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

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Director

(Adult) Community Treatment and Support (CTS) Memo

Purpose

The purpose of the Community Treatment and Support (CTS) work group is to support and facilitate the coordination and collaboration of providers addressing the placement and service delivery needs for adult clients within the Behavioral Wellness system of care. New and existing Clients that may meet criteria for FSP level of care are presented at CTS, along with clients that are stepping down from FSP level of care. Priority triaging is given to clients returning from hospital settings, specifically PHF and out of county placements. In addition, the group's purpose is to maintain a system process that provides standardization, accountability, continuity of care, and clarity across the county.

Process

Currently the system meets weekly at CTS with as many of the providers within our system of care as possible to effectively manage treatment resources. Santa Maria, Santa Barbara, and Lompoc adult programs lead the CTS process of cases being presented at CTS. Each region initially meets for local case presentations/transition needs, then the three regions teleconference as a countywide team. The discussion prioritizes the client's desires where possible, along with the most efficient and least restrictive level of treatment, so as to maintain community placement, progress in achieving expressed goals and ensuring coordination of care.

Instructions

- CTS is a multi-disciplinary Team in which all clinic/program/CBO members share joint responsibility in ensuring that clients are connected to the most appropriate least restrictive services, supports and treatments. CTS in each region is facilitated/led by the Regional manager or Clinical Supervisor for that region.
- Prior to attending CTS meeting
    - It is best practice to have a completed up to date chart (i.e. new or updated assessment identifying impairments due to SPMI)- this may not be possible for IMD clients returning to their home county), Level of Care and Recovery Inventory (LOCRI) and Adult Referral form/FSP referral form is completed when initiating a referral (It is best practice to have all other aspects of the chart in compliance (i.e. care plan, financial intake forms, Health History Questionnaire, MORs/CANs, treatment consents, etc.) when making a referral).
    - The Adult Referral Form/FSP Referral Form is sent one week ahead of the CTS meeting in which the case will be presented. The referring party should scan/email referral to receiving program/clinic's supervisor (cc manager) allowing time to review needed documentation and answer any remaining questions prior to the CTS meeting. This allows for efficiency and processing volume of referrals.
    - This process should be followed even if the client has already relocated and/or the referring program has a preferred receiving program or identified level of care.
    - It is expected that the once we receive the referral for the appropriate level of care, the turnaround time for an intake appointment is 3-5 working days.
- During CTS meeting
    - Staff are expected to come prepared to provide a BRIEF synopsis of the referral that was sent one week ahead of time. The referral should illustrate why the client needs a higher level of care or is ready for a lower level of care. Please reference the LOCRI Memo for Level of Care definitions and criteria (i.e. ACT/Supported Services, field based services, Clinic based, Holman, and Community) and use the one-page adult referral/FSP form information to guide your case presentation.

    - FSP referrals must be presented using the FSP referral form.New or existing clients must be presented at CTS when seeking FSP services. Once accepted into ACT/Supportive Housing a care coordinator must be assigned with the first assignment needing to be the completion of the Full Service partnership agreement (FSP consent form) being reviewed with the client. During this process, FSP services need to be explained to the client and a start date for FSP service need to be documented.
    - CTS is also used to provide updates on status of clients previously referred (ie have been opened to services, barriers to engagement) as needed to be able to close the clinical loop and ensure continuity of care. FSP clients that need to be stepped down will need to be presented at CTS. The end date of FSP service must be documented along with the step down plan.
- Follow-up from CTS meeting:
    - Staff are expected to sign in and keep weekly attendance. The Manager or Supervisor is expected to keep minutes along with a weekly agenda.
    - Staff are expected to review provided minutes, notify facilitator (Manager/Supervisor) of corrections, updates, errors and follow through on agreed upon warm handoff coordination and outreach plans.
    - Once the receiving program/clinic has opened the client (client attended first appointment and is linked) notify the referring party of linkage/engagement so that the referring program can close the existing fac/progs and discharge from current level of care.