Presenters

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Administrative Director of Behavioral Health
County of Siskiyou Health and Human Services Agency
Outline

Continuum of Care Reform (CCR)

Short-Term Residential Therapeutic Programs (STRTPs)

Child and Family Teams (CFT)

Therapeutic Foster Care (TFC)

Presumptive Transfer (PT)

Children’s Crisis Residential Programs (CCRPs)
Continuum of Care Reform (CCR) – AB 403
Key Components of CCR

Requires final transition of group homes to Short-term Residential Therapeutic Programs (STRTPs) – on the 4th extensions.

Establishes a new structure and level of care protocol for placing agencies to use to determine needs and payment.

Defines functions of the Child and Family Team (CFT), and how to use the CANS to inform treatment progress and decisions.

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).
Short-Term Residential Therapeutic Program
(STRTP)
STRTP

• Mental Health Program Approval – delegated or not – (IN 18-049).

• 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.

• MHPA – changes in protocol confusing to providers and to QM/QA?
STRTP Medi-Cal Certification & the MHP Role

• Interim Licensing Rules now at version 3. Any issues with conversions?

• How many providers have converted in your county, have not converted and are on the low confidence list, and/or have closed leading to a lack of beds?

• Training in Medi-Cal documentation and practices for those who were not Level 13/14, or who are on the low confidence list. Who is responsible for the training?

• Are SMHS being provided as expected, as intended?

• Are any STRTPs for probation or SUS? How funding? Drug Medi-Cal or converted to MH Medi-Cal?
County Perspectives
-Successes
-Learning
-Challenges
DHCS Perspectives
Child and Family Team

ICC and IHBS
Child and Family Team

- CFT composition includes a representative of the MHP. Is this working?
- Convene CFT for youth receiving ICC, IHBS, or TFC who are NOT involved with child welfare or probation.
- Established ICC Coordinator – how have you done this?
- Is time being captured for CANS and CFTs and who is monitoring occurrences?
Chart Review – CFT, ICC, IHBS

• Must make individualized determinations of need for ICC and IHBS based on strengths and needs.

• County tools to establish this process. Nevada County, Solano County, Siskiyou County, Riverside County and Placer County.
ICC and IHBS are provided to benefit all children and youth who meet the following 3 requirements:

- Are under the age of 21
- Are eligible for the full scope of Medi-Cal services; and
- Meet Medical Necessity criteria for Specialty Mental Health Services (SMHS)

In addition, individualized determinations must be made for each child’s/youth’s need for ICC and IHBS, based on strengths and needs. The following criteria should be considered as indicators of need for ICC and/or IHBS and are intended to be used to identify children and youth who should be assessed for whether ICC and/or IHBS are medically necessary. These criteria are not requirements or conditions, but are provided as guidance, in order to assist counties in identifying children and youth who are in need of ICC and IHBS.

Check all that apply:

- Are receiving, or being considered for, Wraparound;
- Are receiving, or being considered for, a specialized care rate due to behavioral health needs;
- Are being considered for other intensive SMHS, including, but not limited to, TBS, or are receiving crisis stabilization/intervention services;
- Are currently in, or being considered for, high-level-care institutional setting, such as group homes or Short-Term Residential Therapeutic Programs (STRTPs);
- Have been discharged within 90 days from, or currently reside in, or are being considered for placement in, a psychiatric hospital or 24-hour mental health treatment facility [e.g. psychiatri inpatient hospital, psychiatric health facility (PHF), community treatment facility, etc.];
- Have experienced two or more mental health hospitalizations in the last 12 months;
- Have experienced two or more placement changes, within 24 months, due to behavioral health needs;
- Have been treated with two or more antipsychotic medications, at the same time, over a three-month period [Healthcare Effectiveness Data Information Set (HEDIS) Specification for Antipsychotics in Children and Adolescents (APC)];
- If the child is zero through five years old and has more than one psychotropic medication, the child is 6 through 11 years old and has more than two psychotropic medications, or the child is 12 through 17 years old and has more than three psychotropic medications;
- Have two or more emergency room visits in the last 6 months due to primary mental health condition or need, including but not limited to, involuntary treatment under California Welfare and Institutions (W&I) Code section 5585.50;
- Have been detained, pursuant to W&I sections 601 and 602, primarily due to mental health needs, or;
- Have received SMHS within the last year, and have been reported homeless within the prior six months.
- Child is involved with two or more child-serving systems [e.g. child welfare system, special education, juvenile probation, drug and alcohol, and/or other health and human services agencies or legal systems. List systems:]

