

Providing Intensive Care Coordination

Quality Assurance Unit

September 23, 2020



Overview of Services

Overview

- Medi-Cal is an insurance for those with limited income & resources
- Specialty Mental Health Services (SMHS)
 - Part of the Medi-Cal “carve out”
 - Provided by mental health specialists
 - Provided to Medi-Cal beneficiaries through LACDMH
 - Includes the “EPSDT benefit”
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit
 - Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medi-Cal
- In addition to traditional SMHS (e.g. MHS, TCM), EPSDT clients are entitled to the following services which are unique to the EPSDT benefit:
 - Intensive Care Coordination (ICC)
 - Intensive Home Based Services (IHBS)
 - Therapeutic Behavioral Services (TBS)
 - Therapeutic Foster Care (TFC)

Overview of EPSDT Benefit Services

ICC – Linking the client to services provided by other child-serving systems, facilitate teaming and coordinate mental health care

- Client involved with 2 or more child-serving systems should be getting ICC to facilitate cross-system communication & planning.
- There must be a Child and Family Team (CFT) in place to guide and plan services driven by the Integrated Core Practice Model (ICPM)

IHBS – Skill building services to help the client improve functioning in the home/community and improving the family's ability to help the client successfully function in the home/community

- Predominantly delivered in the home, school, or community; available wherever & whenever needed, including weekends & evenings
- Must be receiving ICC and other medically necessary SMHS
- There must be a CFT in place to guide and plan services driven by the ICPM

TBS - One-on-one, short-term, intensive, behavioral interventions in the home, school, or community

- Aimed at helping client (and parents/caregivers) manage client's challenging behaviors to be successful in his/her current environment
- Used in conjunction with another SMHS

TFC - Short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC foster parent to a client who has complex emotional and behavioral needs

- Aimed at helping the client remain in a family-like home or in a community setting, avoiding residential, inpatient, or institutional care
- Must be receiving ICC and other medically necessary SMHS
- There must be a CFT in place to guide and plan services driven by the ICPM

New Services (+TBS) versus Traditional SMHS

ICC is similar to Targeted Case Management (TCM)

- TCM – Activities to assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)
- ICC – Team-based activities across various child-serving agencies and family networks to assist a client and family to move from formal (i.e. professional) to natural (i.e. community and family member) support and focused on care coordination

TBS and IHBS are similar to Mental Health Services (MHS)

- MHS – General individual, group or family-based rehabilitation services and interventions that are designed to reduce client's mental or emotional disability
- TBS – Time limited, intensive, one-to-one behavioral mental health service, targeting a specific behavioral need
- IHBS – Intensive rehab-like services provided whenever and wherever the child needs them (including weekend and evenings and in the community)

TFC is a unique day SMHS provided by a foster parent

Background

2013

Katie A v. Bonta Lawsuit settlement agreement with DHCS

- Introduced three covered SMHS for EPSDT benefit – ICC, IHBS, TFC for the DCFS population
- DMH began providing ICC and IHBS under Wraparound, Intensive Field Capable Clinical Services (IFCCS) and Therapeutic Foster Care (TFC)

2017

DHCS expanded ICC, IHBS and TFC to all EPSDT eligible clients, not just those involved with DCFS

- In response, DMH expanded services to all funded programs, and
- DMH required providers to be trained to provide the services

2020

DMH requiring all providers eligible to provider TCM to provide ICC services

- Specific training required and provided by DMH

Intensive Care Coordination (ICC)

All providers are now expected to be able to provide ICC services

ICC Services must be available to EPSDT clients who **require intensive targeted case management services and have the need for cross agency collaboration and teaming**

