

# Children's Initiatives and Programs from a QI Perspective

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# Presenters

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# Agenda

- Continuum of Care Reform (CCR)
- Short-Term Residential Therapeutic Programs (STRTPs)
- Therapeutic Foster Care (TFC)
- Presumptive Transfer
- Children's Crisis Residential Programs (CCRP)



# Continuum of Care Reform (CCR)





## Key Components of CCR

- Requires transition of group homes to Short-term Residential Therapeutic Programs (STRTPs)
- Establishes a new structure and level of care protocol
- Defines functions of the Child and Family Team (CFT)
- Expands the role of the Foster Family Agency (FFA) to provide multiple levels of care and enhances FFA licensing standards
- Requires all new families to be approved as Resource Families (RFs)



# CCR: Opportunities and Challenges

- DHCS and CDSS working together and building upon other efforts, such as Pathways to Well-Being
  - Quarterly legislative updates
  - Stakeholder engagement and trainings
- Strong focus on children and youth
  - Access and availability of services
  - Data



# CCR

- Residential Based Services (RBS) Pilot
- San Bernardino created own RBS project
  - Brought in MHSA dollars
  - Went out to RFP
  - (2) 6 bed houses
  - Wraparound dollars including flexible funds
  - Decision making with child and parent in the room
  - Family Finding
  - Did not discharge from service plan when child went to a different facility.

# CCR Challenges

- Group homes occupied with meeting requirements
- National accreditation issues
- Time spent meeting with the kids
- A lot of disruption in system
- Group homes may not understand the value QM brings

# CCR-Areas of Impact

County run shelter home closure or transition. Priority.

Group Home extensions/ review of program statements to transition to Short Term Residential Therapeutic Programs (STRTP).

Level of Care determination: CWS workers to use to determine placement type and funding. New concept and tool.

CANS being implemented for both Child Welfare and Mental Health but state entities trying to work out combined details.

Rates reformation and new rates structure. Eligibility Impact.

Child and Family Team Meetings within 60 days for all who enter child welfare services. How to combine with MH CFTs.

Resource Family Approval has taken more time than thought and has slowed family approvals. Priority.

Foster Family Recruitment and FFA development. Priority.



# CCR Priority - Emergency Shelter Services

Placer County's first priority with CCR was to comply with the law requiring closure of county run shelters. Koinonia Family Homes assisted Placer to create a community based emergency sheltering system.

Recruitment continues at this time, but older teens with behavioral challenges have been identified as a barrier for finding homes. Concurrent placements have also been a challenge.

The contract was modified to provide an additional 6 dedicated beds with MH and behavioral support. Received STRTP approval as of 12/8/2017. This is used when youth have been assessed as needing this level of short term care.

Most are in the emergency and concurrent homes. Emergency homes are lost when a family wants to keep the child and becomes a concurrent home.



# CCR Priority – FFA Development

Started a regional FFA Collaborative.

Created an FFA openings portal for placements in Placer County and nearby.

Encouraged regional trainings for families and delivery of SMHS – former yes, latter slow to develop due to concerns around Medi-Cal rules and disallowances.

ISFC development is slow, but have 3 providers who operate under an umbrella for contracting.

Need QI as part of the process for training, certification, and monitoring.

# Short-Term Residential Therapeutic Program (STRTP)





# Mental Health Program Approval for STRTPs

- DHCS has updated the following (originally released through IN 17-016):
  - Interim STRTP Regulations
  - Interim STRTP Mental Health Program Approval Protocol
  - The STRTP Mental Health Program Approval Application
- DHCS will issue an information notice regarding the requirements and procedures in April 2018
- The STRTP Mental Health Program Approval Protocol
  - Combines the mental health program approval and Medi-Cal certification
  - Decreases duplication
  - Reduces two onsite reviews into one simultaneous site visit for the initial review
  - The mental health program approval will be done annually and Medi-Cal certification components will be included every 3 years
- STRTPs have 12 months from the date of licensure to obtain the mental health program approval that includes a Medi-Cal certification



# STRTP Program Approval Process & the MHP Role

- The Welfare & Institutions Code Section 4096.5 governs the standards for mental health program approval of STRTPs.
- The statute allows DHCS to conduct the program approvals directly or delegate this responsibility to the county MHP:
  - “(d)(1) The State Department of Health Care Services or a county mental health plan to which the department has delegated mental health program approval authority shall approve or deny mental health program approval requests within 45 days of receiving a request.”
- Each county MHP must determine whether it will accept the delegation of conducting the STRTP program approvals within its county.

