REGIONAL CONVENINGS 2018

CHILDREN AND YOUTH
SPECIALTY MENTAL HEALTH SERVICES

“Moving Policy Into Practice”

November 7, 2018
Redding, CA
Welcome & Overview for the Day
Opening Remarks

Erika Cristo
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Chief, Resource Development and Training Support Bureau, California Department of Social Services
Goals for the Convening

• Support counties in their continued implementation efforts & initiatives related to Specialty Mental Health Services (SMHS) for children and youth

• Provide a forum for multi-agency partners to learn from each other and strengthen their work with cross-system partners
Goals for the Convening

• Provide Updates on:
  ▶ Pathways to Well Being (Intensive Home-Based Services, Intensive Care Coordination, & Therapeutic Foster Care
  ▶ SB 1291—Mental Health Plan Foster Care Services Data
  ▶ AB 1299—Presumptive Transfer of Specialty Mental Health Services
  ▶ Pediatric Symptom Checklist & Child and Adolescents Needs and Strengths Tool
  ▶ AB 501—Children’s Crisis Residential Programs
  ▶ Continuum of Care Reform
  ▶ Short Term Residential Therapeutic Program Mental Health Program Approval
Moving Policy into Practice
Current Policy and Programmatic Efforts and Initiatives
Pathways to Well Being (ICC, IHBS and TFC)
Pathways to Well Being

• Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)
  – Monitoring Provision of Services
  – Demonstration Project Identifier (DPI)

• Medi-Cal Manual for ICC, IHBS, and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, Third Edition

• Removal of lockout for ICC and IHBS in Group homes/STRTPs (IN 17-055)
Screening, Referral, Assessment and Provision of Specialty Mental Health Services

- DHCS and CDSS Data Efforts
  - Understand “full picture” and how children and youth move through mental health and child welfare

- Understand how many children are screened, how many children are referred and assessed and how many children receive services and what types of services

Goal is to identify and address gaps
Therapeutic Foster Care

- TFC is available as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to children and youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria.

- TFC:
  - Short-term, intensive, highly coordinated, trauma-informed, and individualized intervention provided by a TFC parent to a child or youth who has complex emotional and behavioral needs.
  - Intended for children and youth who require intensive and frequent mental health support in a family environment.
Therapeutic Foster Care

– Should not be the only SMHS a child or youth receives; the child or youth also must receive ICC and other medically necessary SMHS, as set forth in the child’s or youth’s client plan

– Must have a Child and Family Team (CFT) in place to guide and plan TFC service provision

– Progress of TFC should be reviewed, in coordination with the CFT, at least every 3 months
• **TFC** consists of one or more of the following:

  – **Plan Development** (limited to when it is part of the CFT meeting)
    • TFC parent participates in planning, monitoring and review process as a member of the CFT. The TFC parent observes, monitors and alerts the CFT about changes in the child’s needs

  – **Rehabilitation**
    • TFC parent implements interventions, as directed by the LMHP/WRMHP, which include trauma informed strategies, as set forth in the child’s client plan (i.e. provide skills-based interventions such as coaching and modeling)

  – **Collateral**
    • TFC parent will meet the needs of the child or youth in achieving his or her client plan goals by reaching out to significant support person(s), and by providing consultation and/or training
• TFC will be provided by TFC parents, under the direction of a TFC Agency (a Foster Family Agency in most cases)

• The TFC Agency:
  – Ensures that the TFC parent meets Resource Family Approval (RFA) program standards and the required qualifications as a TFC parent
  – Recruits, oversees and trains TFC parents
  – Monitors the child’s or youth’s progress in meeting client plan goals related to TFC
  – Maintains documentation (progress notes)

• The TFC Agency may also provide other SMHS, if included in its contract with a Mental Health Plan
The TFC Agency will employ a Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMHP) who will:

- Direct the TFC parent regarding the interventions the TFC parent will provide, as identified in the child’s or youth’s client plan.

- Meet with the TFC parent, face-to-face, in the TFC parent’ home, a minimum of one (1) hour per week.

- Review and co-sign progress notes, ensuring that each progress note meets Medi-Cal SMHS and contractual requirements.
• The TFC Parent must:
  
  – Be at least 21 years old and must meet “other qualified provider” qualifications (i.e., has a high school degree or equivalent)

  – Meet and comply with all basic foster care/resource parent requirements

  – Meet and comply with all requirements and training related to the role as a TFC parent

  – Must have forty (40) hours of initial TFC parent training and must complete twenty-four (24) hours of annual, ongoing training
The TFC parent(s) must write and sign a daily progress note for each day that TFC is provided.