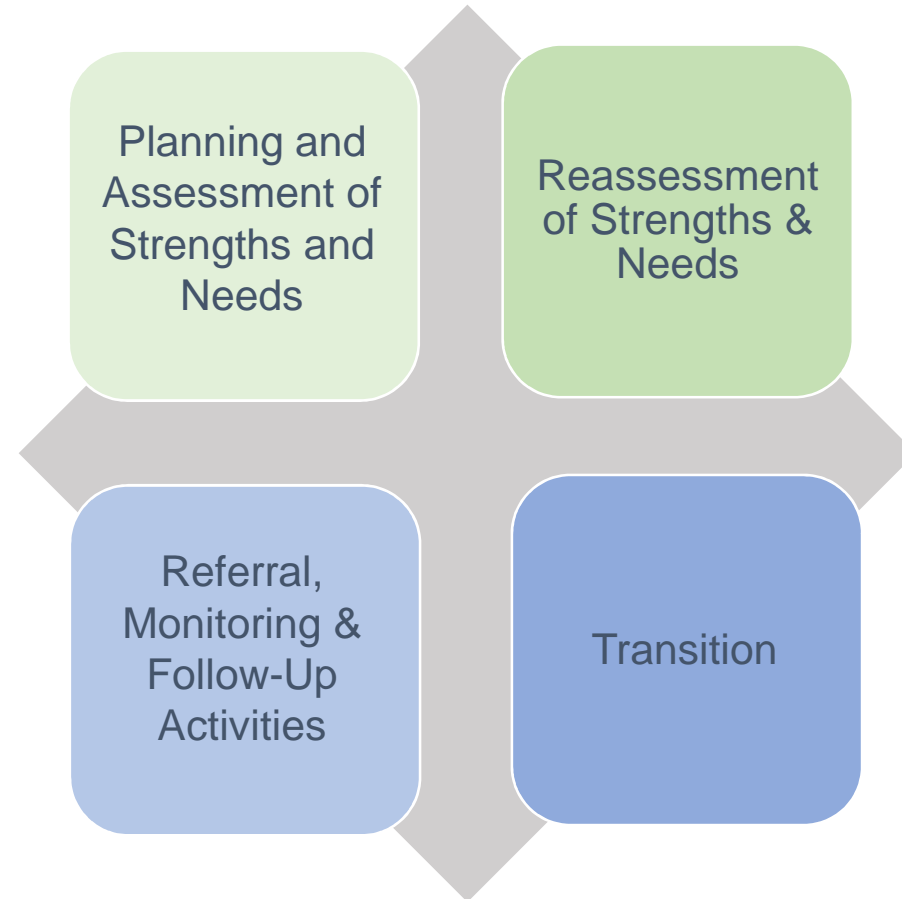
ICC Services must be provided using:

- The **Integrated Core Practice Model (ICPM)** which fundamentally changes the way staff engage with, view and relate to the child by working within a team environment
- The **Child and Family Team (CFT)** where individuals come together during a **CFT meeting** to identify the client's strengths and needs, develop a client and family centered treatment plan and strategies for achieving goals
- An assigned **ICC Coordinator** who is responsible for ensuring the CFT maintains fidelity to the ICPM, organizing the logistics of the CFT and educating the CFT on the ICPM

Intensive Care Coordination (ICC)

All providers are now expected to be able to provide ICC services

There are four (4) reimbursable ICC service components that guide the coordination of care for the client:





Who should be
getting ICC Services?

ICC Eligibility Criteria

Intended for clients who:

- Meet Medical Necessity (i.e. a clinical assessment must have been completed)
- Are under the age of 21 with full scope Medi-Cal
- Are involved in two or more child-serving systems (e.g., Special Education, Probation, Child Welfare, Medical, Drug & Alcohol, Regional Center) and/or
- Have more intensive needs than those typically addressed with TCM (refer to next slide for examples) and/or
- Require cross-agency collaboration

Form and Process:

- Once medical necessity has been determined, complete the **Intensive Care Coordination (ICC) Eligibility Form** for any child who has full scope Medi-Cal
- If client meets eligibility criteria, decide with the child and family if ICC would be beneficial
- If client receives ICC services, they are eligible (pending pre-authorization) to receive Intensive Home Based Services (IHBS), an intensive form of rehabilitation to address behavioral needs in the community

ICC Eligibility

Examples of Intensive Needs

Receiving/Being Considered For:

- Wraparound
- IFCCS
- FSP
- ISFC
- Specialized care rate (e.g. D Rate), or other intensive SMHS (e.g. TBS)
- Crisis stabilization/intervention services;
- High-level-care institutional settings, such as group homes or Short-Term Residential Therapeutic Programs (STRTPs)

Psychotropic Medication Treatment/Diagnosis

- 2 or more antipsychotic medications, at the same time, over a three-month period
- For 0-5 year olds, client has more than one psychotropic medication or more than one mental health diagnosis
- For 6-11 year olds, client has more than two psychotropic medications or more than two mental health diagnoses
- For 12-17 year olds, client has more than three psychotropic medications or more than three mental health diagnoses

Frequency/Utilization of Hospitalization/ER

- 2 or more mental health hospitalizations in the last 12 months
- 2 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
- 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

Other


- At least 1 placement change due to behavioral health needs
- SMHS within the last year, and have been reported homeless within the prior six months
- Detained, pursuant to W&I sections 601 and 602, primarily due to mental health needs