# STRTP Program Approval Process & the MHP Role

- MHPs that decide to accept the delegation for STRTP program approvals will conduct ALL the program approvals within the county border whether or not the county contracts with the provider.
  - If an MHP that is conducting program approvals has specific concerns about a provider that may impact or impede the STRTP program approval process, the county should alert DHCS and CBHDA of these concerns.
- MHPs may not conduct program approvals for STRTPs outside the county border.
- DHCS will conduct ALL the STRTP program approvals in counties where the MHP has decided to not accept the delegation from DHCS.

# STRTP Medi-Cal Certification & the MHP Role

- Pursuant 9 CCR Section 1810.435 and the MHP contract, each MHP must conduct Medi-Cal certification and a site review for each contracted organizational provider.
- Whether or not counties accept the delegation of the STRTP program approval for STRTPs within its county borders, the MHP is still responsible for the Medi-Cal certification for providers with which the county chooses to contract.

# STRTP's

## What County QI Needs to Know

- Managing potential large volume.
- STRTP's under contract.
  - How handle site certification, monitoring, training to Medi-Cal requirements?
  - Relationship between program, QM, fiscal and compliance.
  - Duck soup of what contractors have to contend with.
  - How does QM interact with these agencies?
  - Counties have to orient STRTP's as partners.
  - Minimize friction.

# FFA STRTP's

- Change how we contract with providers.
  - Aggregate contracts.
  - Usually cost specific.
  - Can't exceed without amending contract.
  - Board has to approve.

# FFA STRTP's Continued

- Potential Issues:
- What if don't use money?
- CFS doesn't place
- Over utilize and under utilize

# FFA STRTP's Continued

- Monitor usage
- Not cookie cutter
- No FTM evidence
- Work to be more individualized
- Expanded level of support
- Can add additional contracts
  - Only have to fill out RFQ application
  - Approval from Director
  - Able to contract with provider within 30 days
- For QM:
  - Can do certifications one at a time as they come in.
  - Do not have to worry about being buried with certifications all at once.



# CCR-STRTP

Facilities seeking licensure as a STRTP must demonstrate the capacity to meet the treatment level needs of children and make available an array of “core services” including specialty mental health services (SMHS), in order to transition quickly back to a home based family placement.

The STRTP must be licensed by CCL, meet Mental Health Program Approval status by DHCS or the County MHP, and Medi-Cal certified by the County MHP and directly deliver or arrange for the SMHS on site or close by.

A number of STRTPs have passed some of the requirements, but many still seem to be in a holding pattern. Concerned about the mid-range providers either becoming STRTPs (need major support and training), or going out of business creating capacity issues.



# CCR – STRTP Challenges

Some County MHPs do not have the training or capacity to conduct the MH Program Approval, particularly for programs that do not have a history of SMHS provision such as drug treatment providers who have primarily served probation youth.

If the state has to conduct many MH Program Approvals, then the STRTP conversions may go slower creating capacity challenges.

County QI teams will be tasked with the oversight, training, and monitoring of these programs for Medi-Cal compliance. County at risk if new providers fail to document properly.

Placer uses an umbrella contract for group homes historically and are continuing for STRTPs. Adds flexibility and speed when placing youth in a new facility. Can add directly to the umbrella contract.

# STRTP Rates

The new standard rate for STRTP's is \$12,498 per month, which is only the board and care rate.

The STRTP facility will also request authorization for delivery of specialty mental health services which will cost additional thousands of dollars, depending on clinical need. Authorization review, and or monitoring for clinical need is often a QI function to process.

Some STRTPs are asking for even more dollars to be paid in a "patch" rate for additional services to be provided for specialized care, or for difficult to place youth. This is a financial burden and is again, often a QI function to monitor for compliance with Medi-Cal regulations.

Very difficult to monitor these additional services and whether they can be billed to Medi-Cal.



# CCR – Other Challenges

Non-STRTPS and FFAs requesting Medi-Cal Certification and SMHS contracts:

- Former Drug-medical residential provider,
- Network Providers creating an organization and asking for a contract outside of the RFP process,
- THPP, THPP-Plus, and THPP+FC providers who have been billing Medi-Cal for SMHS provided to out of county youth placed in county.

Impact on County QI for training, certification and monitoring.

Impacting on funding under EPSDT.