The progress note must meet Medi-Cal documentation standards.

The TFC Agency must comply with the mental health documentation requirements prescribed by the county MHP in accordance with the contract between DHCS and the local MHP.
• The unit of service for TFC is a calendar day
  – A day must be claimed only for each calendar day in which TFC is provided

• The per diem rate for TFC includes:
  – The TFC Agency’s administrative and LMHP/WRMHP staff costs; and
  – The payment to the TFC parent for the provision of TFC

• The interim per diem rate depends on whether or not the TFC Agency is a contractor of the MHP or is county owned and operated
The Medi-Cal Manual includes:

– Description and indicators of need for TFC
– TFC agency role, TFC parent qualifications and training requirements
– Settings, limitations and lockouts
– Claiming and reimbursement
– Documentation requirements
– Sample progress notes
– Vignettes pertaining to three, trauma-informed TFC case examples
• DHCS and CDSS released the Therapeutic Foster Care Resource Toolkit

• Includes learning objectives for each of the identified TFC trainings topics

• Provides information and resources to assist TFC Agencies in their development of a TFC parent training program to meet the 40-hour pre-service and 24-hour ongoing TFC training requirements
Therapeutic Foster Care

• Next Steps
  – Moving forward with implementation of TFC
  – Availability and readiness of Foster Family Agencies
  – TFC parent recruitment
  – Child welfare, juvenile probation and MHPs working together on recruitment efforts for FFAs and TFC parents
Therapeutic Foster Care

- Webinar Recordings
  - TFC webinar
  - TFC and Intensive Services Foster Care (ISFC) webinar
Questions & Answers
Senate Bill (SB) 1291
SMHS Data on Foster Care
Children & Youth
• SB 1291 requires annual MHP reviews to be conducted by an External Quality Review Organization (EQRO) & commencing July 1, 2018 requires those reviews to include specific data for Medi-Cal eligible minor and non-minor dependents in foster care

• EQRO will report on:
  – Access to & timeliness of mental health services
  – Quality of mental health services
  – Translation & interpretation services
  – Performance data
  – Utilization data
• The intent of SB 1291 is to improve the ability of the State and Counties to oversee SMHS for Foster children and youth and to track outcomes related to those services

• EQRO will utilize existing DHCS and MHP data to obtain, review and validate data

• This data will be shared with County Board of Supervisors and will include data to assist in the development of MH service plans, performance outcomes system data and metrics, as specified
Based on the EQRO’s findings, DHCS is to notify MHPs in writing of any deficiencies found in the access, timeliness, and quality of services.

MHPs are required to submit corrective action plans to DHCS based on deficiencies identified by the EQRO.

DHCS is required to post corrective action plans prepared by MHP and EQRO data on DHCS website.
Questions and Answers
Break
Assembly Bill (AB) 1299
Presumptive Transfer of Specialty Mental Health Services
Overview of AB 1299

• Assembly Bill (AB) 1299 established presumptive transfer

• Presumptive transfer means a prompt transfer of the responsibility for providing or arranging and paying for SMHS from the county of original jurisdiction to the county in which the foster child or youth resides

• Presumptive transfer is intended to provide children and youth in foster care who are placed outside their counties of original jurisdiction timely access to SMHS
Policy Guidance

- DHCS and CDSS issued MHSUDS Information Notice 17-032 & All County Letter 17-77 as initial policy guidance

- Includes information on:
  - Exceptions and conditions that must be met to determine if presumptive transfer may be waived
  - Role of the Child and Family Team
  - Role of the placing agency and information that must be provided to the county of residence MHP
Exceptions to Presumptive Transfer

• Presumptive transfer may be waived if any of the exceptions below exist:
  • The transfer would disrupt continuity of care, or would delay the child or youth’s access to services
  • The transfer would interfere with family reunification efforts documented in the child or youth’s individual case plan
  • The child or youth’s placement outside of the county of jurisdiction is expected to last less than six months
  • The child or youth’s residence is within 30 minutes of travel time to his or her established SMHS provider in the county of jurisdiction

• In addition, a demonstration that the MHP in the county of original jurisdiction can contract and provide services within 30 days must also be in place
On June 22, 2018, DHCS and CDSS issued MHSUDS Information Notice 18-027 & All County Letter 18-60.

Provides guidance on expedited transfers, condition C, placement notification requirements, child and family team process, exceptions to transfer and waiver determinations, requesting a hearing, as well as policy guidance related to SB 785, SMHS provided my multiple counties, MEDS, psychiatric hospitalizations and substance use disorder services.

