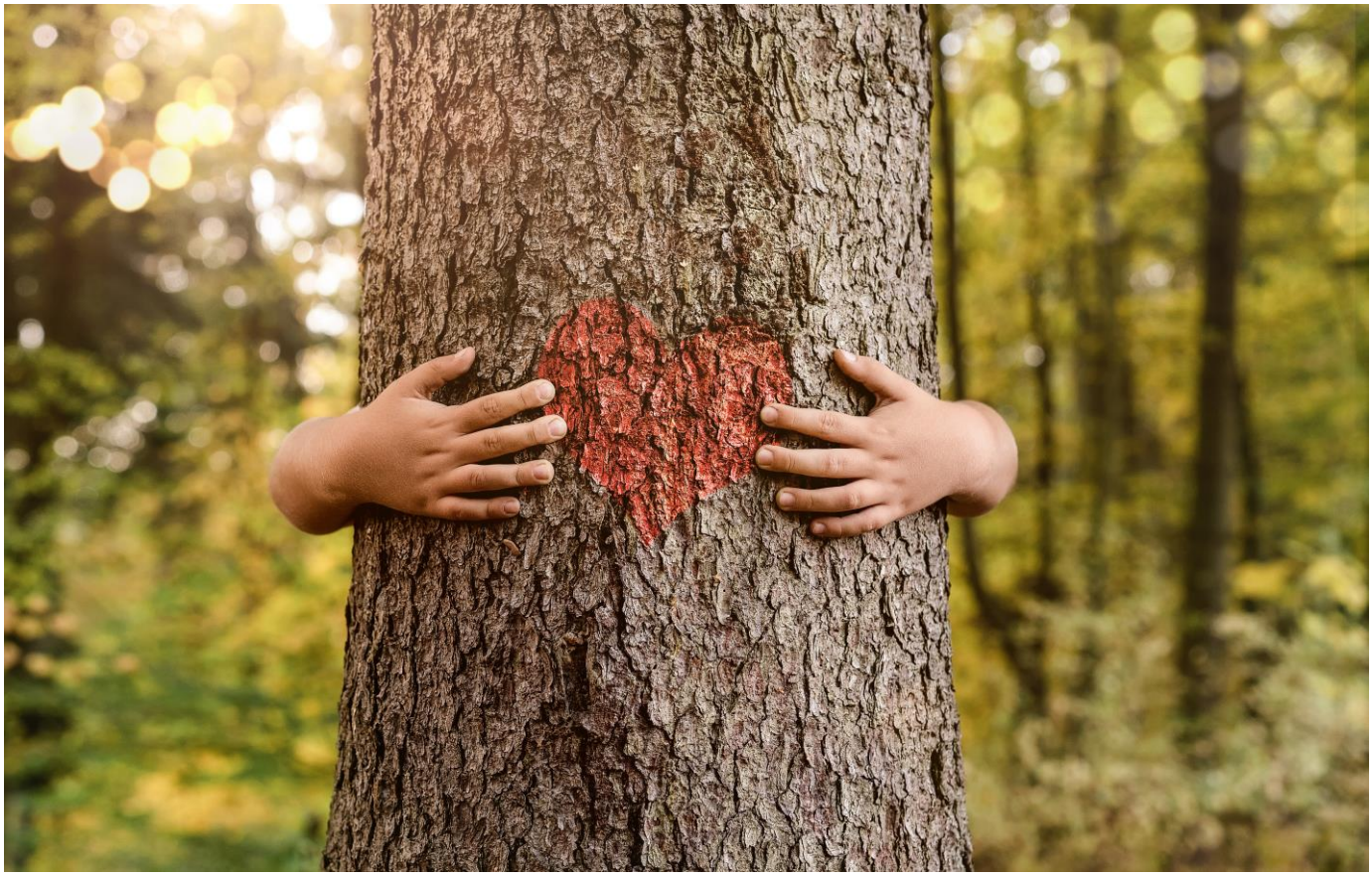
Katie-A / Pathways to Wellbeing
Mental Health Services
Operational Manual



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

July 2019

Contents

Introduction/Departmental Policy

On July 18th, 2002, a lawsuit entitled Katie-A et al. v. Diana Bonta et al. was filed seeking declaratory and injunctive relief on behalf of a class of children in California who:

1. Are in foster care or are at imminent risk of foster care placement;
2. Have a mental illness or condition that has been documented, or if an assessment had been conducted, would have been documented; and
3. Need individualized mental health services, including, but not limited to: professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate his/her illness or condition.

