC, Inc.	7174	2	3	3					X																		X																
San Fernando Valley Community MHC, Inc.	7235	2	3	3	X												X								X													X				
San Fernando Valley Community MHC, Inc.	7235	2	3	3		X	X	X									X					X			X													X				
San Fernando Valley Community MHC, Inc.	7252	2	3	3	X	X											X								X													X		X		
San Fernando Valley Community MHC, Inc.	7252	2	3	3			X	X									X								X													X				
San Fernando Valley Community MHC, Inc.	7320	2	3	3	X												X								X		X											X		X		
San Fernando Valley Community MHC, Inc.	7320	2	3	3		X								X			X								X		X											X		X		
San Fernando Valley Community MHC, Inc.	7320	2	3	3			X	X									X							X	X													X				
San Fernando Valley Community MHC, Inc.	7320	2	3	3					X																		X																
San Fernando Valley Community MHC, Inc.	7321	2	3	3	X	X	X	X									X																					X				
San Fernando Valley Community MHC, Inc.	7322	2	3	3	X												X								X													X				
San Fernando Valley Community MHC, Inc.	7322	2	3	3		X											X					X			X													X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
San Fernando Valley Community MHC, Inc.	7322	2	3	3			X										X					X			X												X				
San Fernando Valley Community MHC, Inc.	7322	2	3	3				X									X					X			X									X				X				
San Fernando Valley Community MHC, Inc.	7322	2	3	3					X																		X															
San Fernando Valley Community MHC, Inc.	7354	2	3	3	X										X											X												X		X	X	
San Fernando Valley Community MHC, Inc.	7354	2	3	3		X																				X												X		X	X	
San Fernando Valley Community MHC, Inc.	7354	2	3	3			X	X																														X				
San Fernando Valley Community MHC, Inc.	7369	2	3	3	X										X											X					X							X		X	X	
San Fernando Valley Community MHC, Inc.	7369	2	3	3		X																				X												X		X	X	
San Fernando Valley Community MHC, Inc.	7369	2	3	3			X	X																														X				
San Fernando Valley Community MHC, Inc.	7622	2	3	3	X	X																				X				X							X		X	X	
San Gabriel Children's Center, Inc.	7563	3	5	5	X					X																X					X							X		X		
San Gabriel Children's Center, Inc.	7563	3	5	5		X				X																X												X		X		
San Gabriel Children's Center, Inc.	7563	3	5	5			X										X																					X				
San Pedro MHS	1928	8	DMH DO	4			X	X									X					X		X														X				
San Pedro MHS	1928	8	DMH DO	4					X																		X												X				
Santa Clarita Valley MHC	1905	2	DMH DO	5			X										X							X											X			X				
Santa Clarita Valley MHC	1905	2	DMH DO	5					X																		X												X				
Shields For Family Project, Inc.	7264	6	2	2	X					X	X				X		X						X		X						X							X		X	X	
Shields For Family Project, Inc.	7264	6	2	2		X				X							X								X													X		X	X	
Shields For Family Project, Inc.	7264	6	2	2			X										X							X	X													X				
Shields For Family Project, Inc.	7264	6	2	2					X																		X												X				
Shields For Family Project, Inc.	7365	6	2	2	X					X							X								X						X							X			X	
Shields For Family Project, Inc.	7365	6	2	2		X				X							X								X													X			X	
Shields For Family Project, Inc.	7365	6	2	2			X										X							X	X													X				
Shields For Family Project, Inc.	7365	6	2	2					X																		X																
Shields For Family Project, Inc.	7465	6	2	4	X					X	X				X		X					X		X		X					X	X						X			X	
Shields For Family Project, Inc.	7465	6	2	4		X				X							X					X			X						X							X			X	
Shields For Family Project, Inc.	7465	6	2	4			X										X							X	X													X				
Shields For Family Project, Inc.	7465	6	2	4					X																		X																
Shields For Family Project, Inc.	7536	6	2	4	X					X	X				X		X					X		X		X		X				X						X		X	X	
Shields For Family Project, Inc.	7536	6	2	4		X				X							X					X			X		X											X		X	X	

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Shields For Family Project, Inc.	7536	6	2	4			X										X						X	X													X				
Shields For Family Project, Inc.	7536	6	2	4					X																			X														
