Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Prevention Service: Mental Health

Service Attachment

DEFINITION

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a program for children and adolescents who have symptoms associated with trauma exposure. TF-CBT is intended to treat children/adolescents who have post-traumatic stress disorder (PTSD) symptoms, dysfunctional feelings or thoughts, or behavioral problems. The intervention also supports caregivers in overcoming their personal distress, implementing effective parenting skills, and fostering positive interactions with their child/adolescent.
After ensuring safety of the child/adolescent, TF-CBT is structured into three phases that include:

1. Skill building for the child/adolescent's self-regulation and the caregiver's behavior management and supportive care abilities.
2. Addressing the traumatic experience.
3. Joint therapy sessions between caregiver and child/adolescent.

The goals of TF-CBT are:

1. Improving child PTSD, depressive and anxiety symptoms.
2. Improving child externalizing behavior problems (including sexual behavior problems if related to trauma).
3. Improving parenting skills and parental support of the child and reducing parental distress.
4. Enhancing parent-child communication, attachment, and ability to maintain safety.
5. Improving child's adaptive functioning.
6. Reducing shame and embarrassment related to the traumatic experiences.

TARGET POPULATION

This program targets children/adolescents, who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and child safety is maintained. For purposes of prevention service provision, the child shall be placed in the caregiver home while receiving this service and meet the eligibility criteria of being a candidate for foster care or a pregnant/parenting foster youth and as defined within Nebraska's FFPSA Plan candidacy definition as identified in Nebraska's FFPSA Plan.

LOCATION AND DELIVERY SETTING

TF-CBT is typically offered in a clinical office setting, though it can also be used in residential treatment facilities, schools, and homes.

When providing TF-CBT in the family home, the Contractor shall provide DHHS with each therapist's starting point address at least seven (7) calendar days after the execution of this contract and at least seven (7) calendar days prior to utilizing a new therapist. The distance between the therapist's starting point address and each family's home address will be calculated using MapQuest or Google Maps. Any fraction of a mile calculated shall be rounded up to the nearest mile.

LENGTH OF SERVICE

TF-CBT is typically administered in 12 to 16 sessions. However, it can be delivered in as few as 8 sessions. For particularly complex trauma, it can last for as many as 25 sessions. TF-CBT sessions are scheduled weekly until the end of treatment. Session length can range from 45 to 90 minutes, but typically last for one hour. During these sessions the therapist may meet with the caregiver and child/adolescent separately (i.e., 30 minutes with the caregiver and 30 minutes with the child/adolescent). Or, the therapist may meet with the caregiver and child/adolescent jointly. When feasible, the final set of sessions are often joint as a part of the treatment plan, with the caregiver or other supportive adult and child/adolescent participating together.

STAFF CREDENTIALS

TF-CBT providers shall be licensed masters or doctoral level mental health professionals with a license to provide mental health services in Nebraska as set forth by the Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 38-2101 to 38-2139 of the Mental Health Practice Act and the Uniform Credentialing Act and as set forth by the DHHS Division of Public Health, Licensure Unit.

A person who provides mental health services, regardless of the how such services are delivered, to a client present in Nebraska at the time of service, must hold a current appropriate credential issued by the Nebraska Department of Health and Human Services.

TRAINING AND CERTIFICATION

The Contractor shall have at least 2 years' experience, working with children and families. The Contractor shall have completed or be in process of completing training, as required by the TF-CBT model developer and as outlined in the Federal Prevention Clearinghouse. Information can be found at:

1. https://tfcbt.org/
2. https://tfcbt2.musc.edu/
3. https://preventionservices.acf.hhs.gov/programs/224/show

Prior to provision of TF-CBT, the Contractor shall:

1. Complete TF-CBT-Web: https://tfcbt2.musc.edu/. When completed, this must be documented by attaching a copy of the completion certificate provided by the Medical University of South Carolina and providing a copy to DHHS.
2. Clinicians must attend two consecutive days of training.
3. Clinicians shall provide DHHS with documentation of completion of the above reference training.