- [ ]
- [ ]
- [ ]
- [ ]

- Other need that practitioner identifies that would suggest child would benefit from receiving medically necessary ICC and/or IHBS services. Describe:

- [ ]

Signatures:
Primary Staff: __________________________________________________________

Approving Supervisor: __________________________________________________________
**Riverside County IHBS Referral Form**

PLEASE SEND ALL REFERRALS BY EMAIL TO ANGELA WILLIAMSON AND RAYMOND DEROJOUN & CC NISHA
IN THE SUBJECT LINE INDICATE "IHBS REFERRAL"
AiWilliamson@rcmhd.org; RADeRouen@rcmhd.org; NElliott@rcmhd.org

IHBS REFERRAL

<table>
<thead>
<tr>
<th>Client Information</th>
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<tbody>
<tr>
<td>Name:</td>
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<td>DOB:</td>
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<tr>
<td>Social Security #:</td>
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<tr>
<td>Primary Diagnosis:</td>
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<tr>
<td>Current Residence:</td>
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<tr>
<td>Languages Spoken in the home (list all):</td>
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<td>Client in Group Home:</td>
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<td>Minute Order:</td>
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<tr>
<td>Signed Consent to Treat:</td>
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<tr>
<td>Family Receiving WRAP:</td>
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</table>

Reminder: IHBS is provided outside of the group home setting.

<table>
<thead>
<tr>
<th>Intensive Care Coordinator (ICC) Information</th>
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</thead>
<tbody>
<tr>
<td>ICC Name:</td>
</tr>
<tr>
<td>ICC Phone #:</td>
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<tr>
<td>Clinic Name:</td>
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<tr>
<td>Clinic Address:</td>
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</tbody>
</table>

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<tr>
<th>Goals for IHBS <em>(Goals can be general in nature, not specific like TBS)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td># Hours Requested Per Week:</td>
</tr>
<tr>
<td>CFT Plan and Date of next CFT (If CFT has already occurred) [Otherwise, all authorizations will be for a 90 day time frame unless otherwise directed]:</td>
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</tbody>
</table>

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<tr>
<th>Caregiver Contact Information</th>
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</thead>
<tbody>
<tr>
<td>Caregiver Name:</td>
</tr>
<tr>
<td>Caregiver Address:</td>
</tr>
<tr>
<td>Caregiver Phone #:</td>
</tr>
<tr>
<td>Relationship to Client:</td>
</tr>
</tbody>
</table>
Solano County Pathways to Well-Being Survey

Solano County Behavioral Health
Pathways to Well-Being Survey

Date of Survey: [ ] Avatar Client #: [ ] Client Name: [ ]

1. Does client have an open case with: [ ] Child Welfare [ ] Probation [ ] County of Jurisdiction:

2. Is Client under the age of 21? [ ] Yes [ ] No DOB: [ ] Age:

3. Is Client Full-Scope Medi-Cal eligible? [ ] Yes [ ] No SSN:

   If the answer to either 2 or 3 is "No," skip to the end of the survey, add PSC name and program, and submit.

4. Is Client already identified as: [ ] Katie A Subclass [ ] Pathways [ ] Neither

5. Has Client been offered Child and Family Team meetings (ICC services)? [ ] Yes, Accepted [ ] Yes, Declined [ ] No

   If Accepted, who is the ICC Coordinator? Name: [ ] Agency:

   If the answer to 5 is "Yes," skip to the end of the survey, add PSC name & program, & submit. If the answer to 5 is "No," complete survey.