Examples of Clients Where ICC Might be a Good Fit

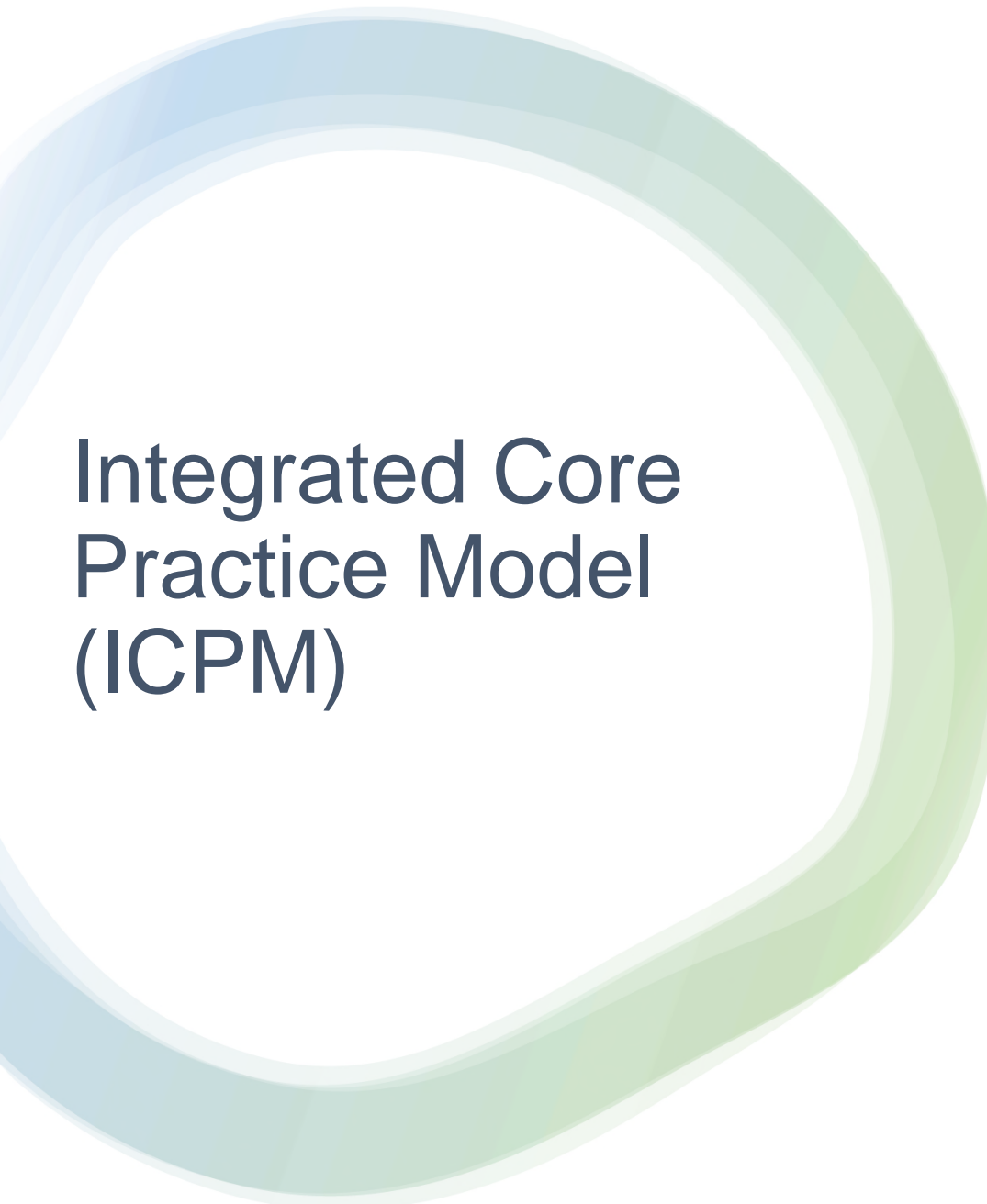
Suzie is an 11 year old female with an IEP in place due to a learning disability and experiences panic attacks that are brought on by school pressures.

Tommy is a 15 year old male who is on three different psychiatric medications. He also has been diagnosed with diabetes and is being treated by his primary care practitioner.

Jose is a 6 year old male whose family is involved DCFS. He is experiencing challenges adjusting to COVID (school through zoom) & DCFS involvement.