During the initial first year of providing TF-CBT, the Contractor shall:

1. Complete three treatment cases.
2. Score at least 80% on a certification exam.
3. Participate in a follow up supervisory consultation for 6-12 months.
4. Certification criteria can be found at: https://tfcbt.org/certification/.
5. The contractor shall ensure the staff within the agency providing TF-CBT, has and maintains the required education, training and/or model certification.
6. Participate in training, as applicable, with DHHS, regarding the NFOCUS billing and claims system.
7. The contractor shall collaborate or consult with the TF-CBT purveyor, as necessary for training, credentialing, and fidelity to the model.

ACCEPTING & RESPONDING TO REFERRALS

The Contractor shall review the referral to determine if the family is appropriate for the service. If it is determined the family is not appropriate for TF-CBT, the Contractor shall notify the Child and Family Services Specialist (CFSS) within 24 hours.

FIDELITY STANDARDS

1. The Contractor shall adhere to the fidelity standards of TF-CBT, as set forth by the model purveyor and the book/manual/available documentation as contained in: Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). Treating trauma and traumatic grief in children and adolescents. Guilford Press.
2. The Contractor shall adhere to model fidelity as established by the model purveyor. This includes, but may not be limited to:
   - Maintain proper model certification and the clinicians being assigned the CFS cases, within personnel files.
   - Maintain the required educational/training requirements consistent with the model developer guidelines and terms of the CFS contract.
   - Participate in personnel file reviews, as determined and performed by DHHS that will include validation of current model certification, and confirmation of educational/training status for staff providing TF-CBT.
   - If certified, clinician must use at least one of the standardized instruments when providing TF-CBT:
     - Child PTSD Symptom Scale for DSM-5 (CPSS-5, children 8 or older)
     - Young Child PTSD Checklist (YCPC, children 7 or younger)
     - Child and Adolescent Trauma Screen-2 (CATS)
3. The Contractor shall log service information as determined by DHHS. This will include, but is not limited to:
   - Family Name
   - Master Case (family identified)
   - Service Type (TF-CBT)
   - Service Begin Date
   - Service End Date
   - Total number of sessions
   - Did the family successfully complete treatment?
   - If the family terminated services early, why?
   - Name of Therapist
   - Youth at home at closure?
4. The Contractor shall establish a Secure File Transfer Protocol with the DHHS contracted evaluation provider, to share outcome assessments (standardized measures), as part of the formal evaluation process required through FFPSA.

PERFORMANCE OUTCOME MEASURES

The Contractor is responsible for reporting data information to DHHS. The Contractor will submit a monthly report, by the 10th of the following month, or upon request by DHHS, that will include, but is not limited to:

1. Interventions provided.
2. Results of any assessments completed.

3. Outcome progression and status.
4. The monthly report will refer to any/all safety threats present at time of referral, and progress towards addressing the safety threat(s).

DHHS shall collect, within its own system, the additional data information for further assessment of performance outcomes:

1. Foster Care Placement status at 12 months from prevention plan start date
2. Foster care entry within 24 months of the prevention plan start date
3. Date of entry into foster care
4. The extent TF-CBT is preventing maltreatment:
    - Maltreatment after discharge from TF-CBT
      Maltreatment while providing TF-CBT
5. At service closing, eighty-five percent (85%) of the families referred by DHHS will have their children in home at discharge.
6. Six (6) months post service discharge, eighty-five percent (85%) of the families who had their children in-home at discharge will have safely maintained their children in-home without removal or placement outside of the home.
7. 100% of children will experience no incidents of substantiated maltreatment while involved in this service.

If the contractor does not meet the performance outcome measures, DHHS may require the contractor to submit a Corrective Action Plan. A Corrective Action Plan must be submitted for review and approval to DHHS within thirty (30) business days of the request. If DHHS requires revisions to the Corrective Action Plan, it will so notify the contractor within ten (10) business days.

MINIMUM REPORTING REQUIREMENTS

The Contractor shall report data measures as required by the TF-CBT purveyor if applicable and/or DHHS, for monitoring the outcomes and fidelity of the service provided. A copy of this information shall be sent to the DHHS Contract Manager by the 10th day of the following month.