In December 2011, the parties reached a Katie-A Settlement Agreement. It is intended that the Katie-A Settlement Agreement will improve the coordination of resources and services and promote greater uniformity in statewide practices by children services, mental health and other service providers. The objectives of the agreement are to:

1. Facilitate an array of services delivered in a coordinated, comprehensive, community-based fashion that combines services access, planning, delivery and transition into a coherent and all-inclusive approach;
2. Support the development and delivery of a service structure and a fiscal system that supports the Core Practice Model (CPM);
3. Address the mild to moderate needs of the Class, and more intensive needs of the Katie-A Subclass with medically necessary Specialty Mental Health Services in his/her own home, a family setting or at the most home-like setting appropriate to his/her needs. This is done for the purpose of facilitating reunification and to meet the child's needs for safety, permanency and well-being.

The Santa Barbara County Department of Behavioral Wellness is committed to the health, safety and well-being of children and families in need of Specialty Mental Health Services and providing high-quality, evidence-based services. The Department shall ensure compliance with the conditions of the Katie A. Settlement Agreement and the standards and guidelines set forth in the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) & Therapeutic Foster Care (TFC) for Medi-Cal Beneficiaries (3rd edition).

The State of California, in collaboration with counties across the state, has made significant progress in the implementation of the Katie A. Settlement Agreement. The Continuum of Care Reform legislation has provided the statutory and policy framework to ensure services and supports provided to every child or youth and his or her family achieve the goals of developing and maintaining a stable, permanent family. The intent of this legislation is to ensure not only access to necessary services, but also to ensure integrated service delivery, reflecting findings of current research across the disciplines that tell us how integrated, collaborative services which demonstrate engagement and partnership with children, youth, and families are most effective in meeting the complex needs of children and families involved in multiple, government-funded service organizations

Pursuant to the Settlement Agreement and building on the core values of the Continuum of Care Reform legislation, the Department shall work collaboratively with agency partners to oversee:

1. The expeditious identification, screening and assessment of children in the child welfare system for mental health services;
2. Referral and linkage to the most appropriate program/service; determine level of care
3. Coordination of Child and Family Teams (CFTs) for the provision of individualized, comprehensive, intensive home-based mental health services;
4. Completion of outcome measures (CANS/PSC) for all clients up to age 21 for the CANS and age 18 for the PSC; and
5. Ensure continuity of care for children and families.

The delivery of ICC, IHBS and TFC services will be based on the principles of the Integrated Core Practice Model (ICPM). Please refer to the Core Practice Model Guide for further guidance on expectations of the model and the required elements for fidelity practice to the model.

Identification, Screening and Referral

All children and youth that become part of an open Child Welfare Services (CWS) will be assessed for specialty mental health needs during the initial assessment. This initial assessment will obtain information about the relevant events and behaviors that brought the child(ren), youth and families into services, potential impairments, risk behaviors and trauma exposure. Through this process, CWS will be able to systematically and expeditiously identify children and youth who need immediate intervention.

Procedure: Referrals for children 5 years and older:

☑ The CWS Child Welfare Worker is responsible for completing the *Katie A. Referral Form* and *Mental Health Screening Tool (Child 6 Years to Adult)* (see Attachment A).

→ For children ages 0-5, use the *Mental Health Screening Tool (Child 0 to 5 Years)* (see Attachment B).

☑ Once completed, the Referral and Screening forms are submitted to the designated Behavioral Wellness email address: BWELLKatieA@co.santa-barbara.ca.us

☑ An Administrative Office Professional (AOP) and designated QCM staff will review submissions to this email address daily Monday through Friday.

☑ The designated AOP and QCM staff will ensure the referrals are logged into the access template in the EHR.

☑ The QCM staff will screen each referral and will offered first available assessment. QCM will log and track timeliness to care.

☑ The AOP will forward the referral to the assigned region.

☑ QCM will keep a master Katie-A database to track authorizations and completion of the Katie-A reports & CANS to ensure these are shared with CWS.

Referrals for children ages 0-5:

☑ The designated AOP and QCM staff will ensure the referrals are logged into the access template in the EHR, then the AOP will forward the referral to the designated CALM intake representative.

☑ Following receipt of notification, the QCM staff will log the referral to CALM on the master Katie-A database to track authorizations and completion of the Katie-A report & CANS and work with CALM to schedule timely offered assessments.

