Child and Family Team
Practice Protocol

There are many elements to the delivery of services in the context of a Child and Family Team (CFT) as it is referenced in the *TR vs. Dreyfus Lawsuit*. This document is a work in progress that will include the work that has been completed, the work under way, and how things work together in relation to the CFT.

TARGET AUDIENCE

This Protocol is specifically targeted to Regional Support Networks and their contracted providers who are responsible for the implementation of the:

- Washington State Mental Health Principles
- Core Practice Model
- Child and Family Team meetings

WHAT IS COVERED IN THIS DOCUMENT

Child and Family Team Protocol

BACKGROUND

WA STATE MENTAL HEALTH PRINCIPLES (Appendix A)

Child and Family Team practice is based on WA State Mental Health Principles (the Principles)*:*

- **Family and Youth Voice and Choice**
- **Team based**
- **Natural Supports**
- **Collaboration**
- **Home and Community-based**
- **Culturally Relevant**
- **Individualized**
- **Strengths Based**
- **Outcome-based**
- **Unconditional**

CORE PRACTICE MODEL (Appendix B)

There are six essential components of the Core Practice Model (CPM) that contain effective CFT practice. These activities are not the goal of the CFT but are rather the process to move toward the goal of identifying and meeting the needs of the youth and family. These essential components of the CPM are not strictly linear and are addressed in the order, frequency, and duration necessary.

The components are:

- **Engagement** with the youth and family
  - Immediate needs identified and addressed
  - Begin exploration of strengths, resources, long-term vision, primary family needs, and potential short-term goals.
  - Identification of additional family members, close family friends, and other potential CFT members.
- **Assessing**
  - Identification of strengths, assets and resources that can be mobilized to address family needs for support.
  - Exploration and understanding of the unique culture of the family
  - Recording of the youth and family's vision of a desired future.
  - Identifying the needs and areas of focus that must be addressed to move toward this desired future.
  - Strengths, needs and culture clarified
- **Teaming**
  - Identification, engagement and participation of additional family members, close family friends, appropriate clinical expertise, and other potential CFT members
  - Meeting schedule and logistics determined
- **Service Planning and Implementation**
  - Vision and goals agreed upon
  - Written team plan developed

- **Monitoring** and **Adapting**
  - Tracking progress and outcomes, keeping the family's vision of the future in mind;
  - Adapting the Service Plan as necessary to address barriers, lack of progress, or new situations;
  - Monitoring timelines for activities;
  - Anticipating and addressing transitions;
  - Reviewing and updating the CANS every 3 months; and
  - Tracking task assignments and their completion.
- **Transition**
  - Planning activities can include some of the following situations:
    - Changes in living environment, relationships and school settings
    - Admission/discharge to and from higher levels of care
    - Shifting from the youth's service delivery system into the adult service system
    - Successful completion of goals and disenrollment from behavioral health services

WA PRINCIPLES AND CPM DEVELOPMENTS

- The Principles and CPM are intended to provide a framework for the success of cross system work on behalf of youth and families served through the Medicaid funded behavioral health system. These are included in the RSN contracts as of 7/12.
- MOUS are being developed among DSHS Administrations and HCA that include agreement that the collaborating state agencies and systems commit themselves, their employees and agents to participate in a state mental health system that delivers services to children and youth guided by the Principles. The CPM embraces the Principles and provides six components that will be addressed in each individual case over the course of treatment and transition.
- RSNs are currently making plans for how to infuse these principles and CPM in their work and are working with DBHR on how to report those efforts to the litigation team.
- A CPM Workforce Development (WFD) Workgroup is developing a plan to support the work currently occurring around the state and incorporate successful activities, materials and curriculum for use in a consistent statewide effort. This group will address WFD across child serving systems.
- Three other SoC WFD workgroups are addressing:
  - Certification and licensing of CPM providers to include limited scope agencies.
  - Youth Peer Counselor Curriculum
  - Parent/Professional partnerships

ACCESS TO INTENSIVE SERVICES WHICH WILL INCLUDE CFT – Appendix C and D

- An Access Graphic Model and Narrative have been established that provides an overview of how a youth moves into and through Medicaid Intensive Mental Health Services.