Integrated Core Practice Model (ICPM)
&
Child and Family Team (CFT)
&
ICC Coordinator



Integrated Core Practice Model (ICPM)

To effectively provide ICC, the ICPM should be used to guide the delivery of integrated and coordinated services

- **What is the ICPM?**
 - A set of practices & principles to guide the delivery of integrated and coordinated services for those serving children, youth, and families
 - A framework that sets the child and family team as the primary vehicle for a team-based process
- **What is the purpose of the ICPM?**
 - Sets out specific collaborative expectations for the multiple systems involved with children, youth, and their families
 - Coordinated integrated assessment and care to:
 - Reduce redundancy of effort
 - Increase access to specialty expertise and resources
 - Improve the care experience for the family

ICPM – 10 Core Principles

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

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 (CFT)

A Child and Family Team must be established to guide the services provided to children/youth & their families

What is a CFT?

- A CFT is a group of people who share a vision with the family and are working to advance that vision
- CFT members are engaged in a variety of processes:
 - To identify the strengths & needs of the child/youth and their family
 - To help achieve positive outcomes for safety, permanency, and well-being

Who are the CFT participants?

- The child/youth and family members
- Formal/professional supports (e.g., psychiatrist, teacher, pediatrician, parent partners)
- Natural supports (e.g., extended family, friends, neighbors, clergy, or others who the child/youth and/or family have identified as a potential source of support)
 - Natural supports will move into a more significant role as professionals work toward transitioning off of the team
- CFT participants should be identified as soon as possible & made aware of the values and principles of the ICPM

Natural Supports in the CFT – Addressing Reluctance



Family members may be reluctant, for a variety of reasons, to identify and invite friends or neighbors to participate in a CFT

May be angry or ashamed of being involved in juvenile probation, mental health, child welfare, etc.

May subscribe to cultural norms that do not accommodate sharing of personal information with “outsiders”

May be challenging for families experiencing mental illness and/or substance use, and/or further complicated by the historical or current impact of trauma



Professionals should work to mitigate reluctance by:

Being patient, offering encouragement, demonstrating respect & cultural humility

Utilizing parent partners, youth partners/mentors

Explaining that inclusion of others can directly support the family members in achieving their goals in a timely & effective manner



CFT Meeting

A CFT meeting is where the CFT members communicate a shared responsibility for assessing, coordinating care, and delivering services

- Working as part of a team positively impacts decision-making and advancing the shared vision
- The use of the CANS and PSC35 can support case planning and provide a platform for the CFT to guide conversations, learn about the child, and identify behavioral patterns
- A CFT meeting must minimally include the involvement of the client and family members
- The CFT meeting must occur at least every 90 days and more often if needed, to address emerging issues, provide integrated & coordinated interventions, and refine the plans
- CFT members should discuss & address any concerns related to sharing information & applicable release of information must be obtained
- During the initial CFT meeting, the ICC Coordinator should provide an overview of the ICPM



CFT Meeting Purpose & Structure

The CFT meeting must have a clear purpose & structured format including:

- Preparatory discussion with ALL members prior to the start of the meeting
 - Provide an explanation of the purpose, people involved, and structure of the meeting
 - Include an opportunity for all team members to ask questions and share concerns
- Meeting agendas developed with the team that reflect the voice of the child/youth and family
- Routinely measuring and evaluating child/youth and family member progress and emerging needs
 - Team meetings can help team members recognize when interventions and treatment plans are working, and when they require revisions
 - The team's role is providing encouragement to continue the work to achieve family goals is a critical component of success



CFT Meeting Facilitator

- Each CFT meeting must have a facilitator
- The role of the facilitator is to:
 - Actively support the agenda
 - Help to identify needed contacts
 - Build consensus within the team around collaborative plans
 - Ensure that family voice and choice is heard throughout the entire teaming process
- Deciding who should facilitate:
 - Must be a member of the CFT
 - Consider the preferences of the child/youth and family members
 - May be influenced by the focus of the CFT meeting



ICC Coordinator

- A key element of ICC services is the establishment of an ICC Coordinator
- The ICC Coordinator may be any member of the mental health treatment team and must be able to claim Specialty Mental Health Services in accord with the Guide to Procedure Codes (refer to Discipline section)
- The **ICC Coordinator** serves as the single point of accountability and is responsible for:
 - Ensuring that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth consistent with the ICPM
 - Facilitating a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth
 - Supporting the parent/caregiver in meeting their child/youth's needs
 - Helping establish the CFT and providing ongoing support
 - Organizing and matching care across providers and child serving systems to allow the child/youth to be served in his/her community
 - Providing care planning and monitoring to ensure that the Client Treatment Plan is aligned and coordinated across all systems