Shields For Family Project, Inc.	7573	6	2	2	X					X	X				X		X				X		X		X						X						X			X	
Shields For Family Project, Inc.	7573	6	2	2		X				X	X						X				X				X												X			X	
Shields For Family Project, Inc.	7573	6	2	2			X			X	X						X							X	X												X				
Shields For Family Project, Inc.	7573	6	2	2					X	X	X																	X														
Shields For Family Project, Inc.	7737	6	2	2	X					X	X				X		X				X		X		X						X						X			X	
Shields For Family Project, Inc.	7737	6	2	2		X				X							X				X				X												X			X	
Shields For Family Project, Inc.	7737	6	2	2			X										X							X	X												X				
Shields For Family Project, Inc.	7737	6	2	2					X																			X														
Shields For Family Project, Inc.	7763	6	2	2	X						X				X									X														X			X	
Shields For Family Project, Inc.	7763	6	2	2		X																																			X	
Shields For Family Project, Inc.	7763	6	2	2			X																		X																
Shields For Family Project, Inc.	7764	6	2	2	X					X	X				X		X						X		X						X						X			X	
Shields For Family Project, Inc.	7764	6	2	2		X				X							X								X												X			X	
Shields For Family Project, Inc.	7764	6	2	2			X										X								X												X				
Shields For Family Project, Inc.	7764	6	2	2					X																			X														
Shields For Family Project, Inc.	7768	6	2	2	X	X																						X													X	
Shields For Family Project, Inc.	7768	6	2	2			X																		X																
Social Model Recovery Systems, Inc.	7131	3	5	5			X																																X				
Social Model Recovery Systems, Inc.	7618	3	5	5			X																X															X				
Social Model Recovery Systems, Inc.	7618	3	5	5					X																			X														
Social Model Recovery Systems, Inc.	7642	3	5	5			X																																X				
Social Model Recovery Systems, Inc.	7642	3	5	5					X																			X														
South Bay Children's Health Center Association	1969	8	4	4	X																						X												X		X	X	
South Bay Children's Health Center Association	1969	8	4	4		X																			X		X												X		X	X	
South Bay Children's Health Center Association	1969	8	4	4			X																		X																	
South Bay Children's Health Center Association	7220	8	4	4	X																						X												X		X	X	
South Bay Children's Health Center Association	7220	8	4	4		X																			X		X												X		X	X	
South Bay Children's Health Center Association	7220	8	4	4			X																		X																	
South Bay MHS	1935	8	DMH DO	2			X										X		X			X		X	X			X							X			X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
South Central Health & Rehab Program (SCHARP)	7242	6	2	2	X	X	X										X							X													X				
South Central Health & Rehab Program (SCHARP)	7242	6	2	2					X																		X															
South Central Health & Rehab Program (SCHARP)	7303	6	2	2	X	X											X							X		X												X		X		
South Central Health & Rehab Program (SCHARP)	7303	6	2	2			X										X							X														X				
South Central Health & Rehab Program (SCHARP)	7303	6	2	2					X																		X															
South Central Health & Rehab Program (SCHARP)	7396	6	2	2	X																										X										
South Central Health & Rehab Program (SCHARP)	7409	4	2	2	X												X							X														X				
South Central Health & Rehab Program (SCHARP)	7409	4	2	2					X																		X															
South Central Health & Rehab Program (SCHARP)	7549	6	2	2	X	X	X																															X				
South Central Health & Rehab Program (SCHARP)	7555	6	2	2	X												X							X														X				
South Central Health & Rehab Program (SCHARP)	7555	6	2	2					X																		X															
South Central Health & Rehab Program (SCHARP)	7654	6	2	2	X								X				X							X		X												X		X		
South Central Health & Rehab Program (SCHARP)	7654	6	2	2		X											X							X		X												X		X		
South Central Health & Rehab Program (SCHARP)	7654	6	2	2			X										X							X														X				
South Central Health & Rehab Program (SCHARP)	7654	6	2	2					X																		X															