For Urgent/Crisis referrals:

☑ If the CWS Child Welfare Worker determines that there is a potential mental health crisis, the CWS worker will contact SAFTY or Mobile Crisis, if there is a potential urgent situation, an urgent referral will be made directly to Behavioral Wellness. "Urgent" will be written at the top of the referral form and in the subject line of the email to BWELLKatieA@co.santa-barbara.ca.us.

☑ In collaboration with SAFTY/Mobile Crisis, Behavioral Wellness will evaluate the crisis as follows:

→ If it is determined that a 5585 psychiatric assessment is necessary, the mental health Practitioner will work with the CWS worker to inform the legal guardian and arrange for the assessment to occur.

→ If the 5585 psychiatric assessment determines that the safety concern does not meet the level of psychiatric hospitalization, the mental health Practitioner will meet with the child, family, caregiver and Child Welfare Worker to stabilize and develop a safety plan for the immediate concern.

Class Eligibility Criteria

Children and youth who meet the criteria for Katie-A Class designation are those who have less intensive needs and meet criteria for mild/moderate specialty mental health

services. Services can be provided in his/her own home, a family setting or the most home-like setting appropriate in order to facilitate reunification and to meet his/her needs for safety, permanence and well-being. Children/youth (up to age 21) are considered to be members of the Katie-A Class if they meet all three of the following criteria:

- Eligible for full-scope Medi-Cal;
- Have an open child welfare services case (see Katie A. Medi-Cal Manual, that outlines child/ youth at risk of being detained; Appendix A, Glossary); and
- Meet the medical necessity criteria for Specialty Mental Health Services as set forth in the California Code of Regulations (CCR), Title 9, Section 1830.205 or Section 1830.210. Mild/moderate medical necessity outlines the probability of deterioration if services are not offered/provided.

Sub-class Eligibility Criteria

Children and youth who meet the criteria for Katie-A Sub-Class designation are those who have more intensive needs and require medically necessary mental health services in his/her own home, a family setting or the most home-like setting appropriate in order to facilitate reunification and to meet his/her needs for safety, permanence and well-being. Children/youth (up to age 21) are considered to be members of the Katie-A Subclass if they meet all of the following criteria:

- Eligible for full-scope Medi-Cal;
- Have an open child welfare services case (see Katie A. Medi-Cal Manual, Appendix A, Glossary); and
- Meet the medical necessity criteria for Specialty Mental Health Services as set forth in the California Code of Regulations (CCR), Title 9, Section 1830.205 or Section 1830.210.

Additionally, the child/youth is:

- Currently in or being considered for: SB163 Wraparound, SPIRIT, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention; **or**
- Currently in or being considered for an STRTP, Crisis Residential, TFC, a psychiatric hospital or 24-hour mental health treatment facility; or has experienced three (3) or more placements within 24 months due to behavioral health needs.

Clinical Mental Health Assessment

The clinical mental health assessment will assess both child/youth and family strengths and underlying needs in order to effectively match services and supports to these needs.

Procedure:

- ☑ Once the referral is received the Katie-A Practitioner will complete the Initial Assessment, CANS, and PSC. The Katie-A Practitioner will present the Assessment to the Children's Clinic Team Supervisor and treatment team who will assign the case to the appropriate level of care. The CCR QCM staff will be notified and provided with the contact information of the assigned clinician.
- ☑ The assigned Practitioner will complete the comprehensive mental health assessment. The assessment will further provide an in-depth evaluation of underlying needs and mental health concerns, as well as a broader assessment of psychological risk factors related to the child's environment. This assessment includes a trauma assessment component, as well as a re-assessment of current functioning to determine the level of care is appropriate.

  → Children/youth determined to meet Class or Sub-class eligibility criteria must be entered into the access template as referred by "Katie-A" in Gateway, and must complete the Katie-A report the same day as the assessment, log on the report that the report is the initial report, and whether the child/youth meets class, sub-class, or no-class.

Communication to CWS about the status of the referral:

- ☑ The assigned Katie-A Practitioner will notify DSS/CWS the status by sending the Katie-A Report and the initial or most recent CANS to CWS via the designated DSS/CWS Katie A. email DSSCWSAOPKatieA@sbsocialserv.org and carbon copy (cc) the CCR QCM staff.

  → If CALM completed the assessment, CALM will complete and submit the Katie-A report and CANS and will sent to Behavioral Wellness and CWS to the designated email address BWELLKatieA@co.santa-barbara.ca.us in addition to DSS/CWS and the CCR QCM staff.