6. Is Client already receiving high-end MH services? (Check all that apply.) [ ] Seneca TBS/IBHS [ ] Group Home TBS

   [ ] County FSP [ ] Seneca TAY FSP [ ] Seneca IH [ ] Seneca KAS [ ] Seneca WRAP [ ] Day Treatment

7. Is Client receiving ITFC, ISFC, or TFC? [ ] Yes [ ] No Foster Family Agency:

8. Is Client receiving a specialized foster care rate due to MH needs? [ ] Yes [ ] No

9. Is Client in a group home/STRTP? [ ] Yes [ ] No Facility Name & City:

10. Has Client had 3 or more foster placements in the past 24 months due to Client’s MH condition? [ ] Yes [ ] No

11. Has Client received mental health services within the last year AND been homeless in the last 6 months? [ ] Yes [ ] No

12. Number of CSU or hospital Emergency Room visits due to Client’s MH condition during the past 6 months:

   [ ]

13. Is Client currently in a psychiatric hospital or 24-hour MH treatment facility (not including CSU)? [ ] Yes [ ] No

14. Has Client been discharged from psychiatric hospital (not CSU) within the past 90 days? [ ] Yes [ ] No

15. Has Client experienced 2 or more psychiatric hospitalizations in the last 12 months (not CSU)? [ ] Yes [ ] No

16. Has Client been treated with 2 or more antipsychotic meds at the same time during the past 3-months? [ ] Yes [ ] No

17. Has Client been treated with separate trials of 2 or more antipsychotic meds during the past 3-months? [ ] Yes [ ] No

18. How many medications are currently prescribed to Client for psychiatric purposes?

19. List all current DSM 5 diagnoses for Client. Do NOT include V Codes, diagnoses in remission, rule outs, or personality traits.

PSC Name: [ ] Agency & Program: [ ]

Submit completed surveys as instructed by your supervisor.

If you have any questions, contact Jennifer Pimental at (707) 530-8988.

10-22-18 ATS
Solano County Youth Transitions in Care (Y-TIC)

Solano County Behavioral Health
Youth Transitions in Care (Y-TIC)
Referral and Authorization Form

Referral Information
This form must be completed electronically. This confidential information is provided to you in accordance with State and Federal laws and regulations, including, but not limited to, applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.
Fax completed referral form & all required supporting documents to Anne Salassi at 707-427-2774, or scan and email to atsalassi@solanocounty.com
For questions, call Anne Salassi at 707-784-8449

Referral For: □ SCMH FSP □ Seneca FAY FSP □ Step-Down from FSP □ Seneca IHH □ Seneca IHBS
□ Seneca TBS (complete Page 5) □ Group Home TBS (complete Page 5) □ Discuss Options
□ Psychological Testing (Available to County Programs Only) Note: Referral does not need to include Required Attachments below.

Required Attachments: (Check all included) □ Current Face Sheet □ Client Service Plan & Addenda □ Service Authorization □ 171 Avatar Report*
□ Current Diagnosis □ Intake Assessment □ Last CANV/ANS Update □ Last Medical Necessity Update
□ 1571 Avatar Report* (if seeing SCMH doctor) or Medication List □ 154 Avatar Report* for past 3 months
□ PFI □ Proof of Medi-Cal Eligibility or Insurance *Note: Contractors may not have access to some Avatar Reports

Referral Date: □ Client Avatar #: □ Client Name:
DOB: □ Age: □ Sex: □ SSN: (enter numbers - no dashes)
Street Address: □ City: □ Zip: □
Race/Ethnicity: □ Preferred Language:
Phone Number: □ Current Living Situation:
Primary Contact: □ Relation to Cft: □ Phone #:

Is Client currently in a Hospital? □ Yes □ No Hospital Name:
Date Hospitalized: □ Reason for Hold: □ Danger to Self □ Danger to Others □ Gravely Disabled
# of Psych Hospitalizations in the Last 12 Months: □ # of Days in Hospital in the Last 12 Months:

Other Agency Involvement or Other Referrals Made:
□ Child Welfare □ Social Worker:
□ County of Jurisdiction:
□ Probation □ Start Date:
□ Probation Officer:
□ Public Guardian □ Conservator:
□ NBRC □ Case Manager:
□ Other:

Referral Source
Referrals By: □ Agency & Program:
Phone Number: □ Fax Number: □ E-mail:

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Revised ATS 6.11.18
Siskiyou County Katie A Eligibility Assessment Form

KATE A. ELIGIBILITY ASSESSMENT FORM

CLIENT INFORMATION

CWS completes Section I - IV.