Special Service For Groups	7124	6	1	2	X	X	X										X							X														X				
Special Service For Groups	7124	6	1	2				X									X							X								X	X				X				
Special Service For Groups	7124	6	1	2					X																		X															
Special Service For Groups	7186	4	1	2	X								X												X		X												X				
Special Service For Groups	7186	4	1	2		X																			X		X												X				
Special Service For Groups	7186	4	1	2			X	X																	X														X				
Special Service For Groups	7187	4	1	1	X								X												X		X												X				
Special Service For Groups	7187	4	1	1		X																			X		X												X				
Special Service For Groups	7187	4	1	1			X	X																	X														X				
Special Service For Groups	7329	8	1	4	X					X			X													X	X					X						X		X		
Special Service For Groups	7329	8	1	4		X				X				X												X	X											X		X		
Special Service For Groups	7329	8	1	4			X	X																														X				
Special Service For Groups	7362	2	1	3	X								X												X		X												X				
Special Service For Groups	7362	2	1	3		X																		X	X		X												X				
Special Service For Groups	7362	2	1	3			X	X																X	X														X				
Special Service For Groups	7510	6	1	2	X																																	X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Special Service For Groups	7510	6	1	2			X																	X													X				
Special Service For Groups	7517	4	1	1	X	X	X										X							X													X				
Special Service For Groups	7517	4	1	1				X									X							X									X	X			X				
Special Service For Groups	7517	4	1	1					X																		X										X				
Special Service For Groups	7579	7	1	4	X								X											X		X											X				
Special Service For Groups	7579	7	1	4		X																		X		X											X				
Special Service For Groups	7579	7	1	4			X	X																X													X				
Special Service For Groups	7619	4	1	1	X												X							X													X				
Special Service For Groups	7619	4	1	1		X											X							X	X												X				
Special Service For Groups	7619	4	1	1			X										X							X	X												X				
Special Service For Groups	7619	4	1	1				X									X							X	X									X	X			X				
Special Service For Groups	7619	4	1	1					X																		X																
Special Service For Groups	7681	6	1	2	X					X			X										X				X										X		X	X		
Special Service For Groups	7681	6	1	2		X				X																	X										X		X			
Special Service For Groups	7681	6	1	2			X	X																													X					
Special Service For Groups	7681	6	1	2					X																			X															
Special Service For Groups	7682	8	1	2	X												X								X												X					
Special Service For Groups	7682	8	1	2		X	X										X							X	X												X					
Special Service For Groups	7682	8	1	2				X									X							X	X									X			X					
Special Service For Groups	7682	8	1	2					X																			X															
Special Service For Groups	7835	1	1	5	X																																X					
Special Service For Groups	7835	1	1	5		X	X	X															X														X					
Spiritt Family Services, Inc.	7527	3	1	1	X										X		X							X	X	X	X				X					X		X	X		
Spiritt Family Services, Inc.	7527	3	1	1		X											X							X	X	X	X									X		X	X		
Spiritt Family Services, Inc.	7527	3	1	1			X																	X																	
St. Anne's Maternity Home	7538	4	1	1	X										X											X					X					X		X			
St. Anne's Maternity Home	7538	4	1	1		X																		X		X										X		X			
St. Anne's Maternity Home	7538	4	1	1			X																	X																	
St. Francis Medical Center	7636	6	2	2	X						X														X													X				
St. Francis Medical Center	7636	6	2	2		X																			X													X				
St. Francis Medical Center	7637	7	2	1	X						X														X													X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																	
St. Francis Medical Center	7637	7	2	1		X																		X														X		
St. Joseph	7114	5	3	3				X									X						X	X								X	X				X			
Star View Adolescent Center, Inc.	7335	8	4	4	X					X	X				X	X					X		X				X			X	X							X		