Note: The ICC Coordinator is not required to facilitate CFT meetings



ICC Service Provision

ICC Service Provision

- ICC service provision requires more active participation by the ICC provider in order to ensure that the needs of the client are appropriately and effectively met
- The CFT is vital to ICC service provision because it provides feedback and recommendations to guide the provision of ICC services
- Engaging the client and his/her family is foundational and must be nurtured and developed throughout ICC service provision
 - In order to do this, it is crucial to allow CFT members to work to reach agreement regarding needed services, including ICC services
 - The CFT meeting allows providers and participants to work together to identify needed changes in the client's treatment plan
- ICC service provision is not limited to when the CFT meeting takes place
 - ICC services may be provided before, after and in-between CFT meetings

ICC Service Provision

- ICC services include four service components
 - Service components are reimbursable activities under Medi-Cal
 - These are similar to the service components covered under TCM and covers all services that would be provided under TCM
 - Note: For a client who is receiving ICC, rarely should there be a need to claim TCM as well
 - Similar to TCM, some of these service components require a treatment plan and some do not

TCM Service Components	ICC Service Components
Assessment	Planning & Assessment of Strengths & Needs
Plan Development	Reassessment of Strengths & Needs
Referral and Related Activities	Referral, Monitoring and Follow-Up Activities
Monitoring and Follow-Up	Transition

ICC Service Component

Planning & Assessment of Strengths & Needs



- Working within the CFT to ensure that plans from all child serving systems are integrated to address the identified goals and objectives and coordinating activities of all involved parties to support and ensure successful change
- Activities:
 - Gathering information and determining the needs of the child/youth and family including **strengths and underlying needs**
 - Ensuring plans from any of the system partners are integrated to comprehensively address the identified goals and objectives
 - **Coordinating** services to support and ensure successful and enduring change

Note: These activities are different from the clinical assessment process which incorporates the use of the Assessment forms and clinical interview to establish medical necessity

ICC Service Component

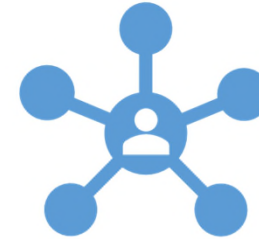
Reassessment of Strengths & Needs



- The ICC Coordinator and the CFT should reassess the strengths and needs of the client and their families at least every 90 days and as necessary to determine if changes are needed to continue supporting and addressing the needs of the client
- Activities:
 - Monitoring intervention strategies
 - Modifying interventions by incorporating approaches that work and refining those that do not

ICC Service Component

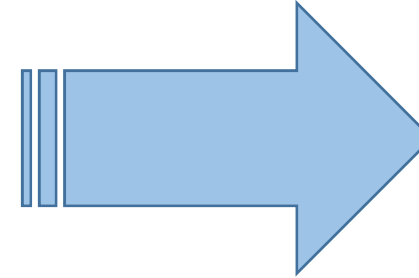
Referral, Monitoring and Follow Up Activities



- The ICC Coordinator conducts referral, linkages and monitoring and follow up activities to ensure the client's needs are met. This includes ensuring services are furnished in accordance with the Client Treatment Plan and are adequate to meet the client's needs
- Activities:
 - Assessing circumstances and resources
 - Making referrals and linking to services
 - Monitoring and follow up activities to ensure that the client's needs are met

ICC Service Component

Transition



When the client has achieved the goals of his/her client plan, the CFT should develop a transition plan for the child/youth and family

- Activities:
 - Develop a transition plan to promote long-term stability by including natural supports and community resources

Note: It's highly recommended that ICC providers begin thinking and planning for transition from the outset of treatment



Procedure Codes and Claiming

ICC Claiming Requirements

Who can claim for ICC?

- Anyone who is qualified to provide TCM services (refer to the Guide to Procedure Codes)
 - Any treatment team member may claim; it is not limited to the ICC Coordinator

When can ICC be claimed?

- After ICC eligibility has been established using the *ICC Eligibility Form*
- While CFT Meetings are a main component of ICC, the **provision of ICC is not limited to when the CFT Meeting** takes place. ICC services may be provided before, after, and in-between CFT Meetings

What can be claimed?

- Any activity that falls within one of the four ICC Service Components
 - This includes participation in the CFT Meeting

Claiming for the CFT Meeting

- Multiple providers may claim **for their time and participation at the CFT Meeting**
- Each provider may claim for the **time contributed to the meeting**, for up to the full length of the meeting, plus documentation and travel time
 - Contributed 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
 - How it can/will be used in providing, planning, and coordinating services to the client (i.e. how the information discussed will impact the client plan)

ICC Procedure Codes

All ICC services must utilize the T1017HK procedure code

- ✓ T1017HK
 - Used for all ICC Services
- ✓ T1017HKSC
 - The SC modifier is added for services delivered over the telephone.
- ✓ T1017HKGT
 - The GT modifier is added for services via telehealth.