I. Must meet A, B, and C below:

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
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</table>

A. Open Child Welfare Case (includes voluntary and involuntary cases)

B. Full Scope Medi-Cal Eligible

C. Meets Mental Health Medical Necessity Criteria

Date of Medical Necessity Determination: ____________________________

AND

II. Currently receiving, or is considered for at least ONE (1) of the following intensive services:

<table>
<thead>
<tr>
<th>Service</th>
<th>None</th>
<th>Considered</th>
<th>Currently Reviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Wraparound (SB 163)</td>
<td></td>
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<tr>
<td>B. Therapeutic Foster Care</td>
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<td></td>
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<tr>
<td>C. Other Intensive EPSDT Services</td>
<td></td>
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<tr>
<td>D. Therapeutic Behavioral Services</td>
<td></td>
<td></td>
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<tr>
<td>E. Crisis Intervention/Stabilization</td>
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</tbody>
</table>

III. Currently placed or is considered for either A or B below:

<table>
<thead>
<tr>
<th>Placement</th>
<th>None</th>
<th>Considered</th>
<th>Currently Reviewing</th>
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</thead>
<tbody>
<tr>
<td>A. Placement in a RCL 10 or above facility</td>
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<tr>
<td>B. Placement in a psychiatric hospital or 24-hour mental health treatment facility</td>
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</tbody>
</table>

IV. Three (3) or more placements in the past TWO (2) years:

<table>
<thead>
<tr>
<th>Type of Placement</th>
<th>Placement/Admission Date</th>
<th>Behavioral/Health a Factor?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No</td>
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</tbody>
</table>

CURRENT LIVING SITUATION

Parent/Guardian’s Home

<table>
<thead>
<tr>
<th>Relation’s Home</th>
<th>In County</th>
<th>Out of County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Home</td>
<td>FFA</td>
<td>ITFC</td>
</tr>
<tr>
<td>Group Home</td>
<td>Level ________</td>
<td>In County</td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
<td>In County</td>
</tr>
</tbody>
</table>

CWS Comments/Additional Information:

Siskiyou County Behavioral Health Level of Services & Medical Necessity Treatment Recommendation Plan (including referral): CHILD MEETS CWS CRITERIA: No | Yes

Siskiyou County Behavioral Health Level of Services & Medical Necessity Treatment Recommendation Plan (including referral): CHILD MEETS MEDICAL NECESSITY: No | Yes

CHILD Welfare Staff: ____________________________ Date: ____________________________

Behavioral Health Staff: ____________________________ Date: ____________________________
Placer County CFT Consent and Sign In

Child and Family Team Meeting  
Sign-In & Confidentiality Agreement Case Name

Child’s Name______________________ Today’s Date: ____________ Meeting Location: ____________________

Child’s Name______________________ Child’s Name______________________

By signing below or on the reverse side, I understand that all the information that is discussed about a child and family during a Child and Family Team Meeting is confidential and I cannot share this information with any other person or agency not affiliated or involved with this child and the Juvenile Court and/or Child Welfare case. (California Welfare and Institutions Code Section 827, 10850, Penal Code Section 11167.5) I also understand that if I do give this information to anyone, I may be breaking the law, and I can be charged with a misdemeanor.

I acknowledge that if any new information about suspected child abuse is disclosed during the meeting, this new information will be reported to Child Welfare Services by people in the meeting who are required by law to make this report (mandated reporters).