# Therapeutic Foster Care (TFC)





# Therapeutic Foster Care (TFC) Service Model

- 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:
  - Is short-term, intensive, highly coordinated, trauma-informed, and individualized
  - Consists of interventions of one or more of the following: plan development, rehabilitation, and collateral
  - Is intended for children and youth who require intensive and frequent mental health support in a family environment
  - Should not be the only SMHS; children and youth must receive ICC and other medically necessary SMHS
  - There must be a CFT in place to guide and plan TFC service provision





# TFC Parent

## 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; *and*
- 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





## TFC Oversight and Support

- 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
- 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 client plan.
  - Meet with the TFC parent, face-to-face, in the TFC parent's 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





## TFC Documentation and Claiming

- 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. If there has not been a daily progress note written, there cannot be billing for that day





# TFC Resources

- 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



# TFC Resources

- 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





## Next Steps

- Moving forward with implementation of TFC
- Availability and readiness of Foster Family Agencies
- Child welfare, juvenile probation and MHPs working together on recruitment efforts for FFAs and TFC parents



# TFC Challenges

- Manual does not answer all questions.
  - Need FAQ's
- No recognition of time.
  - Parent spends 15 minutes de-escalating child vs. parent spending 12 hours de-escalating child.
  - Pay same for 15 minutes and 12 hours.
- Rates
  - Rate for contractor based on cost.
  - How determine cost and be comfortable knowing won't be disallowed?
  - When auditor finds note to be disallowed.
    - How willing will foster parent be to continue?
    - FFA's will struggle.

# TFC Challenges Continued

- San Bernardino has accepted the cost and will be responsible for training to be consistent.
  - This puts off time in implementing.
  - Have to negotiate contract for trainings.
  - Determine cost.
  - Re-amend contract.
- Need consistent rate across providers.
- Will probably implement around the time school starts.
- At some point, the house will be full.

# TFC Challenges Continued

- Externally determining in CFT if TFC is appropriate.
- Have someone in CFT screening.
- Importance of CFT decision.
  - Individual service planning.
  - Each may respond differently.
- TFC should be last service tried because of placement disruption.



# Therapeutic Foster Care

Therapeutic Foster Care services must be developed by counties and service providers. QI will have to develop training for it (although the toolkit helps), and monitor it as well, which is another capacity issue in QI for counties.

State DHCS has finalized the guidelines for this service model for providers, but there are still unclear areas and questions.

Disallowances are a real fear of providers who are hesitant to develop the service.



# Therapeutic Foster Care

Those who want to develop the service in Placer County do not think the rate is high enough to meet their overhead costs.

Families have to be certified as Resource Families now, which is a more intensive and invasive process, as well as additional training.

Providers are also not finding families who want to, much less can perform TFC yet. And counties are concerned about placement disruptions when a youth improves and no longer needs TFC. Not acceptable to have placements disruptions due to this reason and counties will have to decide the risk of continuing and exposure to disallowances.

An RFP was released this Spring including TFC; results are pending.

ISFC providers will consider TFC on a family by family training basis.

# Presumptive Transfer





# Presumptive Transfer

- Effective July 1, 2017, Assembly Bill (AB) 1299, **transfers** responsibility for authorization, provision and payment of SMHS to the MHP in the foster child's county of residence
- Intent is to improve timely access to SMHS for children in foster care who are placed out-of-county
- On July 14, 2017, DHCS and CDSS released [Information Notice 17-032 & All County Letter 17-77](#) to establish initial policy guidance





# Presumptive Transfer

- Role of the Child and Family Team (CFT) Process
  - The CFT process should be seen as the primary venue to discuss recommendations, questions, or concerns regarding placement, services, and supports
  - The CFT process is an opportunity for the child and family, mental health providers, placing agency worker and others to discuss whether presumptive transfer would benefit the child or youth and support the goals in his or her case plan





# Presumptive Transfer

- To ensure effective communication, Counties should:
  - Identify a single point of contact or unit
  - Have a dedicated phone number and/or e-mail address at the Mental Health Plan & Placing agency & public webpage
- Exceptions, determined on an individual basis, may result in a waiver of presumptive transfer





# Presumptive Transfer

- **Waiver of presumptive transfer:** requests by the foster child, the person or agency that is responsible for making MH care decisions on behalf of the foster child, or the child's attorney, and is based on an exception
- **Court Hearing Request:** may be requested by the individual who requested the waiver, the foster child, the person or agency responsible for making MH care decisions may request the court review the placing agency's determination regarding the request for a waiver
- **The Child and Family Team (CFT):** a CFT should be consulted on whether the transfer may impact the delivery of, or access to services