The HK modifier identifies the service as ICC instead of TCM and must be included for all ICC services included telephone and telehealth

ICC Lockouts

ICC has all the same lockouts and rules for service claiming as other SMHS.

Refer to the *Organizational Provider's Manual* and online trainings

- Specifically, ICC is not claimable when:
 - Psychiatric Inpatient Hospital Services, Psychiatric Health Facility (PHF) Services or Psychiatric Nursing Facility Services are being reimbursed except for day of admission and discharge
 - Discharge Planning ICC services *solely for the purpose of coordinating placement upon discharge* from the Psychiatric Inpatient Hospital setting, Psychiatric Health Facility or Psychiatric Nursing Facility *ARE* reimbursable
 - Provided during the same hours of the day as Day Treatment Rehabilitative, Day Treatment Intensive and Group Therapy



Documentation Requirements

ICC Documentation Requirements

ICC has the same documentation requirements as other SMHS.

Refer to the *Organizational Provider's Manual* and online training modules

- Apply the following documentation requirements for ICC services:
 - A treatment plan is required prior to initiating treatment services and updated at least annually or reviewed and updated when there is a significant change in the client's condition
 - Treatment services are services that address a client's mental health needs and are not primarily for the purpose of assessment, plan development, crisis intervention or linkage and referral if a need of immediate concern exists
 - Although a treatment plan is not required for activities related to *Planning & Assessment of Strengths and Needs* and *Reassessment of Strengths and Needs*, it is recommended that an ICC intervention(s) be added to the treatment plan upon determination of eligibility
 - A progress note must be present for every claimed service
 - Plan Development activities under ICC may be combined into a single progress note with another service. (e.g., discussing the treatment plan at a CFT Meeting and completing an updated CANS)
 - For ICC, a single progress note may include multiple service activities within the same calendar day and intended to accomplish the same specific objective (e.g. telephone calls to CFT members to introduce the ICPM)

CFT Meeting & the Client Treatment Plan

There must be a progress note documenting the CFT meeting and the review of the treatment plan at least every 90 days. The formal Client Treatment Plan may or may not need to be updated.

Need to Update the Plan

- Reviewed and monitored the client's treatment plan and progress; and team decided to add a new ICC service
 - (e.g., linking client to after-school sports activities)
- Discussed client's current behaviors and decided to add a new treatment service
 - (e.g., MHS - Individual Therapy)

Do Not Need to Update the Plan

- Reviewed and monitored the treatment plan but did not add any new ICC services or other treatment services.
- New interventions or services discussed and will be provided but are not part of the mental health treatment plan
 - (e.g., teacher to modify assignments to decrease stress – instead of presenting her work in front of class, Jenny will record presentations at home)
 - These should be documented in the progress note but do not need to be part of the formal treatment plan

Treatment Plan Example

- Goal/Objective:
 - Client to reduce panic attacks from 3x per week to 1x per week
- Interventions:
 - Mental Health Services – Provide individual CBT therapy 1x per week to learn to manage panic attacks and not avoid the physical sensations
 - Intensive Care Coordination – Provide care coordination with DCFS and special education to ensure services are coordinated; develop a CFT and meet biweekly for CFT meetings; link client to after school programs and sports activities

Sample ICC Note

Interventions: ICC Coordinator met with client and caregiver for the purpose of engaging family into the ICC process and assessing for strengths and needs. ICC Coordinator explored with client who she would like to include in the CFT meeting to increase the number of informal supports. ICC Coordinator inquired about possible barriers towards including these informal supports during CFT meeting and encouraged her to include as many informal supports as she can to improve the teaming process.

Response: Client and caregiver were responsive during session with ICC Coordinator. Client was able to discuss her current family and identified feelings of sadness due to no longer living with biological mother but would like biological mother to be involved. Client identified a friend to include in the CFT meeting and denied any barriers towards friend participating in the CFT meeting process.

Plan: ICC Coordinator will discuss contact biological mother and the friend to discuss involvement in the CFT meeting.