1. The Contractor shall enter outcome data on a DHHS database as determined by DHHS.
2. The Contractor shall report the race of the child.
3. The Contractor shall report each date that TF-CBT is provided.
4. The Contractor shall provide a written discharge plan to the referring CFS Specialist, prior to discharging the family. The discharge plan shall include the family’s involvement in the creation of the plan as well as specific community services and informal, social supports the family has been connected to during the service.
5. The Contractor shall maintain 100% of all source documentation, for auditing purposes, in a format approved by DHHS which supports each billing entry made through the web portal.

PAYMENT

For the service of TF-CBT, the Contractor shall not claim payment from DHHS under this Contract of any service for which payment is being claimed, even in part, for medical services to individuals paid for by Medicaid or any other payor source. The Contractor shall first bill Medicaid or private insurance for medical and/or treatment services. If Medicaid or private insurance denies payment for treatment services, the TF-CBT provider shall submit a copy of the denial to DHHS and DHHS may pay for treatment services.

1. When Medicaid pays for the medical/treatment services, the DHHS non treatment rate will cover non-medical expenses. Non-medical expenses include but are not limited to:
   - Time to complete routine documentation,
   - Costs for business operations,
   - Non face-to-face time,
   - Mileage and drive time.
   - Face to face contact time with the child(ren) and/or family, outside of the medical/treatment sessions.

2. When Medicaid denies payment for services, the DHHS rate will cover non-medical expenses in addition to the medical/treatment services.
3. 3. If attendance at court or family team meetings is requested by either DHHS, courts, or required for model fidelity then the Contractor can bill for services at the DHHS established TF-CBT non-treatment rate.
4. The Contractor shall submit an N-FOCUS generated electronic claim through the web portal, unless otherwise directed by DHHS.
5. No additional costs shall be paid by DHHS, unless and except as specifically stated with the Contract and any attachment(s).
6. The Contractor shall maintain 100% of all source documentation, for auditing purposes, in a format approved by DHHS which supports each billing entry made through the web portal. The Contractor shall submit denied claims from Medicaid as supporting documentation for the higher rates billed to DHHS.

ESTABLISHED RATE

For the service of TF-CBT, DHHS shall pay the Contractor the following:

1. When Medicaid pays for the medical/treatment service, DHHS shall pay the Contractor $17.40/hour for non-treatment services. This can be paid in in 15-minute increments. DHHS shall pay the Contractor per the following payment schedule for a partial hour.

1-15 minutes	$ 4.35
16-30 minutes	$ 8.70
31-45 minutes	$ 13.05
46-60 minutes	$ 17.40

2. When Medicaid denies payment for the medical/treatment service, DHHS shall pay the Contractor $191.40/hour for non-treatment services. This can be paid in in 15-minute increments. DHHS shall pay the Contractor per the following payment schedule for a partial hour.

1-15 minutes	$ 47.85
16-30 minutes	$ 95.70
31-45 minutes	$ 143.55
46-60 minutes	$ 191.40

3. DHHS must pre-approve in writing any Contractor requests to utilize more than one staff person to work with a family simultaneously.

EVALUATION STRATEGY

The contractor shall collaborate with a DHHS contracted evaluation provider, to participate in an evaluation study of the provision of TF-CBT to child welfare involved families. This collaboration will involve:

1. Participating in web-based surveys
2. Voluntarily participating in interviews to describe implementation challenges and successes.
3. Provide the legal guardian of the participant, with a consent form, requesting consent for information from participating in TF-CBT, be provided to the DHHS contract evaluation provider, for purposes of conducting and evaluation.

Additionally, TF-CBT providers will be required to collect trauma-related outcome assessment data for every FFPSA client for evaluation purposes. These data will be collected during treatment and submitted to DHHS to be used in the evaluation.

DHHS RESPONSIBILITIES

DHHS shall collect fidelity information through DHHS CQI and provide information to the DHHS contracted evaluation provider via a Secure File Transfer Protocol.