# Placing Agencies Responsibilities

- Engage child, family, mental health provider, and others in a strength-based CFT process
- Requires placing agencies to provide notification and information on presumptive transfer, requirements for requesting a waiver, waiver determinations and the process for submitting a request for a hearing
- Responsible for updating address changes in MEDS
- In response to a request to waive presumptive transfer, make individualized determination on whether any exceptions apply





# Mental Health Plan Responsibilities

- MHPs are required to provide or arrange and pay for SMHS for foster youth who reside in their county, unless a waiver of presumptive transfer is granted
- Under the conditions of a waiver, the MHP in the county of jurisdiction must be able to demonstrate they can enter into a contract with a SMHS provider in order to ensure SMHS can be provided to the foster youth who is being placed out of county
- MHPs in the county of residence are to be notified of youth placed in the county who have been assessed and require SMHS, have been screened and need to be assessed for SMHS, or have not been screened or assessed but a determination is made by a guardian, family member or provider that the child should be assessed for SMHS



# Forthcoming Guidance on Presumptive Transfer

- CBHDA collaborating with CSAC, CWDA, and CPOC to provide input to DHCS and CDSS on the development of additional policy guidance.
- Forthcoming DHCS Information Notice/CDSS All County Letter on AB 1299 will address the following:
  - Expedited transfer
  - Flow charts for various scenarios under presumptive transfer
  - Notification requirements and template forms
  - Role of the Child and Family Team process within presumptive transfer
  - Exceptions and waivers to presumptive transfer

# Forthcoming Guidance on Presumptive Transfer

- (Con't) Forthcoming DHCS Information Notice/CDSS All County Letter on AB 1299 will address the following:
  - Requesting a hearing
  - Service Authorization Requests (SARs)
  - Medi-Cal Eligibility Data System (MEDS)
  - SMHS provided by multiple MHPs
  - Responsibilities for psychiatric inpatient hospitalization under presumptive transfer
  - Substance use disorder services

# Presumptive Transfer Challenges

- No consistent uniformity across Counties.
  - 58 Counties – each address differently.
  - Some Counties have a lot of facilities and some have none.
  - May find a solution for one County and cause a different issue for another County.
- Potential costs per child.
  - Over 3000 youth from other Counties in San Bernardino.
  - Potential upfront fifty percent share of cost.
  - Before San Bernardino was serving 1000 youth from other Counties.
  - Potential cost of 5-6 million dollars more.
- Some facilities don't have any of our youth, but want to contract.
  - Need to have Electronic Health Record (EHR).
  - Other Counties pay more.
- Re-distributing funds not sufficient.





# Presumptive Transfer - Challenges

Only four exceptions/waivers noted in the law. Must be initiated by the placing agency (Child Welfare or Probation) decided within a Child and Family Team Meeting. If agreement is not reached, a judicial hearing is held.

In Placer, since it is an integrated system of care, we are often creating an exception to block the transfer when we place a child/youth in an STRTP due to the placement anticipated to be less than 6 months and interfering in reunification efforts if we transferred. Our bench is in agreement with this strategy.

Creating issues when placing counties request services that are limited in counties, such as day treatment or Wraparound, while other services are available.



# Presumptive Transfer - Challenges

Vast fiscal implications. Five groups homes that we did not have any monitoring or oversight of due to them being drug and alcohol out of county probation placements. As an STRTP, they also require training and monitoring which is an added task for county QI units, but also with PT, the financial exposure is significant as well.

Flat EPSDT funding is going to be a challenge for those counties who now have more financial exposure.

Some child welfare and probation placing agencies are notifying county MHPs of a placement in the county regardless of whether MH needs are suspected or identified, which may lead to unnecessary assessments. Some QI units also often are receiving these as the identified point of contact.



# Children's Crisis Residential Programs



# Children's Crisis Residential Programs (Assembly Bill 501)

- 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
- AB 501 authorizes CDSS to license a Short-Term Residential Therapeutic Program (STRTP) to operate as a CCRP





## Children's Crisis Residential Programs: DHCS and CDSS Roles

- DHCS and CDSS are working with various stakeholders to establish CCRP standards and procedures for oversight, enforcement, and issuance of children's crisis residential mental health program approvals
- An Information Notice with information and guidance is forthcoming