- ☑ If the assessment determines that the child/youth does not meet criteria for Specialty Mental Health Services (no-class), the assigned Katie-A practitioner will provide/offer treatment recommendations and/or referrals, then move the case to the non-Medi-cal fac/prog for tracking of the CANS completion only. The CANS will be completed for all subsequent updated CANS until CWS closes the case or re-refers back for services. The Katie-A Practitioner will need to code the CANS to "assessment code" in order to not claim the CANS to DHCS.

Release of Information (ROI) and Confidentiality

Adhering to the Integrated Core Practice Model (ICPM) principles of honesty and transparency, it is critical for the child/youth and family to understand what information must be shared and what information they can choose to share or keep confidential from other team members. Although the ultimate decision lies with the family, it is important to engage them in a discussion about the pros and cons of sharing information among team members so that they can make informed decisions. As new members join the team, these discussions should be revisited.

Procedure:

- ☑ After the clinical mental health assessment is complete, the assigned Practitioner should engage the child/youth (when appropriate) and/or family in a discussion about the ICPM team approach, confidentiality, privacy, mandated reporting and releases of information.
- ☑ When reviewing assessment results, the assigned Practitioner will discuss with the child and family what part of the assessment, if any, must be shared with Child Welfare Services (CWS) and which parts the family may choose to share. Although the decision to share the latter information ultimately rests with the family, the assigned Practitioner engages the family around understanding the positive aspects that sharing this information with the Child Welfare Worker and/or members of their Child and Family Team (CFT) will have in helping to achieve the child/youth and family's desired outcomes.
- ☑ Prior to the coordination of the first CFT meeting, the assigned Practitioner will review and complete the *Multi-Disciplinary Team Services Authorization for Use, Exchange and/or Disclosure of Protected Health Information (PHI)* form (see Attachment C). Copies of the signed form will be maintained in the child/youth medical record.
- ☑ It must be noted that when sharing the CANS with CWS, the ROI must be completed and sent along with the CANS to CWS. If there are SUD symptoms/impairments endorsed on the CANS, those items must be blacked out prior to sending the CANS to CWS unless the client/family has agreed that SUD information can be shared with CWS on the ROI.

Service Planning and Coordination of Child and Family Team (CFT)

Service planning involves incorporating the CANS within the treatment plans that are tailored to build on the strengths and protective capacities of the youth and family members in order to meet the individual needs for each child and family. Strengths-based individualized plans specify the goals, objectives, roles, strategies, resources and timeframes for coordinated implementation of supports and services for the child, family and caregivers.

- The initial CFT must be scheduled within the first 30 days of detention or opening of case.
- The CFT team must include at minimum, the client, parent, CWS, and a Behavioral Wellness rep. it is best practice to encourage the client/family to invite informal supports as it becomes appropriate.
- The CANS must be presented with the client/family at the CFT and used to guide the CFT process and used in the development of the treatment plan goals and interventions. The CANS can be presented in draft and then updated after the CFT.

Within the context of the Child and Family Team (CFT), service planning and implementation includes the design of incremental steps that move children and families from where they are to a better level of functioning.

Additionally, all service plans must:

- Be complimentary, consistent and coordinated, with steps toward goals and tasks prioritized by the team so the family is not pulled in different directions.
- Identify roles and responsibilities.
- Be culturally responsive and trauma informed.
- Timeframes for accomplishing goals.
- Coordinate all individual agency/service provider/community/tribal partner plans.
- A copy of the CFT plan must be provided to the family, Behavioral Wellness, and CWS, and updated at each CFT if needed.
- Ensure services are provided in the most appropriate and least restrictive settings within the community with family voice and choice being the primary factor in making decisions on intervention strategies.

Procedure:

☑ The assigned Practitioner is responsible to collaborate with CWS to coordinate the initial Child and Family Team (CFT) meeting, ensuring that all partner agencies and natural supports are present. Behavioral Wellness and CWS will determine who will facilitate the meeting and be called the "lead facilitator."

☑ The assigned Practitioner or CWS worker will document the CFT meeting which includes the client/family strengths, barriers, updates/progress and the decisions (plan) made by the team on the *CFT Individualized Care Plan (ICP)* template (see Attachment D). a copy of the plan will be provided to the client/family, CWS and behavioral Wellness. The documented CFT Meeting must outline who was present and who was the designated facilitator.

☑ A "Katie-A Service Plan Addendum" will be used for the development of the Child and Family Team (CFT) developed service plan. The Addendum will be included in

the client medical record as a component to the master Coordinated Service Plan for the child/youth. The Addendum will be updated accordingly, following the collective direction of the CFT.