Star View Adolescent Center, Inc.	7335	8	4	4		X				X							X				X						X			X							X		
Star View Adolescent Center, Inc.	7335	8	4	4			X										X																						
Star View Adolescent Center, Inc.	7335	8	4	4				X									X																						
Star View Adolescent Center, Inc.	7367	8	4	4	X					X	X				X	X					X		X				X			X	X							X		
Star View Adolescent Center, Inc.	7367	8	4	4		X				X							X				X						X			X							X		
Star View Adolescent Center, Inc.	7367	8	4	4			X										X																						
Star View Adolescent Center, Inc.	7367	8	4	4				X									X																						
Star View Adolescent Center, Inc.	7493	6	4	2	X					X	X					X					X		X				X			X							X		
Star View Adolescent Center, Inc.	7493	6	4	2		X				X							X				X						X			X							X		
Star View Adolescent Center, Inc.	7493	6	4	2			X										X																						
Star View Adolescent Center, Inc.	7493	6	4	2				X									X																						
Star View Adolescent Center, Inc.	7503	4	4	1	X						X				X											X				X							X		
Star View Adolescent Center, Inc.	7503	4	4	1		X											X									X				X							X		
Star View Adolescent Center, Inc.	7503	4	4	1			X										X																						
Star View Adolescent Center, Inc.	7503	4	4	1				X									X																						
Star View Adolescent Center, Inc.	7856	4	4	1	X																																		
Star View Adolescent Center, Inc.	7856	4	4	1		X											X																						
Star View Adolescent Center, Inc.	7856	4	4	1			X										X																						
Star View Adolescent Center, Inc.	7856	4	4	1				X									X																						
Stirling Academy, Inc.	7185	2	3	3	X	X																				X										X		X		
Stirling Academy, Inc.	7481	2	3	3	X	X																				X										X		X		
Sunbridge Harbor View Rehab Ctr, Inc.	7270	8	4	4	X					X																X										X		X	X	
Sunbridge Harbor View Rehab Ctr, Inc.	7270	8	4	4		X				X							X							X		X										X		X	X	
Sunbridge Harbor View Rehab Ctr, Inc.	7270	8	4	4			X										X							X															
Tarzana Treatment Center, Inc.	4053	1	3	5					X																		X												
Tarzana Treatment Center, Inc.	4054	2	3	3	X	X	X																													X				
Tarzana Treatment Center, Inc.	4054	2	3	3					X																		X												
Tarzana Treatment Center, Inc.	4055	1	3	5	X	X	X																													X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
Tarzana Treatment Center, Inc.	7522	2	3	3	X	X																		X													X				
Tarzana Treatment Center, Inc.	7531	1	3	5	X	X																		X													X				
Tarzana Treatment Center, Inc.	7531	1	3	5			X										X							X																	
Tarzana Treatment Center, Inc.	7649	2	3	3	X	X	X																	X													X				
Tarzana Treatment Center, Inc.	7650	8	3	4	X	X	X																														X				
Tarzana Treatment Center, Inc.	7832	2	3	3	X	X	X																														X				
Telecare Corporation	7406	6, 7	7	4		X								X																											
Telecare Corporation	7250	7, 8	7	4				X									X							X	X									X	X			X				
Tessie Cleveland Community Services Corp.	7641	6	2	2	X								X														X				X						X		X		
Tessie Cleveland Community Services Corp.	7793	8	2	2	X								X														X										X		X		
Tessie Cleveland Community Services Corp.	7793	8	2	2		X																					X										X		X		
The Children's Center of Antelope Valley	7488	1	5	5	X												X										X				X						X		X		
The Children's Center of Antelope Valley	7488	1	5	5		X											X										X										X		X		
The Children's Center of Antelope Valley	7488	1	5	5			X																														X				
The Guidance Center	7249	8	4	4	X										X										X		X										X		X		
The Guidance Center	7249	8	4	4		X																			X		X										X		X		
The Guidance Center	7249	8	4	4			X																	X																	
The Guidance Center	7279	6	4	2	X										X										X		X										X		X		
The Guidance Center	7279	6	4	2		X																			X		X										X		X		
The Guidance Center	7279	6	4	2			X																	X																	
The Guidance Center	7433	8	4	4	X										X										X		X					X						X		X		