Several flowcharts and notification templates are also included.
Expedited Transfers

- Expedited Transfers:
  - In situations when a child or youth is in imminent danger to themselves or others or is experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization.
  - If a CFT cannot be convened prior to placement, the county placing agency must immediately contact the MHP in the county of residence to notify the MHP of the placement and the need to provide or arrange and pay for SMHS to meet the needs of the child or youth.
Condition C

• Applies to any foster child or youth who resides in a county other than the county of original jurisdiction after June 30, 2017, who continues to reside outside of the county of original jurisdiction after December 31, 2017, and for whom the responsibility to provide or arrange, and pay for SMHS, has not transferred to the county of residence

• Under Condition C, placing agencies are required to complete notification responsibilities regarding conditions of presumptive transfer, waiver requests, and waiver determinations 10-days prior to the foster child or youth’s next scheduled status review held after December 31, 2017
Placement Notification Requirements

• Placing agencies are responsible for informing the following individuals about presumptive transfer requirements, a description of the exceptions, and the right to request a waiver:
  – foster child or youth
  – the foster child or youth’s attorney
  – the person or agency responsible for making mental health care decisions on behalf of the foster child or youth
  – the assigned social worker and/or juvenile probation officer

• Attachment C provides a template informing notice that placing agencies may use for this purpose
Placement Notification Requirements

- The placing agency should document these notifications in the child or youth’s case file.
- These notification requirements can be met by completing the forms included as Attachments C and D (or similar forms).
- For children and youth who are not receiving SMHS, placing agencies must still notify the MHP in the county of residence.
Notification Templates

- Presumptive Transfer Informing Notice (Attachment C);
- Notice of Presumptive Transfer of SMHS for Foster Child or Youth Placed Out of County (Attachment D)
- Presumptive Transfer Waiver Request Form (Attachment E)
- Presumptive Transfer Waiver Determination Notification (Attachment F)
Waiver of Presumptive Transfer

- On a case-by-case basis, presumptive transfer may be waived.
- A waiver request places a hold on the transfer of responsibility for SMHS until such time that the placing agency in the county of original jurisdiction has made a determination that the waiver meets the required conditions and is in the best interest of the child or youth.
- In this situation, the county of original jurisdiction is responsible for continuing to provide, or arrange for the provision of, and pay for SMHS to the child or youth without interruption until the placing agency makes a determination regarding the waiver.
- Attachments A and B address situations in which a waiver is not requested and when it is.
  - Flowcharts depict procedural notification timeframes, the parties that must be notified at various points of time during presumptive transfer.
Waiver Request

• A waiver request must be made to the placing agency within seven calendar days of the placing agency’s determination to place a child, youth, or NMD out of county
  – The date of the county’s presumptive transfer informing notice starts the seven day time period for waiver requests

• If a request to waive presumptive transfer is made the placing agency is responsible for determining if waiver is appropriate
  – Placing agency must consult with CFT and other professionals when determining if waiver is appropriate
Role of the CFT

- Presumptive transfer must be discussed by the CFT

- The CFT process informs placement decisions, as well as the child or youth’s foster care case plan, and mental health treatment plan

- If an out of county placement occurs and SMHS are presumptively transferred to the county of residence, the SMHS provider(s) from the county of residence MHP
  - Becomes part of the child or youth’s CFT
  - The CFT process should be seen as the primary venue to discuss questions, recommendations, or concerns regarding placement, services, and supports
  - The CFT should be consulted on whether the transfer may impact the delivery or access to SMHS
Placement in STRTPs

- Placement expected to last less than six months, and the child or youth will return to the county of original jurisdiction after the STRTP placement, this placement meets the criteria of an exception to presumptive transfer.

- If the placing agency determines that a waiver is in the best interest of the child or youth and the contract requirements for approving a waiver are met, the existing waiver process (including notification requirements) must still be completed.

- If a child or youth placed in an STRTP, whose stay was expected to last less than six months, stays longer than six months, the CFT should discuss whether the waiver should continue.

- Providers may not make waivers, or the absence of waivers, a general condition of accepting placements.

- MHPs may not compel providers, including STRTPs, to make waivers a general condition of accepting placements.
Requesting a Hearing

- An individual who requested a waiver, or any party to the case who disagrees with a determination made by the placing agency may request judicial review prior to the county’s determination becoming final within seven calendar days of being notified of the placing agency’s determination.

- The court has up to five court days to set a hearing on the matter, and until such time, presumptive transfer is on hold.

