

# **BHRS AND AFS SPECIALTY MENTAL HEALTH SERVICES PARTNERSHIP**

**Updated as of 12/2/2024**



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# ALTERNATIVE FAMILY SERVICES (AFS)

- A Resource Family Agency for 45 years
- Provides Specialty Mental Health Services in 5 other Bay Area Counties:
  - San Francisco
  - Alameda
  - Contra Costa
  - Sonoma
  - Sacramento
- Partnering with BHRS to provide 3 additional services to children and families



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# AGENDA

This presentation reviews how EPSDT services will be delivered in San Mateo County. Main topics to be reviewed include:

- Overview of EPSDT Medi-Cal benefit for youth and adults under 21
- Integrated Core Practice Model
- Child and Family Teams and Meetings
- Overview of ICC, IHBS, and TFC services
- ICC Eligibility Screening form and Referral Workflow
- Documentation of Services
- Questions and Feedback?

# EPSDT BENEFIT



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# OVERVIEW OF EPSDT BENEFIT

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is a component of Specialty Mental Health Services (SMHS).
- The EPSDT benefit provides comprehensive and preventative health care services for children and youth under age 21 who are enrolled in Medi-Cal.
- In addition to traditional SMHS services, EPSDT clients are also entitled to:
  - Intensive Care Coordination (ICC)
  - Intensive Home-Based Services (IHBS)
  - Therapeutic Foster Care (TFC)
  - Therapeutic Behavioral Services (TBS) - provided by Fred Finch



# HISTORY OF ICC SERVICES



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# WHO WAS KATIE A.?

- Class action lawsuit filed in 2002 addressing gap in intensive mental health services for youth in foster care. Settlement reached in 2011.
- Former foster youth
- Suffered 37 placement changes, 19 trips to psychiatric facilities, and eventual incarceration
- Lack of coordination between Behavioral Health and Social Services caused gaps in treatment
- Lack of in-home support prevented family reunification



# HISTORY OF ICC

- **2013:** Implementation of Katie A. vs. Bonta Lawsuit settlement services for "Katie A. Subclass:"
- Introduced 3 covered SMHS within the EPSDT benefit for Child Welfare population: ICC, IHBS, TFC.
- **2017:** ICC, IHBS and TFC **expanded to all EPSDT eligible clients**, not just those involved with CFS.
- Now called **Pathways to Well-Being** rather than Katie A. services



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# Integrated Core Practice Model



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# INTEGRATED CORE PRACTICE MODEL

- A set of practices and principles guiding delivery of ICC services
- A framework that sets the Child and Family Team as the primary vehicle for a team-based process
- Sets out specific expectations for collaboration
- Reduces redundancies in services
- Increases timely access to resources
- Improves the care experience for the child and family
- Based on Wraparound services



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# Values of the Integrated Core Practice Model

## Family Voice and Choice

- Identify and prioritize the **client's and family's perspectives** and reflect perspectives within the plan

## Team-Based

- Select committed members through informed decisions by the family and input from **team members**

## Natural Supports

- Seek and encourage full participation of **family members' networks** of interpersonal and community relationships

## Collaboration and Integration

- Approach team decision making with an open-mind: be prepared to **share and to listen to and be influenced by** other team members in an effort to cooperate and share responsibilities

## Community-Based

- Implement service and support strategies that are **accessible and available within the community** where the family lives

# Values of the Integrated Core Practice Model (Cont'd)

## Culturally Respectful

- **Cultural Humility**, respect and build on the values, preferences, and identity of the family members and their community

## Individualized

- Customize plans and resources to the **specific needs of the individual child, youth, and family members**

## Strengths-Based

- Identify, build on, and enhance the capabilities, knowledge, skills and **assets** of the child, youth, family members, community, and other team members

## Persistence

- **Do not** give up on, blame, or reject children, youth, or their families. When faced with setbacks, it is an opportunity for change and revision of plans to meet the client's needs and achieve goals

## Outcomes-Based

- Track progress toward **outcomes and goals to keep the plan on track** and make revisions when necessary

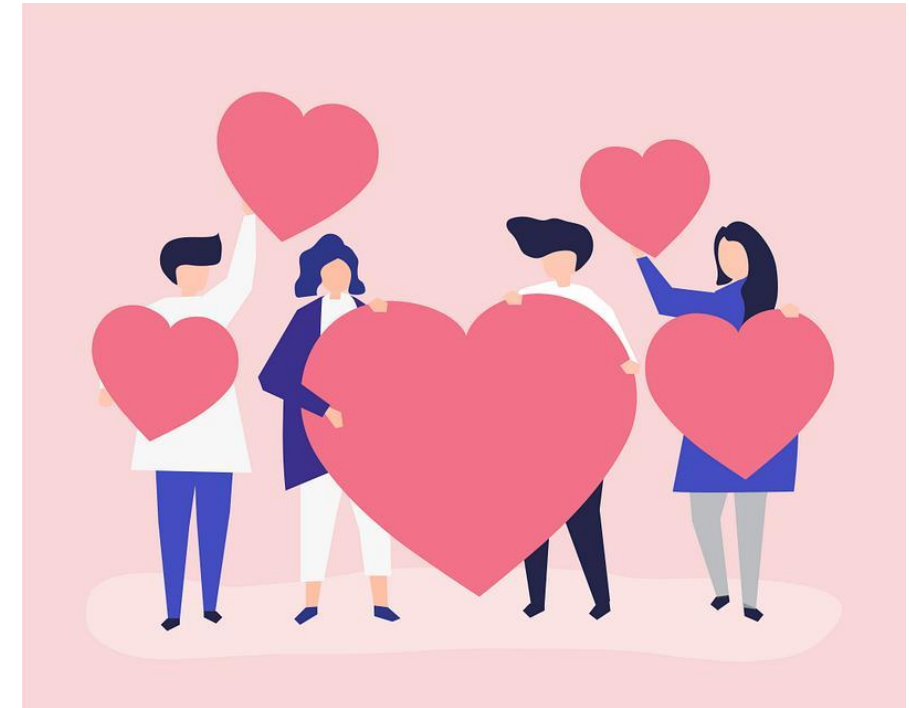
# CHILD AND FAMILY TEAM and CFT MEETINGS



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# WHAT IS A CHILD AND FAMILY TEAM?

- A CFT is a group of people with a shared vision working to support the client and family.
- **A CFT must be established to help guide ICC and IHBS services.**
- The CFT identifies strengths and needs of the youth and their family.
- Goal is to achieve positive outcomes for safety, permanency and well-being.



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# WHO IS PART OF A CHILD AND FAMILY TEAM?

- Child and family including parents and relatives
- Child and family community members including church members, neighbors, coaches, CASA's, Youth Group leaders, mentors, etc.
- Peer Specialist
- TBS Worker
- BHRS Clinicians, Supervisors as needed
- Any other type of provider working with the family



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# WHAT IS A CFT MEETING?