- ☑ Behavioral Wellness assigned staff who participate in the CFT must document the CFT as ICC within the Gateway CFT template for the service. Ensure that the staff clearly checks the box that the CFT was the initial CFT, then any subsequent CFT's will either be updates or discharge CFT progress notes. The documentation within the CFT template must include all who were present, clearly outline who the facilitator was, The DIRT elements that include the main interventions/ areas of discussion, and outline what the goals/plan is for any follow up needed. Only one CFT template can be completed to per client regardless of staff who participated in the CFT. All other specialty mental health staff that attended would document their claimable note separately within the regular outpatient progress note template.
- ☑ The scheduling of a CFT is required every 90 days for Sub-Class members. The CFT needs to be offered. If the CFT is not held due to the client/family declining the meeting, then the CFT Template will need to be completed to document the CFT did not take place as offered. The box where client declined CFT will need to be checked.
- ☑ The scheduling of a CFT is required every 6 months for Class members. The CFT needs to be offered. If the CFT is not held, document that the CFT did not take place within the CFT template.

Intensive Care Coordination (ICC) services

While the key service components of Intensive Care Coordination (ICC) are similar to Targeted Case Management (TCM), ICC differs in that it is fully integrated into the Child and Family Team (CFT) process and it typically requires more frequent and active participation by the ICC coordinator to ensure that the needs of the child/youth in the Katie-A Subclass are appropriately and effectively met.

ICC service components/activities include: assessing; service planning and implementation; monitoring and adapting; and transition. These components/activities are corresponding examples are described as follows:

Assessing

- Assessing client's and family's needs and strengths
- Assessing the adequacy and availability of resources
- Reviewing information from family and other sources
- Evaluating effectiveness of previous interventions and activities

Service Planning and Implementation

- Developing a plan with specific goals, activities and objectives

- Ensuring the active participation of client and individuals involved and clarifying the roles of the individuals involved
- Identifying the interventions/course of action targeted at the client's and family's assessed needs

Monitoring and Adapting

- Monitoring to ensure that identified services and activities are progressing appropriately
- Changing and redirecting actions targeted at the client's and family's assessed needs, not less than every 90 days for Sub-Class members and 6 months for Class members.

Transition- Continuity of Care

- Developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

Intensive Home-Based Services (IHBS)

Intensive Home-based Services (IHBS) are intensive, individualized and strength-based, face to face needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services.

Consistent with the Medi-Cal Specialty Mental Health Services regulatory requirements and the Integrated Core Practice Model (ICPM), IHBS includes but is not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the child the fully participate in the CFT;
- Improvement of self-management of symptoms including self-administration of medications as appropriate;
- Education of the child and/or their family/caregivers about, and how to manage, the youth's mental health disorder or symptoms;

- Support of the development, maintenance and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with achieving stable and permanent family life;
- Support to address behaviors that interfere with seeking/maintaining a job;
- Support to address behaviors that interfere with a child/youth's success in educational objectives; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking/maintaining housing and independent living.

IHBS Service Settings:

IHBS may be provided in any setting where the child/youth is naturally located, including the house, schools, recreational setting, child care center or other community setting. IHBS is available whenever and wherever is needed by the child and family (including evenings and weekends). IHBS is typically (though not exclusively) provided by a paraprofessional under clinical supervision, including peers or parent partners.

IHBS may NOT be provided to children in group homes, but may be provided to children living in group homes, outside of the group home setting if the purpose is transitioning the child to a permanent home environment.

- IHBS services must be offered to all Sub-class members. If a client/family declines IHBS services, document reason the service was declined.
- Consider if expanded IHBS services need to be offered or provided, if so, send an IHBS referral for expanded IHBS services that can be offered after hours/weekends or expanded hours during certain days of the week to the Regional Manager for approval.

References

Integrated Core Practice Model Manual: https://www.countyofsb.org/behavioral-wellness/Asset.c/5261

Katie A. Medi-Cal Manual: https://www.countyofsb.org/behavioral-wellness/Asset.c/5262

DHCS MHSUDS Information Notice 18-022: The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide: https://www.countyofsb.org/behavioral-wellness/Asset.c/5264

Attachments

Attachment A – Katie A. Referral Form and Mental Health Screening Tool (Child 6 Years to Adult)

Attachment B – Mental Health Screening Tool (Child 0 to 5 Years)

Attachment C – Multi-Disciplinary Team Services Authorization for Use, Exchange and/or Disclosure of Protected Health Information (PHI) form

Attachment D – CFT Individualized Care Plan (ICP) template

Attachment E – IHBS expanded service referral form