- Delivery of existing SMHS to the child or youth must continue without interruption, and be provided or arranged for, and paid for by the MHP in the county of original jurisdiction.

- Placing agencies are required to provide the court with information related to a request to waive presumptive transfer that includes a description of the process followed by the placing agency, the CFT, and others in making its determination on the waiver.
The provisions of SB 785, including its Service Authorization Request (SAR) provisions, are no longer necessary or required for foster children or youth under the conditions of presumptive transfer, or under a waiver of presumptive transfer.

For children and youth who receive assistance under Kin-GAP, the county of original jurisdiction continues to retain responsibility for authorizing and reauthorizing SMHS under the provisions of SB 785.

Similarly, children and youth whose adoptions are finalized and who receive assistance under the AAP are no longer dependents of the court; and, as such, are not subject to the provisions of AB 1299.
• DHCS and CDSS continue to consider using an indicator, screen, or other field in the Medi-Cal Eligibility Data System (MEDS) for this purpose.

• There are limitations with using MEDS for this purpose, such as updates to MEDS are not displayed in “real-time,” access to MEDS is limited to designated personnel, thereby excluding many agencies and individuals that need to access this information, and MEDS changes are long-term solutions due to the time they take to complete.
SMHS Provided by Multiple MHPs

• There are times a foster child or youth is placed outside of the county of original jurisdiction, when it may be appropriate for the MHP in the county of original jurisdiction to provide SMHS while the MHP in the county of residence is also providing or arranging, and paying for SMHS

• Examples:
  – When the SMHS provider(s) in the county of original jurisdiction has an established relationship, the provider(s) may continue to provide SMHS throughout the transition of the child or youth to the new SMHS provider(s) in the county of residence. During the transition these SMHS are paid for by the MHP in the county of original jurisdiction; or
– When the SMHS provider(s) has an established relationship with a child or youth’s significant support person (e.g. parent, family member) and the provider(s) will continue to be involved in the child or youth’s life during and after the out of county placement, the provider may continue to provide collateral services to the foster child or youth’s significant support person during a transition period until this relationship can be transferred to a new SMHS provider, or until this service is no longer needed

  • In this example, the MHP in the county of residence is responsible for providing or arranging, and paying for the ongoing SMHS
Psychiatric Inpatient Hospitalization

• Examples:

  – A foster child or youth that resides in the county of original jurisdiction receives psychiatric hospital inpatient services in a county outside of the county of original jurisdiction. Presumptive transfer does not apply in this scenario because psychiatric inpatient hospitalizations are not considered foster care placements and the foster child or youth will return to the county of original jurisdiction following the psychiatric inpatient hospital stay. The county of original jurisdiction retains responsibility for the provision of and payment for the psychiatric inpatient hospitalization.

  – A foster child or youth that resides outside the county of original jurisdiction, but is waived from presumptive transfer, receives psychiatric hospital inpatient services. Due to the waiver, presumptive transfer does not apply in this scenario and the county of original jurisdiction retains responsibility for the provision of and payment for the psychiatric inpatient hospitalization, regardless of the county in which the hospitalization occurs.
Psychiatric Inpatient Hospitalization

– SMHS for a foster child or youth that resides outside the county of original jurisdiction are presumptively transferred to the county of residence and the foster child or youth receives psychiatric inpatient hospital services outside of the county of residence. Since SMHS for this foster child or youth have been presumptively transferred, the county of residence is responsible for the provision of, and payment for psychiatric inpatient hospitalization regardless of the county in which the hospitalization occurs.
Substance Use Disorder Services

- The responsibility for the Drug Medi-Cal benefit for substance use disorder treatment services did not change as a result of AB 1299.

- The responsibility for the Drug Medi-Cal benefit remains with the county of original jurisdiction, even if the responsibility for the provision of, and payment for, SMHS has transferred to the foster child or youth’s county of residence.
Assembly Bill (AB) 501 Children’s Crisis Residential Program
The intent of AB 501 is to address a gap in crisis residential services for children and youth.

Children’s Crisis Residential Programs (CCRP) will provide:
- Short-term crisis stabilization services; reassessment every 10 days
- Therapeutic intervention
- Specialized programming
Overview of AB 501

• An STRTP could have a dedicated unit to function as the CCRP

• An STRTP could function as a CCRP only

• An STRTP does not have to have a CCRP
DHCS and CDSS are working in consultation with various stakeholders to establish CCRP program standards, interim licensing standards, and procedures for oversight, enforcement, and issuance of children’s crisis residential mental health program approvals. Areas of discussion include:

- Natural supports
- Admission criteria
- Commonality of need
- Length of stay beyond initial 10 days

Information notice with information and guidance is forthcoming
Questions & Answers
Break
Pediatric Symptom Checklist & Child and Adolescents Needs and Strengths (CANS) Tool
DHCS has selected the **Pediatric Symptom Checklist (PSC-35)** and the **Child and Adolescents Needs and Strengths (CANS)** tools to measure child and youth functioning.