- **Facilitated by AFS:** neutral role, supports team in making decisions
- Strengths are celebrated and supported
- Child and family determine their needs and how each team member can support them
- CFT Plan is created collaboratively and maintained over time to identify action items and progress
- CFT Members decide together if and when IHBS services are necessary to support the child.
- Transparent and direct communication is supported, power differentials and obstacles to effective teaming are addressed



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# CFT MEETING AND PLAN STRUCTURE



Welcome



Needs and Challenges



Confidentiality and Group Agreements



Action Plan



Hopes for child and family in this meeting and overall



Safety Plan if needed



Strengths and Progress



Set Next Meeting



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# CFT MEETING PLAN



## CFT Plan and Minutes (Office)

ICC/IHBS Child and Family Team (CFT) Client Care Plan and Meeting Minutes

**Section A**

Youth:	Meeting Date:	Next Meeting Date:
Intensive Care Coordinator:	CFT Facilitator:	Provider Agency:

As of meeting date, does youth meet Katie A. subclass criteria?  
--Select One--

Team Member Present:	Relationship:	Phone &/ or Email:
Team Member Present:	Relationship:	Phone &/ or Email:
Team Member Present:	Relationship:	Phone &/ or Email:
Team Member Present:	Relationship:	Phone &/ or Email:
Team Member Present:	Relationship:	Phone &/ or Email:
Team Member Present:	Relationship:	Phone &/ or Email:

Other Team Members Present:

**Section B**

HOPE STATEMENT -- Youth and Family Goal/Desired Outcome

STRENGTHS

CHALLENGES

PREVIOUS TASK REVIEW

Refer for IHBS:

Team Discussed eligibility to receive IHBS, current needs and timing of adding IHBS

IHBS being provided

Client and family have declined IHBS at this time. Team to reassess, as needed

Referral not needed at this time

Referral to be submitted.

List behaviors to be addressed with IHBS

SAFETY/RISK: A separate Safety Plan is required if there is a significant risk/concern in past 90 days.

DISCUSSION ITEMS: Specific agenda items gathered from team members. This may include brainstorming, decision-making and key discussion points.

Specify who ELSE does child, youth or family want present at NEXT CFT meeting?

**Section C**

Area of Need: Social, Education, Vocation, Physical or Mental Health, Independent Living, etc.

Goals/Objectives to address need

Date Added to Plan

TASK TO ADDRESS NEED Next Steps

Who:	When:	Progress Status
		--Select One--

Area of Need: Social, Education, Vocation, Physical or Mental Health, Independent Living, etc.

Goals/Objectives to address need

Date Added to Plan

TASK TO ADDRESS NEED Next Steps

Who:	When:	Progress Status
		--Select One--

Area of Need: Social, Education, Vocation, Physical or Mental Health, Independent Living, etc.

Goals/Objectives to address need

Date Added to Plan

TASK TO ADDRESS NEED Next Steps

Who:	When:	Progress Status
		--Select One--

Area of Need: Social, Education, Vocation, Physical or Mental Health, Independent Living, etc.

Goals/Objectives to address need

Date Added to Plan

TASK TO ADDRESS NEED Next Steps

Who:	When:	Progress Status
		--Select One--



# CFT MEETING PLAN

Section A			
<b>Youth:</b>	<b>Meeting Date:</b>	<b>Next Meeting Date:</b>	
<b>Intensive Care Coordinator:</b>	<b>CFT Facilitator</b>	<b>Provider Agency:</b>	
<b>As of meeting date, does youth meet Katie A. subclass criteria?</b>			
--Select One--			
<b>Team Member Present:</b>	<b>Relationship:</b>	<b>Phone &amp;/ or Email:</b>	
<b>Team Member Present:</b>	<b>Relationship:</b>	<b>Phone &amp;/ or Email:</b>	
<b>Team Member Present:</b>	<b>Relationship:</b>	<b>Phone &amp;/ or Email:</b>	
<b>Team Member Present:</b>	<b>Relationship:</b>	<b>Phone &amp;/ or Email:</b>	
<b>Team Member Present:</b>	<b>Relationship:</b>	<b>Phone &amp;/ or Email:</b>	
<b>Other Team Members Present:</b>			

# CFT MEETING PLAN

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**Section B**

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**HOPE STATEMENT -- Youth and Family Goal/Desired Outcome**

|

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**STRENGTHS**

|

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**CHALLENGES**

|

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**PREVIOUS TASK REVIEW**

|

# CFT MEETING PLAN

Refer for IHBS:

Team Discussed eligibility to receive IHBS, current needs and timing of adding IHBS

IHBS being provided

Client and family have declined IHBS at this time. Team to reassess, as needed

Referral not needed at this time

Referral to be submitted.

List behaviors to be addressed with IHBS

**SAFETY/RISK:** A separate Safety Plan is required if there is a significant risk/concern in past 90 days.

**DISCUSSION ITEMS:** Specific agenda items gathered from team members. This may include brainstorming, decision-making and key discussion points.

Specify who ELSE does child, youth or family want present at NEXT CFT meeting?

# CFT MEETING PLAN

Section C

Area of Need: Social, Education, Vocation, Physical or Mental Health, Independent Living, etc.

Goals/Objectives to address need

Date Added to Plan

TASK TO ADDRESS NEED Next Steps

Who:

When:

Progress Status

--Select One--

# CFT MEETING PLAN

**Section D**

**Problem List/Service Plan**

**Problem List**

|

If no, explanation.

**Child Welfare Case Plan**

|

If no, explanation.

**Education (e.g. IEP)**

|

If no, explanation.

**Probation**

|

If no, explanation.

**Other:**

If no, explanation.



# CFT MEETING PLAN

## ELECTRONIC SIGNATURES (if available)

External Signature of:

Client (Youth)

Name:

Date Signed:

External Signature of:

Family Member

Name:

Date Signed:

External Signature of:

Family Member

Name:

Date Signed:

External Signature of:

Family Member

Name:

Date Signed:

External Signature of:

Family Member

Name:

Date Signed:

External Signature of:

ICC Coordinator

Name:

Date Signed:

External Signature of:

Child Welfare Worker

Name:

Date Signed:

External Signature of:

CFT Team Member

Name:

Date Signed:

# CONTINUUM OF CARE REFORM

- Implemented in 2015: legislation revamping placement and treatment services for Foster Youth
- Created CFT Meetings facilitated by Social Services, San Mateo CFS has already implemented this
- End goal is for only one CFT Meeting process for clients



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# ICC, IHBS, and TFC services



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Elevating children and families as experts in their lives and in knowing what they need.



Collaboration among the youth, their family and community support persons, their Mental Health providers, and any other involved providers.



Increasing in-home support to families.

## INTENSIVE CARE COORDINATION SERVICES

# ICC VS. TARGETED CASE MANAGEMENT

- ICC is intended for children and youth with more intensive needs and whose treatment requires cross-agency collaboration
  - ICC services require an Intensive Care Coordinator
  - ICC services will include Targeted Case Management (TCM) activities: referral, linkage, monitoring, and follow up
- Targeted Case Management (TCM) is referral, linkage, monitoring, and follow up



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# ROLE OF THE ICC COORDINATOR:

- Maintains thorough knowledge of the Integrated Core Practice Model (ICPM)
- Ensures all services are accessed, coordinated and guided by the values of the ICPM during the full delivery of ICC and IHBS Services.
- Supports family in identifying natural supports using Family Seeing activities
- Ensuring that the family's network is participating in the CFT Meetings
- Supports youth and family in identifying their goals/needs to elevate their voice and choice



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# ROLE OF THE ICC COORDINATOR:

- Intensively collaborates with youth, family, and system/service providers to ensure all safety and emotional/behavioral needs are being met
- Provides care planning and monitoring to ensure treatment is aligned and coordinated across systems and service providers.
- Reviews other service plans to ensure this alignment (IEPs, TBS plans, etc.)
- Speaks with each individual CFT Team Member in preparation for each CFT Meeting



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# ROLE OF THE ICC COORDINATOR:

- Sends copy of CFT Plan to all CFT Team Members
- Debriefs with child and family after CFT Meetings to explore needs and supports for next CFT meeting.
- Communicates CFT action items to any member who was not present
- Monitors team member's progress on action items prior to the next CFT
- Supports the youth and family in progressing toward being able to facilitate their own team and services



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# HOW LONG DOES ICC LAST?