Sample ICC Note

- **Goal(s):** 1) Client to reduce panic attacks from 3xweek to 1 week. 2) Client will complete and turn in homework assignments on time from 1xweek to 4xweek.
- **Intervention:** This ICC Coordinator spoke with client's teacher, Ms. R, on the phone for the purpose of coordinating care since Ms. R will not be able to attend the upcoming CFT meeting. This ICC Coordinator explored with Ms. R about what are client's strengths and what are some things that are working for him while in class. This ICC Coordinator clarified the techniques used in class and explored if they may be useful techniques to use in the home so that client would be able to complete his homework assignments.
- **Progress:** Ms. R informed that client has been turning in 1-2 incomplete homework assignments or will turn in 1-2 completed homework assignments late for the past 2 weeks. Ms. R has noticed that since client is not able to receive a star on the homework board on the days he does not turn in homework or when it is incomplete, he appears anxious but has not had a panic attack in the past week. Ms. R indicated her concerns for client is that his grades will drop due to the incomplete assignments and lack of participation in class. Ms. R has noted that there have been times in which client appeared to be close to a panic attack and when she placed her hand to her chest to cue client to deep breathe as Rehabilitation Specialist taught, client has been able to report feeling calmer. Ms. R indicated that client seems to do better after she sits with him and work with him 1:1 for a period of time. Through her cues, she is able to get client to reengage and participate with the class later.
- **Plan:** This ICC Coordinator will provide Ms. R's feedback and updates on client with the CFT during the next CFT meeting on [date]. Information gathered today will be used to coordinate care with the CFT. After CFT meeting, ICC Coordinator or assigned CFT member will inform Ms. R of the outcomes of the meeting and inform of the next meeting time.

Sample ICC Note

- Goal(s): 1) Client to reduce panic attacks from 3xweek to 1 week. 2) Client will complete and turn in homework assignments on time from 1xweek to 4xweek.
- Participants: Client, mother, brother, ICC Coordinator, Clinician, and Rehab Specialist.
- Progress: ICC Coordinator reported information shared by Ms. R (see previous note for details). Mother shared that 2 days ago he redirected client to stay on task with homework and client suffered a panic attack. Mother stated that client continues to display isolative behaviors: no eye contact and answers briefly with “yes” or “no” when his brother tried to engage him to play basketball at the park. Client is observed to have issues with interacting appropriately with his mother and younger brother at home. Client agreed and did not deny that he has been behaving that way and is trying to sooth himself.
- Intervention(s): ICC Coordinator prompted each participant of the CFT to identify, explain and clarify observations and suggest strategies to cope with anxiety to coordinate services. CFT members identified client’s need to feel heard and examined different ways to assist client with expressing himself appropriately. Clinician explained to mother that her current communication style with child tends to elevate client’s anxiety. Clinician assisted mother in voicing thoughts in a calm manner to model appropriate communication with client. Clinician suggested updating the CTP to include family therapy.
- Response/ Observed Behavior(s): Client described his experience of anxiety as sweaty palms, pounding heart, breathing hard, and fear of getting trouble for not knowing how to do his homework. Mother stated he did not realize her daughter’s fear of getting in trouble was triggered by how she was communicating with him. Mother stated she would like someone to come to the home to work with client on his anxiety at times when anxiety is most likely to occur such as after school when doing homework. Client, mother, and brother are open to family therapy.
- Plan: Based on the discussion at the CFT meeting and agreement from all CFT members, the Rehab Specialist will meet with client 2x a week to practice relaxation techniques such as modeling and prompting appropriate responses to interactions in the home beginning next week. Clinician will continue meeting with client weekly for therapy and will meet with family to discuss goals of family therapy. Next CFT meeting scheduled for [date].



Putting It All Together: Documentation & Claiming

Standard Course of Action

- **Assessing**
 - Complete a mental health assessment and establish medical necessity.
 - Complete ongoing needs and strengths evaluation (e.g. CANS and PSC35)
 - Complete the *ICC Eligibility Form* to determine suitability for ICC services
- **Planning**
 - Establish a Child & Family Team (CFT) with the child/youth and family
 - Develop a client treatment plan (utilizing the CANS) within the CFT Meeting
 - Monitor and revise the client treatment plan within the CFT Meeting
- **Treating**
 - Link clients to services provided by other child-serving systems, facilitate teaming, and coordinate mental health care