- Agreement has been established that Access to Care Guidelines have not been and will not be altered. There will be a consistent training (developed by the CPMWFD workgroup in coordination with the RSNS) for RSNs and Providers to clarify and provide consistency around the definition of high risk behaviors and B Diagnoses.
- Agreement has been established that RSNs will continue to serve youth under the current state plan service array. Work is being done on:
  - the definition of Intensive Services,
  - crosswalking state plan services with WIYS (plaintiff defined intensive services),
  - developing consistent tracking mechanisms
  - funding strategies
  - tools to identify youth that may need intensive services,
  - criteria for those services
  - protocols to refer and assess them
  - Once the previous are complete, the CPMWFD workgroup will work on training and TA on these areas as well.

CHILD AND FAMILY TEAMS (CFT)

After the Principles and CPM development, achieving consistency around CFTs was felt to be the first area that could be addressed in our current funding environment as it is the most effective method of delivering the CPM and most RSNs reported having some form currently occurring. All RSNs will **begin** to develop CFTs in October 2012.

THE DEFINITION OF A CFT

The role of the Child and Family team includes:

- Assemble as a group of caring individuals to work with and support the youth and family that, in addition to the youth and family, community members and various agency and provider staff involved in service delivery, includes at a minimum a facilitator and a family support partner or family specialist for youth.
- Continue the process of engagement with the family and or caregivers about their strengths and needs, ensure that services are well coordinated, and provide a process for transparent communication.
- Identify the strengths and needs of the youth and develop an individualized, strengths-based, youth and family-focused plan to address them.
- Implement the plan and refer the youth and family to resources in the community.
- Monitor and modify the individualized plan to address the youth's changing strengths and needs and/or improve the effectiveness of the plan and services/supports provided.
- Develop and implement a transition plan as soon as the team determines it is appropriate.

EXPECTATIONS OF A CHILD AND FAMILY TEAMS

Child and Family Teams (CFT) are designed for children and youth who have complex emotional, behavioral and social issues who typically require care coordination across two or

more systems. In such cases, the CFT facilitates cross system coordination to support outcomes in the restoration of a higher level of functioning for the youth and family. The CFT drives the treatment planning process to ensure that services and supports are provided in accordance with the WA State Children's Mental Health System principles and the Core Practice Model. The practice/structure expectations of CFTs include:

- The CFT process is voluntary for the family.
- The facilitator engages with the family using a structured process that helps him/her understand the family's strengths/needs and culture before any team meeting with other professionals or team members is held.
- The facilitator develops a "vision statement" for a better future with the family that provides a basis for planning and transition.
- The facilitator will have a working knowledge of the service system as well as the community and its available supports.
- The facilitator maintains a committed team and is qualified with the necessary skills and persuasiveness to bring people and resources to the table[1] in support of the youth and family.
- A team is convened that includes representatives of all providers and systems with major roles in the family's life.
- Natural supports are identified by the family and included on the team
- A written plan of care is developed that documents:
  - The family's needs/goals and strategies that are tied to those needs/goals.
  - A crisis plan is developed that clearly describes what leads to crises for the family and ways to prevent or respond to them.
  - A Family Wellness Plan is developed outlining the family strengths, calming activities, plans and important contact information.
- The plan identifies the needs of all family members (not just the identified youth) and includes related strategies.
- Efforts will be made to connect to experienced family and/or youth support when the team identifies the need.
- The team will be expected to meet with sufficient regularity to make progress on goals and maintain clear and coordinated communication.
- The team assesses progress toward the family's needs or goals at each meeting.
- The facilitator is expected to check in with families, professionals and team members on progress made on assigned tasks between meetings.