- Intended to be 6-9 months
- Child and Family Team together determines when ICC is no longer needed
- Goal is for family to take over coordination of services and transition out of needing ICC and other intensive supports



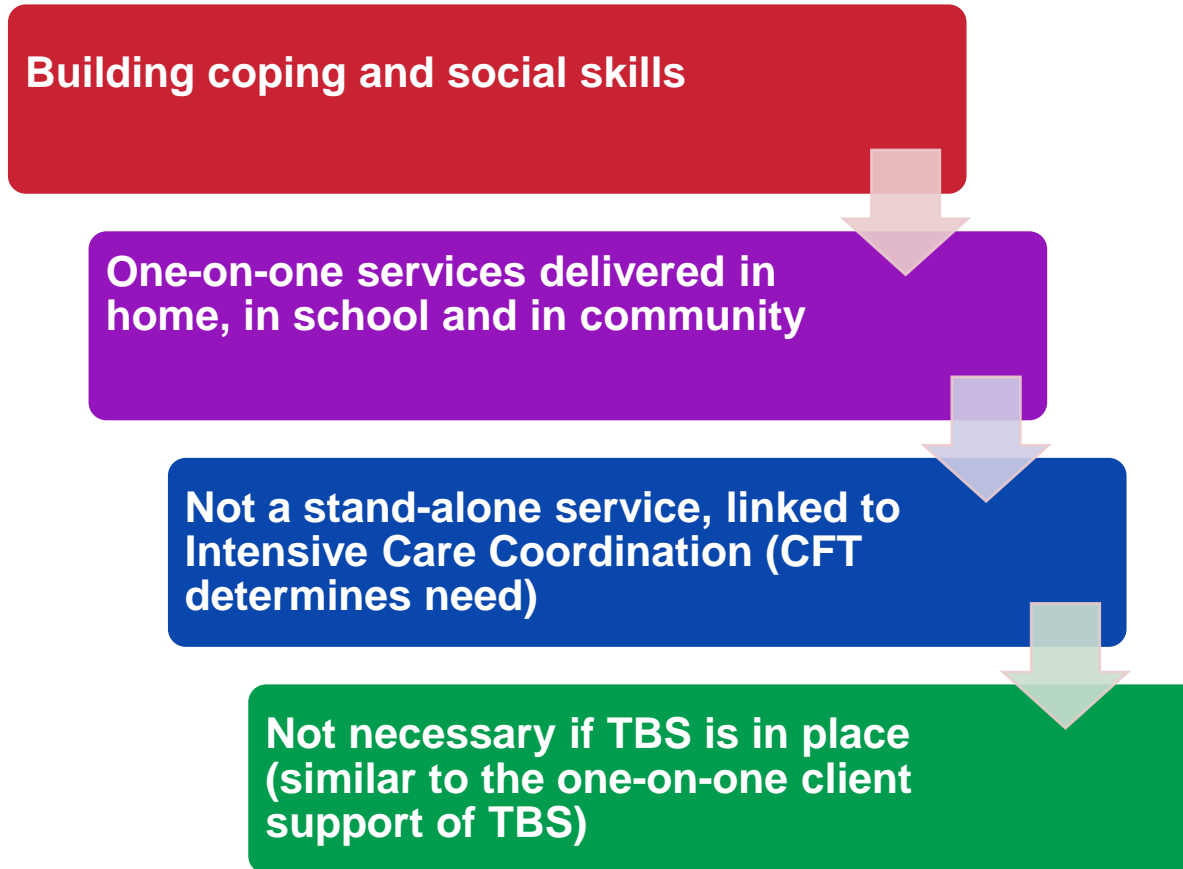
# HOW TO EXPLAIN ICC SERVICES TO MY CLIENT

- Review the different systems and people involved in helping the child/youth
- Explain or remind them of the need to coordinate with everyone involved in order to be most helpful
- Explain how it will help their team work together for what they need
- Ask “how does that sound?” rather than “Do you want...”
- Describe how meetings can make sure everyone is on the same page



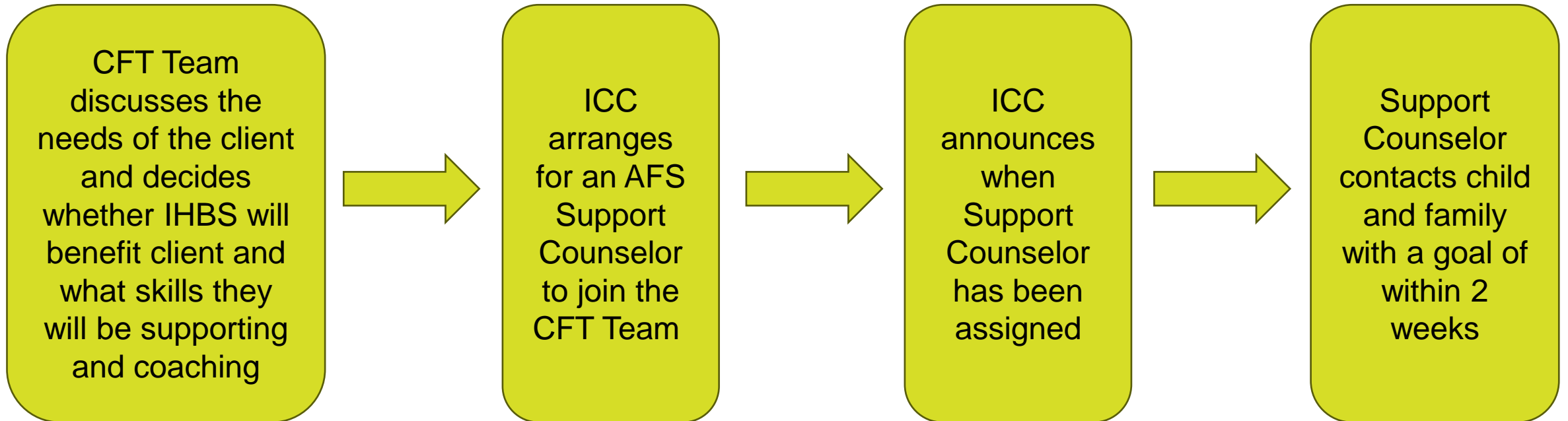
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# INTENSIVE HOME-BASED SERVICES (IHBS):



***The need for IHBS services will be determined by the CFT members during CFT Meetings***

# INTENSIVE HOME-BASED SERVICES (IHBS) Referral Process



# THERAPEUTIC FOSTER CARE (TFC)

- TFC workflows are still being created and the rollout of services will be announced at a later date
- For children who need intensive therapeutic support, they are placed within a TFC home
- Daily mental health interventions are provided by an AFS TFC Parent, under the supervision of an AFS Clinical Supervisor
- TFC parents receive specialized training
- TFC parents document services in a daily progress note based on the goals and needs of the child identified by the CFT Team



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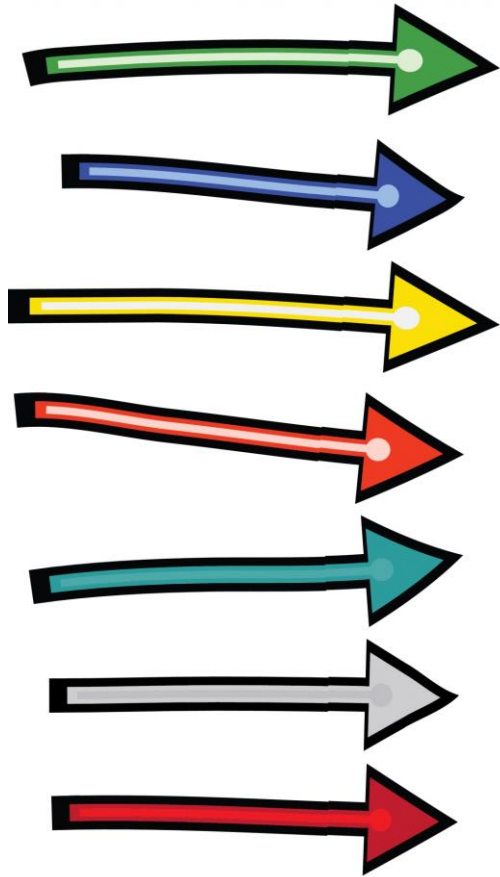
# THERAPEUTIC FOSTER CARE (TFC)

- Service descriptions:
  - Participating in the creation of plans: Safety Plans, contributing to treatment planning
  - Skill Building: Daily living, social, recreation, functioning, medication, hygiene/grooming
  - Implementing Behavioral Support Plans
  - Working with significant people in the child's life to support their relationships and meet the child's needs



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# WHAT SERVICES WILL AFS PROVIDE?