ACTIVITY	DOCUMENTATION	TYPE OF SERVICE	SERVICE COMPONENT(S)	PROCEDURE CODE
Meet with the client and family for the initial assessment	Full Clinical Assessment CANS-IP PSC35 Progress Note	MHS	Assessment	90791
Meet with the client and family to review the assessment findings and begin developing the treatment plan (e.g., Individual therapy and ICC)	CANS-IP ICC Eligibility Form Client Treatment Plan Progress Note	MHS	Plan Development	H0032
Meet with client and family to discuss the ICPM and identify CFT members	Progress Note	ICC	Planning and Assessment of Strengths and Needs	T1017HK
Contact CFT members by phone and describe the CFT process	Progress Note	ICC	Planning and Assessment of Strengths and Needs	T1017HKSC
Facilitate the initial CFT Meeting	Client Treatment Plan Progress Note	ICC	Planning and Assessment of Strengths and Needs	T1017HK

ACTIVITY	DOCUMENTATION	TYPE OF SERVICE	SERVICE COMPONENT(S)	PROCEDURE CODE
ICC Coordinator gathered and reviewed case information from DCFS for the purpose of needs and strengths assessment	Progress Note	ICC	Planning & Assessment of Strengths & Needs or Reassessment of Strengths and Needs	T1017HK
ICC Coordinator linked client into a Boys & Girls Club to assist in refining communication skills and increasing socialization	Progress Note	ICC	Reassessment of Strengths & Needs	T1017HK
ICC Coordinator facilitated a CFT meeting to monitor progress towards client plan goals	Progress Note	ICC	Reassessment of Strengths & Needs	T1017HK
Case Manager participated in CFT meeting by prompting members to identify, explain and clarify observations of client and suggest strategies to cope with depressive symptoms for the purpose of coordination of care	Progress Note	ICC	Planning & Assessment of Strengths & Needs or Reassessment of Strengths & Needs	T1017HK
During a CFT Meeting the ICC Coordinator, behavior specialist, client, parents, the child welfare worker, and teacher's aide discussed potential strengths identified by the CANS	CANS-IP Progress Note	ICC	Planning & Assessment of Strengths & Needs or Reassessment of Strengths & Needs	T1017HK

ACTIVITY	DOCUMENTATION	TYPE OF SERVICE	SERVICE COMPONENT(S)	PROCEDURE CODE
During a CFT Meeting the ICC Coordinator and the CFT members discussed client's level of participation and progress at the Boys & Girls (B&G) Club over the past month. They identified what she likes about participating in the B&G Club activities. CFT members also discussed aspects of her participation at the B&G Club that are not going as well	Progress Note	ICC MHS	Referral, Monitoring & Follow Up Activities	T1017HK
ICC Coordinator referred and coordinated client's registration with the local youth center in order to increase client's socialization with peers	Progress Note	ICC	Referral, Monitoring & Follow Up Activities	T1017HK
Rehabilitation Specialist monitored client progress in socialization with peers at the youth center by calling the youth center to get an update	Progress Note	ICC	Referral, Monitoring & Follow Up Activities	T1017HKSC
ICC Coordinator called mother to get a status update on enrolling client into tutoring	Progress Note	ICC	Referral, Monitoring & Follow Up Activities	T1017HKSC
During a virtual CFT Meeting, the CFT members also identified ways of maximizing community resources and activities, to ensure long-term stability for the client and her family	Progress Note	ICC	Referral, Monitoring & Follow Up Activities or Transition	T1017HKG T

ACTIVITY	DOCUMENTATION	TYPE OF SERVICE	SERVICE COMPONENT(S)	PROCEDURE CODE
To better assist the client in transition away from formal supports, the CFT participants reviewed Susie's and her family's personal strengths and external resources	Progress Note	ICC	Transition	T1017HK
The CFT members identified the presence and effectiveness of the following natural supports: church youth group, soccer team, B&G Club leadership group	Progress Note	ICC	Referral, Monitoring & Follow Up Activities Or Transition	T1017HK
CFT members discussed and strategized a plan for when a new CFT member will be joining the team, including what information the new member will need to know immediately, such as strengths, needs, and safety and trauma topics, to work with client and family	Progress Note	ICC	Transition	T1017HK

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MAN WHO SURVIVED JUMP FROM GOLDEN GATE BRIDGE SHARES HIS STORY

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References and Resources

The requirements for reimbursement and the rules for documentation are found in:

- LACDMH Policy 401.03
- *Short-Doyle/Medi-Cal Organizational Provider's Manual*
- *A Guide to Procedure Codes for Claiming Mental Health Services and the IBHIS Addendum Guide to Procedure Codes*
- Medi-Cal Manual on the Department of Health Care Services website:
 - http://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Katie%20A/Medi-Cal_Manual_Third_Edition.pdf
 - https://www.cdss.ca.gov/Portals/9/ACIN/2018/I-21_18.pdf?ver=2018-05-18-143357-423
 - https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/Integrated_Core_Practice_Model.pdf