- The PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible.

- Parents/caregivers complete PSC-35 (parent/caregiver version) for all children and youth ages 3 to 18.
• The CANS is a structured assessment used to identify youth and family actionable needs and useful strengths
  – It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes

• Providers complete the California CANS (form dated October 3, 2016) through a collaborative process which includes children and youth ages 6 up to age 20, and their caregivers (at a minimum)

• These functional assessment tools are completed at the beginning of treatment, every six months following the first administration, and at the end of treatment
Data Collection

• MHPs are expected to collect and report data obtained from PSC-35 and CANS on a monthly basis

• With the exception of Los Angeles County, all counties must begin submitting monthly data to DHCS on February 28, 2019

• First data submission must include data collected from the county’s required implementation date (either July 1, 2018, or October 1, 2018) through January 31, 2019
Continuum of Care Reform (CCR)
Continuum of Care Reform

- Child and Adolescence Needs and Strengths (CANS)
- Child and Family Teams (CFT’s)
- STRTPs
Questions and Answers
Lunch
STRTP Mental Health Program Approval
STRTP Mental Health Program Approval

- DHCS issued interim regulations through an Information Notice (MHSUDS IN 17-016, issued May 5, 2017), which established requirements and procedures for STRTPs to obtain mental health program approval.

- DHCS and has updated the STRTP Interim Regulations and is in the process of issuing another information notice (IN) regarding the programmatic requirements and procedures for STRTPs to obtain mental health program approval based on input provided by stakeholders. It is anticipated that the IN will be finalized in December 2018.
STRTP Mental Health Program Approval

• As of November 1, 2018, DHCS and delegates have received 91 STRTP applications from prospective applicants seeking mental health program approval.

• DHCS released MHSUDS Information Notice 18-049, issued October 23, 2018, to provide MHPs with information regarding the delegation of the mental health program approval task requirements for STRTPs within the county’s borders.

• A county may request that DHCS delegate the mental health program approval task to its MHP by completing and sending the “Delegation of Approval Task” form.
If DHCS approves the county’s request for the delegation of the mental health program approval task, DHCS will issue a written Notice of Approval delegating the county MHP the authority for approval, oversight, enforcement, due process and other responsibilities over the mental health programs at the STRTPs within its borders as described in the Interim STRTP regulations.
Questions and Answers
County Panel
Successes & Challenges from the Field on Cross System Collaboration and Practice
County Panel Presentation

Facilitators: Kimberly Mayer, MSSW, Director, CIBHS
Kim Suderman, LCSW, CIBHS Consultant

Butte County
- Angela Meli, Supervisor, Administrative Analyst, Children’s Services, Butte County Department of Employment and Social Services
- Sara Watts, MFT, Program Manager, Butte County Department of Behavioral Health

Humboldt County
- Jeremy Nilsen, MFT, Deputy Branch Director, Humboldt County Mental Health
- Alison Phongsavath, MSW, Humboldt County Department of Health and Human Services, Child Welfare Program Manager
- Jody Green, Probation Division Director, Humboldt County Probation Department
Questions and Answers
Table Discussions
Report Out From Table Discussions and Identify Best Practices
**Future Convening Dates**

**Provider Convenings:**

<table>
<thead>
<tr>
<th>Convening 1</th>
<th>Sacramento (Central Region - Northern)</th>
<th>Tuesday, Dec 11</th>
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<tr>
<td>Convening 2</td>
<td>Riverside (Southern California)</td>
<td>Wednesday, February 20</td>
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<tr>
<td>Convening 3</td>
<td>Visalia (Central Region – Southern)</td>
<td>Thursday, March 7 or Friday, March 8</td>
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<tr>
<td>Convening 4</td>
<td>Bay Area Region</td>
<td>Wednesday, May 8</td>
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<tr>
<td>Convening 5</td>
<td>Northern Region</td>
<td>Tuesday, June 11</td>
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<tr>
<td>Convening 6</td>
<td>Long Beach (LA Region)</td>
<td>Tuesday, June 4</td>
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Closing Remarks & Wrap-Up

Send Feedback, Questions, Comments to:

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