- AFS will typically be the ICC Coordinator. *There may be certain circumstances where BHRS will be the ICC Coordinator.*
- CFT Facilitation
- If determined in the CFT Meeting that IHBS is warranted, AFS will provide IHBS services to the client and family.
- TFC services



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# DO I REFER TO WRAPAROUND OR ICC?

- There is not technically a set rule for when you should refer to Wraparound vs. Intensive Care Coordination. ***Please discuss with your supervisor if you have any questions***
- If a client meets criteria for ICC services, and they are in a Wraparound program, the **Wrap program will provide ICC services, including CFT meetings and IHBS** (if determined in a CFT meeting)
- AFS will not offer 24-hour crisis response, therapy services, or psychiatry, but Wrap programs will.





# 10 Minute Break



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# ICC Eligibility Screening Form and Referral Workflow Process



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Name:  
DOB:  
MH#:

Pathways to Well-Being Sub-class Eligibility Determination (6-21)

- Does the above mentioned child have full scope Medi-Cal? Yes  No
- Does the above mentioned child have an open child welfare case? Yes  No
- Does the above mentioned child meet Medical Necessity criteria? Yes  No

If yes, see Assessment/ Reassessment dated: \_\_\_\_\_

Is the child currently receiving or being considered for any of the following services?

	Currently receiving service	Being considered for the service
Wraparound	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Therapeutic Foster Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Therapeutic Behavioral Services	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Placement in a SMI	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Placement in a Psychiatric hospital or 24-hour mental health treatment facility	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2 or more Hospitalizations in the last 12 months	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2 or more Antipsychotic medication at the same time over a 3-months period	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6-11 yrs old and has 2 psychotropic medications	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12-17 yrs old and has more than 3 psychotropic medications	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6-11 years old has more than 2 Mental health diagnoses	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12-17 years old and has more than 3 mental health diagnoses	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2 or more Emergency room visits in the last 12 months due to primary mental health condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

- Has the child had two or more placements within 24 months due to behavioral health needs? Yes  No

Child meets criteria for the Pathways to Well-Being sub-class: Yes  No

Is this a CHANGE to class/sub-class? Yes  No

*"Children meet criteria for the Pathways to Well-Being sub-class if:  
-The answers to numbers 1, 2 and 3 are all "yes" and  
-The child is in, or being considered for, any of the services in 4 or the answer to 5 is "yes"*

If child meets Pathways to Well-Being sub-class criteria, what is the child's current living situation:

group home  foster home  relative's home  with parent

Print name and title (Assessor) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print name and title (Supervisor) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

90 day assessment - 1 <sup>st</sup> Quarter	90 day assessment - 2 <sup>nd</sup> Quarter	90 day assessment - 3 <sup>rd</sup> Quarter
Child meets Pathways to Well-Being sub-class criteria: <input type="checkbox"/> yes <input type="checkbox"/> no	Child meets Pathways to Well-Being sub-class criteria: <input type="checkbox"/> yes <input type="checkbox"/> no	Child meets Pathways to Well-Being sub-class criteria: <input type="checkbox"/> yes <input type="checkbox"/> no
See progress note dated _____ for update of ICC plan.	See progress note dated _____ for update of ICC plan.	See progress note dated _____ for update of ICC plan.

RETIRED

# Pathways To Well-Being Sub-Class Eligibility Form



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# ICC Eligibility Screening Form



Confidential Patient Information: See California Welfare and Institutions Code Section 5328

## Eligibility Screening Form: ICC Services

Client Name: [Redacted] DOB: [Redacted] MHN: [Redacted]  
 Gender: [Redacted] Pronouns: [Redacted] Race/Ethnicity: [Redacted]  
 Language: [Redacted] Medi-Cal #: [Redacted] Issue Date: [Redacted]  
 Address: [Redacted] Phone: [Redacted]  
 Caregiver Name: [Redacted] Relationship: [Redacted] Language: [Redacted]  
 Caregiver Name: [Redacted] Relationship: [Redacted] Language: [Redacted]  
 Address: [Redacted] Phone: [Redacted]

- Does the child/youth/young adult (age 0-20) have full-scope Medi-Cal?  YES  NO
- Does the child/youth/young adult (0-20) meet medical necessity for Specialty MH Services (SMHS)?  YES  NO  
If YES, see current MH Assessment dated [Redacted] or CANS dated [Redacted]
- Do any of the following apply to the child/youth/young adult (age 0-20)?  YES  NO

<input type="checkbox"/> Specialized Care rate (for Caregivers' additional time to address BH issues)	<input type="checkbox"/> Age 0-5 w/ more than 1 MH Dx OR more than 1 psychotropic med
<input type="checkbox"/> Intensive SMHS (TBS, Crisis Stabilization, In-Home Crisis Support)	<input type="checkbox"/> Age 6-11 w/ more than 2 MH Dx OR more than 2 psychotropic meds
<input type="checkbox"/> Received SMHS AND homeless during prior 6 mos.	<input type="checkbox"/> Age 12-20 w/ more than 3 MH Dx OR more than 3 psychotropic meds
<input type="checkbox"/> 2 or more psychiatric hospitalizations in the last 12 mos.	<input type="checkbox"/> 2 or more antipsychotic meds at same time for over 3 mos.
<input type="checkbox"/> Psychiatric hospitalization and/or Discharged in the last 90 days	<input type="checkbox"/> 2 or more ER visits due to mental health in the last 6 mos.
<input type="checkbox"/> Living in a Short Term Residential Treatment Program (STRTP)	<input type="checkbox"/> 2 or more placement changes due to behavioral health needs in the last 24 mos.
<input type="checkbox"/> Probation or other Justice/Legal System	<input type="checkbox"/> Wraparound/FSP Wrap
<input type="checkbox"/> Open or Voluntary CPS/Child Welfare case	

Other indicators where ICC may be recommended:

[Redacted]

**Intensive Care Coordination (ICC):** ICC is a targeted case management service that facilitates communication and collaboration amongst caregivers, family members, natural supports, and multiple system providers. ICC services include assessment of, care planning for, and coordination of services, including urgent services. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. **Once ICC is approved, then this form will be submitted to the contract agency who will review the form and contact the provider completing this form.**

CHOOSE ONE: A child/youth/young adult is eligible for ICC if the answers to questions 1, 2 AND 3 above are all "Yes"

Client is eligible for ICC services and services are recommended

Reason for referral (include behavior issues, mental health symptoms, and change of level of care):

[Redacted]

Client is eligible for ICC services and services will not be provided at this time

Please explain why:

[Redacted]

Client is NOT eligible for ICC services (Questions 1-3 are not all "Yes")

This eligibility screening form was completed by:

Name: [Redacted] Email/Phone: [Redacted] / [Redacted]  
 Title/Program: [Redacted] / [Redacted] Date: [Redacted]  
 Supervisor signature: [Redacted]

**EMAIL or FAX completed form to:**  
 Pathways to Well-Being Mental Health Program Specialist (PTW MHPS)  
[SMHS-Referrals@smcgov.org](mailto:SMHS-Referrals@smcgov.org) or (650) 341-7389