The Guidance Center	7433	8	4	4		X																			X		X										X		X		
The Guidance Center	7433	8	4	4			X																	X																	
The HELP Group Child and Family Center	7394	5	3	2	X										X		X										X										X		X	X	
The HELP Group Child and Family Center	7394	5	3	2		X								X			X										X										X		X	X	
The HELP Group Child and Family Center	7394	5	3	2			X										X																				X				
The HELP Group Child and Family Center	7394	5	3	2				X									X																				X				
The HELP Group Child and Family Center	7624	2	3	3	X										X	X	X										X				X						X		X	X	
The HELP Group Child and Family Center	7624	2	3	3		X											X										X										X		X	X	
The HELP Group Child and Family Center	7624	2	3	3			X										X							X														X				
The HELP Group Child and Family Center	7624	2	3	3				X									X																				X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
The Institute For The Redesign of Learning (Almansor)	7368	3	5	5	X	X																															X				
The Institute For The Redesign of Learning (Almansor)	7667	7	5	1	X	X																				X											X		X		
The Institute For The Redesign of Learning (Almansor)	7708	3	5	5	X	X																				X											X		X		
The Village Family Services	7564	2	3	3	X						X				X		X								X	X					X						X		X	X	
The Village Family Services	7564	2	3	3		X											X								X	X											X		X	X	
The Village Family Services	7564	2	3	3			X										X							X	X													X				
The Village Family Services	7851	2	3	3	X																				X																	
The Village Family Services	7851	2	3	3		X																			X																	
The Village Family Services	7851	2	3	3			X																		X																	
The Village Family Services	7857	2	3	3	X																				X																	
The Village Family Services	7857	2	3	3		X																			X																	
The Village Family Services	7857	2	3	3			X																		X																	
Ties For Families	7702	8	DMH DO	4	X										X						X			X					X								X		X		X
Ties For Families	7702	8	DMH DO	4		X															X																X		X		
Tobinworld	7530	2	5	5	X	X				X							X										X										X		X	X	
Trinity Youth Services	7552	3	1	1	X																						X										X		X		
Trinity Youth Services	7552	3	1	1		X																			X		X										X		X		
Trinity Youth Services	7552	3	1	1			X																		X																	
UCLA Ties For Adoption (The Regents)	7446	5	3	3	X										X												X									X	X				X
UCLA Ties For Adoption (The Regents)	7446	5	3	3		X																					X										X				
United American Indian Involvement, Inc.	7414	4	1	1	X	X																					X										X		X		
Valley Coordinated Children Services	7340	2	DMH DO	3																												X										
VIP Community Mental Health Center, Inc.	7480	4	1	1	X										X	X	X							X		X		X									X		X	X	
VIP Community Mental Health Center, Inc.	7480	4	1	1		X											X									X		X									X		X	X	
VIP Community Mental Health Center, Inc.	7787	3	1	1	X																											X									
VIP Community Mental Health Center, Inc.	7791	4	1	1	X	X											X																				X				
Vista Del Mar Child & Family Svcs	7196	5	2	2	X										X	X										X		X									X	X		X		
Vista Del Mar Child & Family Svcs	7196	5	2	2		X																				X		X									X	X		X		
Vista Del Mar Child & Family Svcs	7196	5	2	2			X																			X																
West Central Family MHS	1908	6	DMH DO	2		X											X					X		X	X													X		X		
West Central Family MHS	1908	6	DMH DO	2			X	X									X					X		X	X													X				

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			Legal Entity SD	Pro. No. SD	PEI - Child	PEI - TAY	PEI - Adult	PEI - Older Adult	Special Program																																		
West Central Family MHS	1908	6	DMH DO	2					X																			X															
West Valley MHC	6841	2	DMH DO	3			X										X		X			X		X	X										X			X				
West Valley MHC	6841	2	DMH DO	3				X									X		X			X		X	X								X		X			X				

* Currently, DBT and PE are for DMH Directly Operated Providers Only