NAMES and SIGNATURE of PARTICIPANTS – Signing below does not reflect agreement with a safety plan that may be developed but is an agreement to the confidentiality statement and release of protected information.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Print Name</th>
<th>Signature</th>
<th>Phone Number</th>
<th>E-mail Address</th>
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</thead>
<tbody>
<tr>
<td>Child</td>
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<tr>
<td>Social Worker</td>
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<tr>
<td>Supervisor</td>
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<td>CASA</td>
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<td>CLC</td>
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<tr>
<td>Facilitator</td>
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Next Steps

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<tr>
<th>Who</th>
<th>When</th>
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Behavioral Health Driven CFT (Children Family Team) Meeting

Facilitator: ___________________ Date: ______________

Name of client: __________________________

Who attended CFT: ___client ___mother/ father ___ BHSII ___ Therapist ___TBS coach ___P.P. ___BHSIII ___ Other: ___________________

Interpreter used: □No □Yes – what language? ___________________

Explain the purpose of the meeting.

Meeting Rules:

- Confidentiality
  - Please be mindful of each other and no interrupting each other.
  - No arguing please.
  - Please reframe from going off topic.

Introductions/Roles.

What are ________________ Strengths/likes?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Areas of Concerns? (please summarize)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Goals:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Intervention/Outcome of the meeting/Plan (who will do what):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Any Questions/Other:

______________________________________________________________________________
______________________________________________________________________________

Next tentative Behavioral Health driven CFT Meeting (in 60 days): _______________________
Chart Review – CFT, ICC, IHBS continued

• Reassess needs every 90 days.

• Claims for ICC and IHBS use correct codes.

• Each provider in CFT claim for their time including documentation and travel.
County Perspectives
-Successes
-Learning
-Challenges
DHCS Perspectives
Therapeutic Foster Care (TFC) Service Model
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. Are you auditing for this?
- 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.
Questions

Do you have TFC homes? How many?

What are barriers to establishing homes?

What strategies have been working to address barriers?
Therapeutic Foster Care – 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.

**Question - Is this part of your auditing process?**
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.

Question – Is this a part of your auditing process?
TFC Service Model

Medi-Cal Manual and Toolkit does not answer all questions.

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.

How are you auditing for this? And, when auditor finds note to be disallowed, how willing will foster parent be to continue?

FFA’s will struggle with keeping Resource Parents who are trained and willing to do TFC.
Therapeutic Foster Care

TFC services for youth who meet medical necessity.

“Affirmative responsibility” to determine if youth need TFC. What does this mean?
County Perspectives
-Successes
-Learning
-Challenges
DHCS Perspectives
Presumptive Transfer – AB 1299
Presumptive Transfer

Effective July 1, 2017, 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; Subsequent IN: 18-027.

Legislation is being proposed to exempt or automatically waive STRTP placements and/or group home placements due to short term nature of treatment.
Presumptive Transfer

Presumptive Transfer must be discussed within the Child and Family Team process. It should be made on an individual case-by-case basis only if one of the exceptions exists.

To ensure effective communication, Counties are supposed to have two elements:
- An Identified Point of Contact or Unit.
- A dedicated telephone number and/or email address at the MHP agency and public webpage.

Question – who is monitoring these requirements?
Presumptive Transfer Concerns

Is the policy consistent with Info Notice?

Assume responsibility for service delivery as your own child or youth – capacity issues?

Accept assessment from placing county?
Presumptive Transfer Concerns - continued

Access to emergency psychiatric services without prior authorization.

Expedited transfers within 48 hours. Is this being tracked? By whom?

Waiver contingent on ability to contract within 30 days. Has this been an issue for counties? Coupled with continuity of care?
Children’s Crisis Residential Programs (AB 501)
Intention of the bill is to address a gap in crisis residential services for children and youth. (IN 19-004).

Provides short-term crisis stabilization services with reassessment every 10 days.

Provides a “Therapeutic Intervention” and “Specialized Programming”.

AB 501 also authorizes California Department of Social Services (CDSS) to license a Short-Term Residential Therapeutic Program (STRTP) to operate as a CCRP.

**Question – how are you going to monitor these in your county?**
Children’s Crisis Residential Programs – other concerns

• Established need, but lack of providers throughout the state.

• Funding issue for the board and care portion. CDSS has declined to fund. Says it is a Medi-Cal responsibility.

• If an STRTP does have some CCRP beds, who will monitor? CCL or MHP?
County Perspectives
- Successes
- Learning
- Challenges
DHCS Perspectives