### THIS SECTION TO BE COMPLETED BY PTW MHPS

APPROVED for:  
 ICC  Pathways to Well-Being  Katie-A subclass (CFS Involvement)

Copies forwarded to:  
 MIS/Billing  Contract Agency  IPRC ([PROB\\_IPRC\\_Referrals@smcgov.org](mailto:PROB_IPRC_Referrals@smcgov.org)) w/IPRC referral form

Approved By: [Redacted] Signature: [Redacted] Date: [Redacted]

# Client and Parent/Guardian Information



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**Confidential Patient Information:** See California  
Welfare and Institutions Code Section 5328

## Eligibility Screening Form: ICC Services

Client Name:	<input type="text"/>	DOB:	<input type="text"/>	MHN:	<input type="text"/>
Gender:	<input type="text"/>	Pronouns:	<input type="text"/>	Race/Ethnicity:	<input type="text"/>
Language:	<input type="text"/>	Medi-Cal #:	<input type="text"/>	Issue Date:	<input type="text"/>
Address:	<input type="text"/>			Phone:	<input type="text"/>
Caregiver Name:	<input type="text"/>	Relationship:	<input type="text"/>	Language:	<input type="text"/>
Caregiver Name:	<input type="text"/>	Relationship:	<input type="text"/>	Language:	<input type="text"/>
Address:	<input type="text"/>			Phone:	<input type="text"/>



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# ICC Eligibility Criteria

Criteria for Specialty Mental Health Services (SMHS) is explained below

1. Does the child/youth/young adult (age 0-20) have full-scope Medi-Cal?  YES  NO
  2. Does the child/youth/young adult (0-20) meet medical necessity for Specialty MH Services (SMHS)?  YES  NO
- If YES, see current MH Assessment dated \_\_\_\_\_ or CANS dated \_\_\_\_\_

SMHS Access Criteria for YOUTH	
For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either Criteria (1) <b>OR</b> (2) below:	
Criteria (1)	Criteria (2)
The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by <b>ANY</b> of the following:	The beneficiary meets <b>both</b> of the following requirements in a) <b>AND</b> b), below:
<ul style="list-style-type: none"> <li>a. Scoring in the high-risk range under a trauma screening tool approved by the department,* OR</li> <li>b. Involvement in the <b>child welfare system</b>, OR</li> <li>c. <b>Juvenile justice involvement</b>, OR</li> <li>d. <b>Experiencing homelessness</b></li> </ul> <p><i>* MHPs are not required to implement a trauma screening tool until DHCS issues additional guidance regarding approved tool(s) for the purposes of SMHS access criteria. As of the publication of this manual, DHCS has not yet provided this guidance.</i></p>	<ul style="list-style-type: none"> <li>a. The beneficiary has at least one of the following:                             <ul style="list-style-type: none"> <li>i. A significant impairment</li> <li>ii. A reasonable probability of significant deterioration in an important area of life functioning</li> <li>iii. A reasonable probability of not progressing developmentally as appropriate.</li> <li>iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.</li> </ul> </li> <li>b. The beneficiary's condition as described above (Criteria 2a) is due to one of the following:                             <ul style="list-style-type: none"> <li>i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM-5 and the ICD-10.</li> <li>ii. A suspected mental health disorder that has not yet been diagnosed.</li> <li>iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.</li> </ul> </li> </ul>
<p><i>If a beneficiary under age 21 meets the criteria as described in Criteria (1) above, the beneficiary meets criteria to access SMHS; it is <u>not</u> necessary to establish that the beneficiary also meets Criteria (2) above.</i></p>	

Page 18 of the BHRS Documentation Manual for SMHS



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# ICC Eligibility Criteria

If “YES” is checked, please **select at least one item** below that applies to the client on the day you complete the form, or if any apply within 30 days of completing the form (such as being considered for Wrap, TBS, or hospitalization)

3. Do any of the following apply to the child/youth/young adult (age 0-20)?

YES  NO

<input type="checkbox"/>	Specialized Care rate (for Caregivers’ additional time to address BH issues)
<input type="checkbox"/>	Intensive SMHS (TBS, Crisis Stabilization, In-Home Crisis Support)
<input type="checkbox"/>	Received SMHS <b>AND</b> homeless during prior 6 mos.
<input type="checkbox"/>	2 or more psychiatric hospitalizations in the last 12 mos.
<input type="checkbox"/>	Psychiatric hospitalization and/or Discharged in the last 90 days
<input type="checkbox"/>	Living in a Short Term Residential Treatment Program (STRTP)
<input type="checkbox"/>	Probation or other Justice/Legal System
<input type="checkbox"/>	Open or Voluntary CPS/Child Welfare case

<input type="checkbox"/>	Age 0-5 w/ more than 1 MH Dx <b>OR</b> more than 1 psychotropic med
<input type="checkbox"/>	Age 6-11 w/ more than 2 MH Dx <b>OR</b> more than 2 psychotropic meds
<input type="checkbox"/>	Age 12-20 w/ more than 3 MH Dx <b>OR</b> more than 3 psychotropic meds
<input type="checkbox"/>	2 or more antipsychotic meds at same time for over 3 mos.
<input type="checkbox"/>	2 or more ER visits due to mental health in the last 6 mos.
<input type="checkbox"/>	2 or more placement changes due to behavioral health needs in the last 24 mos.
<input type="checkbox"/>	Wraparound/FSP Wrap

Other indicators where ICC may be recommended:



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# 3 Outcome Options

Choose one of the three outcomes based on:

1. The answers to Questions 1-3
  - If the answers to all 3 questions are “YES,” then the client qualifies for ICC services
2. Your clinical judgment
3. The client’s agreement (or disagreement) of services

**CHOOSE ONE:** A child/youth/young adult is eligible for ICC if the answers to questions 1, 2 **AND** 3 above are all “Yes”

Client is **eligible** for ICC services and **services are recommended**

Reason for referral (include behavior issues, mental health symptoms, and change of level of care):

Client is **eligible** for ICC services and **services will not be provided** at this time

Please explain why:

Client is **NOT eligible** for ICC services (Questions 1-3 are not all “Yes”)



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# Clinician information, Supervisor signature and where to submit the screening form

This eligibility screening form was completed by:

Name:  Email/Phone:  /

Title/Program:  /  Date:

Supervisor signature:

## **EMAIL or FAX completed form to:**

Pathways to Well-Being Mental Health Program Specialist (PTW MHPS)

[SMHS-Referrals@smcgov.org](mailto:SMHS-Referrals@smcgov.org) or (650) 341-7389



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# Pathways to Wellbeing MH Program Specialist Section

**THIS SECTION TO BE COMPLETED BY PTW MHPS**

APPROVED for:

ICC

Pathways to Well-Being

Katie-A subclass (CFS involvement)

Copies forwarded to:

[MIS/Billing](#)

[Contract Agency](#)

IPRC ([PROB IPRC Referrals@smcgov.org](mailto:PROB_IPRC_Referrals@smcgov.org)) w/IPRC referral form

Approved By:

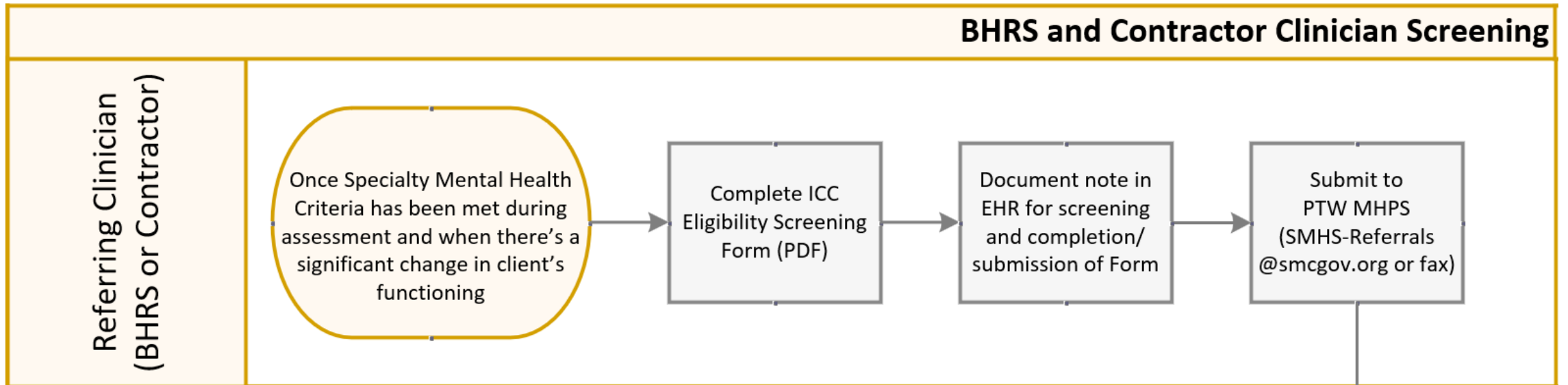
Signature:

Date:

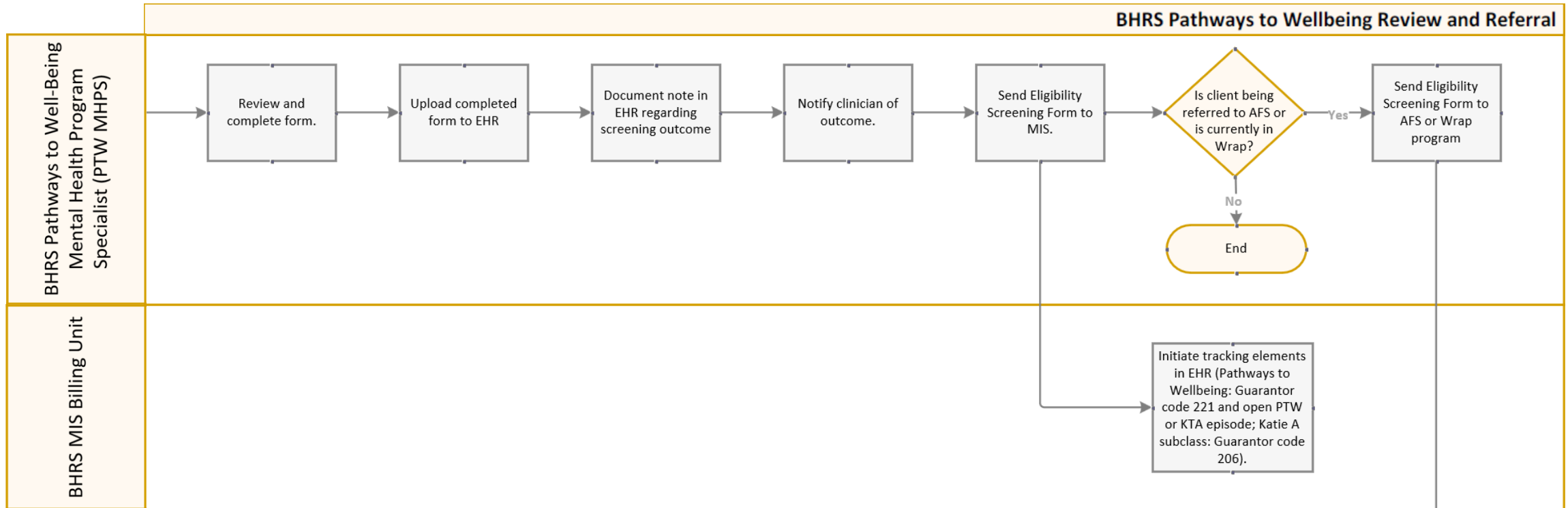


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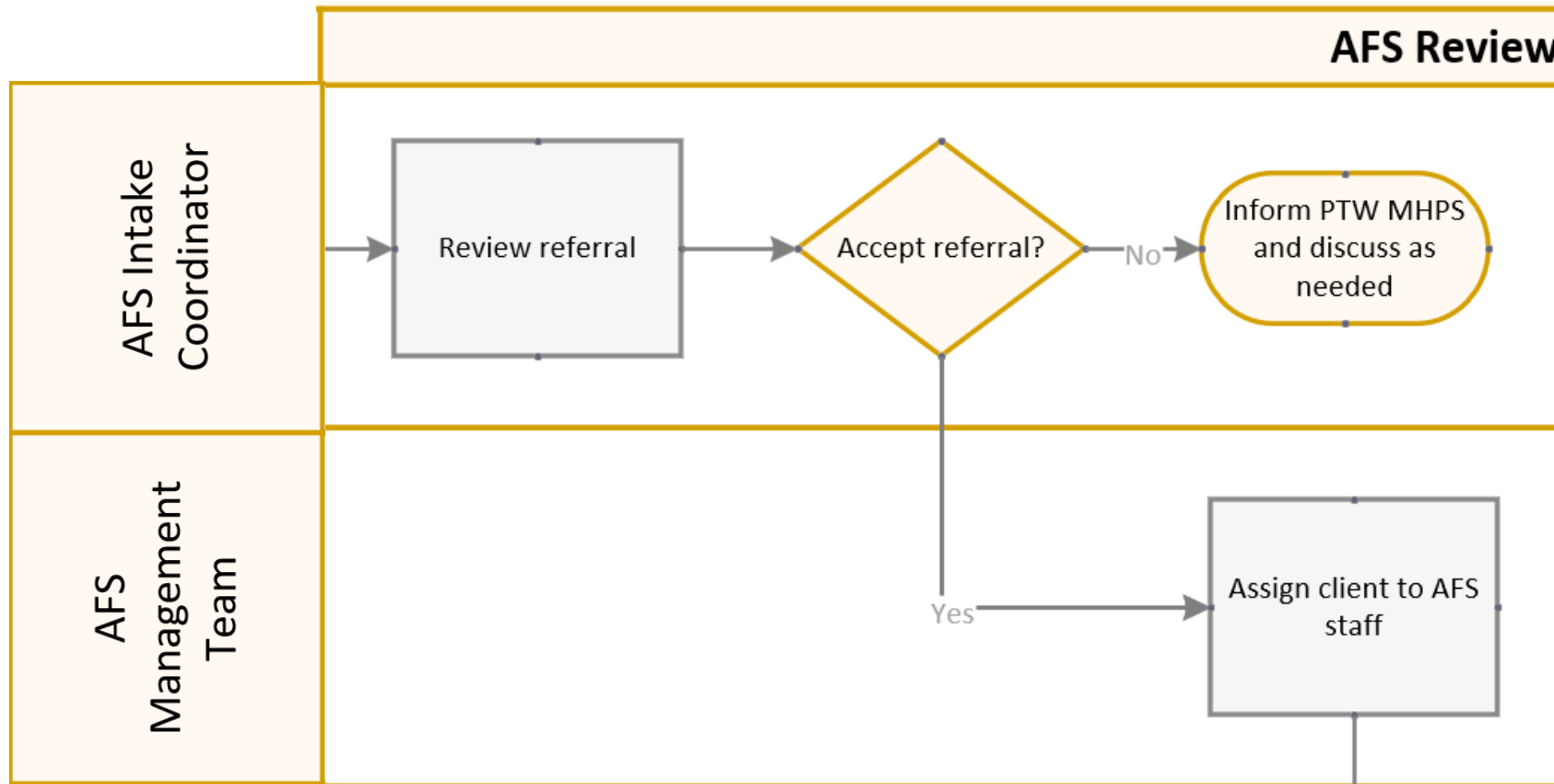
# ICC ELIGIBILITY SCREENING FORM REFERRAL WORKFLOW PROCESS



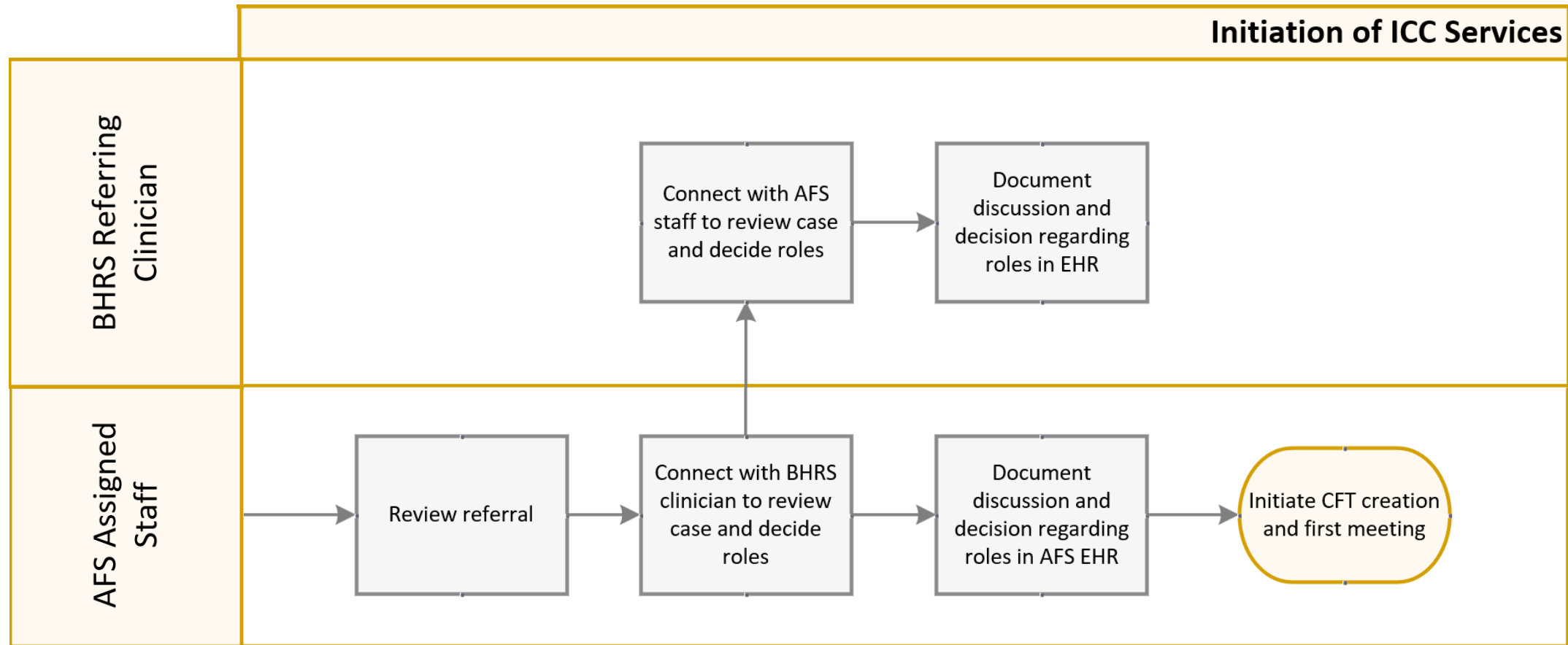
# ICC ELIGIBILITY SCREENING FORM REFERRAL WORKFLOW PROCESS



# ICC ELIGIBILITY SCREENING FORM REFERRAL WORKFLOW PROCESS



# ICC ELIGIBILITY SCREENING FORM REFERRAL WORKFLOW PROCESS



# Documentation of Services

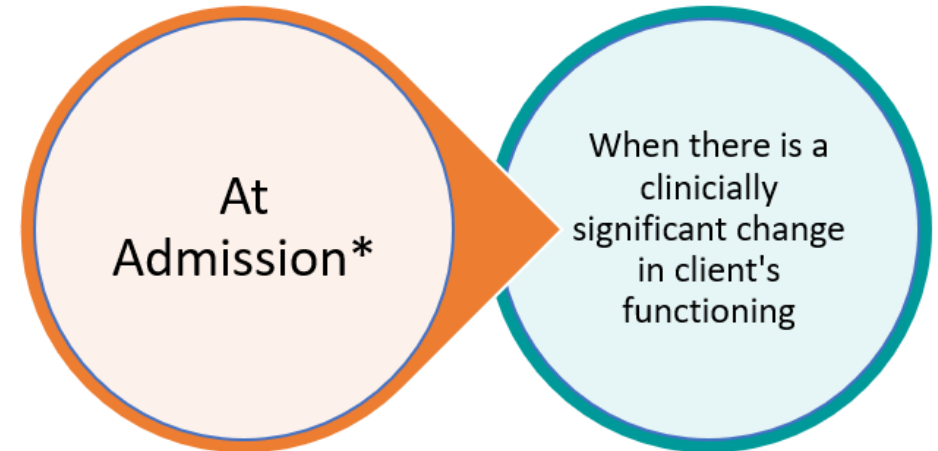


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# DOCUMENTATION: SCREENING FOR ICC ELIGIBILITY

- Screening for ICC eligibility should be completed:
  - At admission (within about 60 days)
  - *And whenever there is a clinically significant change in client's functioning*



\*Must be completed within approximately 60 days of admission



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# DOCUMENTATION: SCREENING FOR ICC ELIGIBILITY

Document the evaluation of a beneficiary's ICC Eligibility in a Progress Note. This should be completed for each Medi-Cal client age 20 and under.

Providers must use the ICC Eligibility Screening Form to make this determination.

This is a Case Management service, however if you are evaluating the beneficiary for ICC eligibility during an assessment service, you could bundle this service in with your assessment progress note.

*All documentation of ICC services should be completed in your clinic/program episode.*



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# SAMPLE ICC ELIGIBILITY SCREENING NOTE



**Service Code: Case Management (51CA)**

**Service Time: 14 minutes** (*Time taken to determine ICC eligibility via eligibility form*)

**Documentation Time: 4 minutes** (*Time to write progress note*)

**Travel Time: 0 minutes**

**List people involved in the services and their role:**

*Clinician*

**SERVICE:** Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues discussed, progress toward goals).

*Clinician evaluated beneficiary's eligibility for ICC services. Beneficiary appears to meet criteria for ICC services and referral form has been sent. Beneficiary is 10 years old, has a current IEP, is diagnosed with both Generalized Anxiety and Major Depressive Disorder, and has open CPS case. See eligibility form dated 6/27/24 for more information. Mother also reported that family is currently homeless and in need of resources.*

**PLAN:** Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).

*Clinician will communicate outcome of ICC referral to mother and submit referral for community worker to assist family with housing and additional resources to help meet basic needs.*

**NEXT APPOINTMENT:** (Include earliest offered appointment date for next appointment).

*Next appointment is scheduled on 7/4/24.*



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# SAMPLE ICC ELIGIBILITY PROGRESS NOTE



**Service Code: Assessment (5CA)**

**Service Time: 73 minutes** (*Assessment appointment time and determining ICC eligibility*)

**Documentation Time: 8 minutes** (*Time to write progress note*)

**Travel Time: 34 minutes** (*Round-trip from office to library*)

**List people involved in the services and their role:**

*Beneficiary*

*Beneficiary's mother*

**SERVICE: Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues discussed, progress toward goals).**

*Clinician met with mother and beneficiary at local public library to complete intake paperwork including the Advanced Health Care Directive, AOB, Consent to Treatment, Notice of License, Consent to e-communications and mother signed an ROI for the beneficiary's aunt who is one of the beneficiary's primary support persons.*

*Clinician began collecting information regarding presenting problems and family history for the Initial Mental Health Assessment. Mother reports family is currently homeless, and her son has been bullied at school causing anxiety and depressive symptoms. Beneficiary has current school IEP and family has open CPS case.*

*Clinician completed ICC Eligibility Screening Form. Client appears to meet eligibility for ICC services and referral has been sent. See form dated 6/27/24 for more information.*

**PLAN: Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).**

*Clinician will continue to meet with beneficiary and mother to continue gathering information to complete the Initial Mental Health Assessment.*

**NEXT APPOINTMENT: (Include earliest offered appointment date for next appointment).**

*Next appointment is scheduled on 7/4/24.*



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# DOCUMENTATION: CASE MANAGEMENT WHEN ICC IS APPROVED

- **After your client has been approved for ICC Services**, document all Targeted Case Management (aka Case Management) services as Intensive Care Coordination using **ICC\_CA**.
- ICC Services are the equivalent of Targeted Case Management services but for client's with **more intensive needs, and/or whose treatment requires cross-agency collaboration**, and therefore are referred to as ICC instead of TCM after a client is determined eligible for ICC services.
- Anyone who is qualified to provide Case Management Services can provide ICC services.
- Both BHRS and AFS treatment team members may bill for ICC services, **regardless of who is designated as the ICC Coordinator**.



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# DOCUMENTATION: WHAT ARE ICC SERVICES?

**TARGETED CASE MANAGEMENT SERVICES THAT ARE CODED AS ICC\_CA AFTER YOUR CLIENT IS DETERMINED ICC ELIGIBLE INCLUDE:**

- Services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services.
- The service activities may include, but are not limited to: communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of beneficiary progress; placement services and care plan management.
- ✓ Services may be with the beneficiary or significant support persons.
- ✓ Services may be provided In-Person, via Phone or Video.



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# REMINDER!

ICC is for clients ages 20 and under.

When using the ICC\_CA and CFTICC\_CA service codes to document ICC related services, remember **that these codes can only be used for client's ages 20 and under**.

**Claims will be denied by the State if the client is age 21 and over!**

**\*\*Providers should always think about transition planning, but especially for client's nearing  
21 years old\*\***



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# DOCUMENTING CFT Meetings

Use Service Code **CFTICC\_CA** to document your attendance and participation in Child and Family Team Meetings.

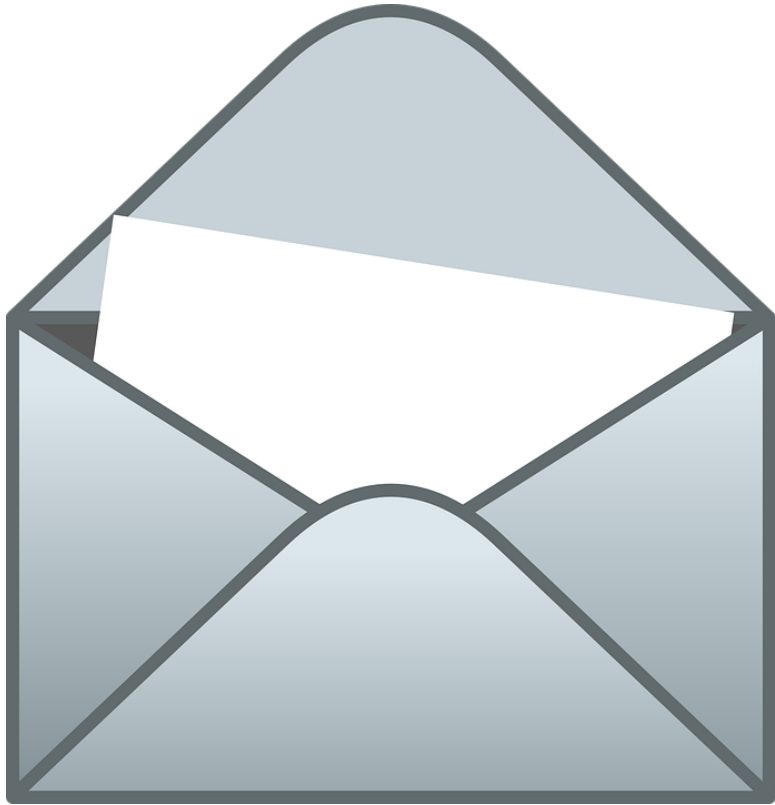


- Each service provider may claim for the full length of the meeting, plus documentation and travel time.
- Service time can include **active listening, sharing information and/or providing feedback.**
- Any time claimed in a CFT Meeting must be **supported by documentation** including:
  - What information was shared that supports the needs of the client
  - How it can/will be used in providing, planning, and coordinating services, and/or how information discussed will impact any care planning for the client.



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# WHEN TO ISSUE A NOABD



A Notice of Adverse Benefit Determination (NOABD) should be sent to the beneficiary in the following circumstance:

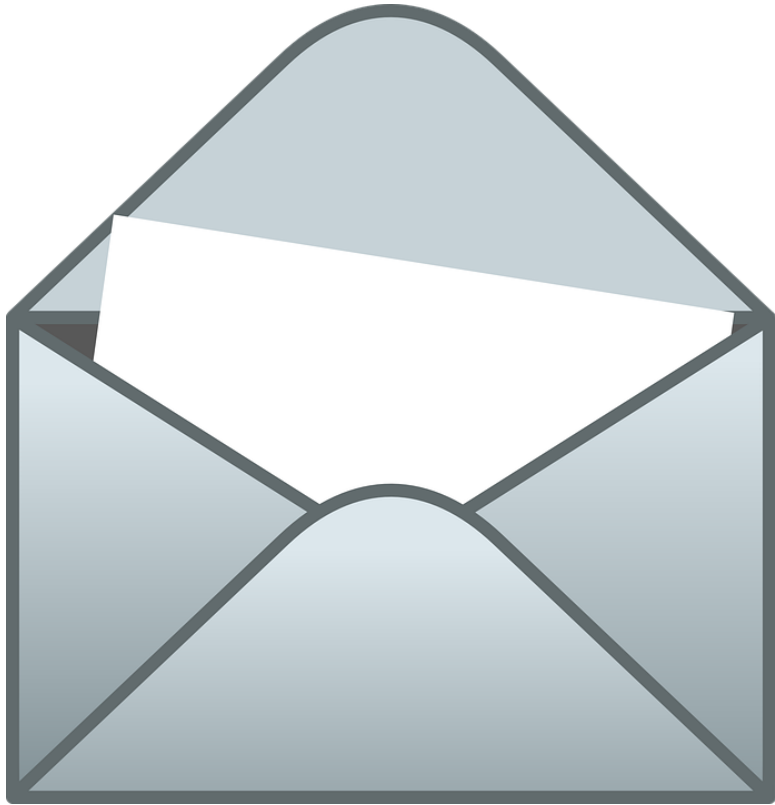
- The beneficiary does NOT meet eligibility for ICC services and is not in agreement with this decision = BHRS will issue a Denial NOABD.



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# WHEN TO ISSUE A NOABD



A Notice of Adverse Benefit Determination (NOABD) should be sent to the beneficiary in the following circumstances:

- AFS is not able to offer or provide services within 10 days of receiving a referral = AFS provider is responsible for issuing the Timely Access NOABD.
- AFS terminates services when the beneficiary no longer meets criteria for services and the beneficiary is not in agreement with the termination = AFS will issue a Termination NOABD.
- If the beneficiary stops engaging in services = AFS will issue a Termination NOABD.



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# QUESTIONS and FEEDBACK?



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