AREAS CURRENTLY UNDER DEVELOPMENT

- Clarity on the criteria for youth that "shall" be offered a CFT once they are developed. The current criterion, "Children and youth whose individualized strengths and needs indicate that they would benefit by having a CFT" is purposely quite broad to allow best

[1] Note: The size, scope and intensity of the involvement of CFT members is driven by the needs and desires of the youth and family. There are a number of ways people and resources can be "brought to the table". The expectation is that team members will actively engage in sharing responsibility and decision making. "Convening/Meeting" can occur with some participants via phone as well as in person as appropriate for the issues, the geography and the family's *preferences.*

practice for cross system youth. We *may* need to identify clearer criteria that can be used before the full implementation of the Child and Adolescent Needs and Strengths (CANS) Assessment as well as after. (CSIT, CMHC)

- What constitutes a "qualified facilitator" (SoC WFD workgroups)
- Definition of/guidance for full participation in a CFT (CPM WFD workgroup)
- Incorporation into the cross system MOUs for full participation in CFTs. Accountability structures will be included. (CSIT)
- Quality tools to measure success of CFT and CPM structure, cross system participation, and tracking. (Data /Quality Group)
- A method by which individual service requests that come from the CFT care planning process go forward. (CMHC)
- A consistent set of essential elements to be included in the curriculum for the CPM and CFTs (CPM WFD workgroup)

CHILD & FAMILY TEAM (CFT) MEETINGS

All RSNs will begin reporting CFT meetings by November 1, 2012 (SERI-Appendix E)

PURPOSE

Child & Family Team (CFT) Meetings are for the development, evaluation or modification of a cross system care plan in accordance with WA Children's Mental Health System Principles, care planning is family driven, youth guided and focused on strengths and needs. The CFT facilitates cross system coordination to support outcomes in the restoration of a higher level of functioning for the youth and family. The cross-system care plan is maintained in the official mental health provider client record and each participating member receives a copy.

POPULATION SERVED

This service is designed for children and youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more systems.

MEMBERSHIP

Membership on the CFT is determined by the family and youth in collaboration with service providers and includes natural supports that the family / youth designate as well as representatives of involved providers and systems.

FACILITATION

The CFT is facilitated by a member identified by the team that is able to maintain a consistent presence, guide the team process, coordinate planning efforts, and be responsible for sign-in sheets and meeting minutes that document efforts, agreements and progress.

FREQUENCY

The team meets with sufficient regularity to assess progress and maintain clear & coordinated communication in order to carry out the plan.

REPORTING

Encounter time is based on client time. In the case of a CFT "client" refers to the time of the youth or family, either or both of whom must be present. One CFT meeting may be reported by the RSN to the state as only one encounter.

Mental Health Professional (MHP) or staff supervised by a MHP will utilize the code H0032 with Modifier HT

ADDITIONAL INFORMATION

All families are unique and as such, each CFT experience is necessarily different from another. Frequency of CFT meetings, location and nature of meetings, intensity of activity between CFT meetings, and level of involvement by formal and informal supports necessary to adequately support youth and families will vary depending on the following:

- The size of the team, coordination efforts required, and the ability of the CFT to work effectively together;
- The number of distinct services and supports necessary to meet the needs of the youth and family;
- The frequency of CFT meetings necessary to effectively develop a plan, track progress and make modifications when needed;
- The number of agencies/systems involved;
- The severity of symptoms and the effectiveness of services;
- The stress that is currently affecting the youth and family.
- Geographic location (rural teams may meet, discuss and plan over the phone or via telemed); and
- The preferences of the youth and/or family

Meetings that result in decisions effecting the youth and family cannot occur without the family's full participation. Decisions effecting substantive changes in service delivery should not be made without the participation of the full CFT. CFT practice is flexible and, when necessary, adapts to accommodate parallel processes such as Family Team Decision Making (FTDM), or permanency planning (DES/DCYF), Person Centered Planning (DES/DDD) and Individualized Education Programs (IEP) (Special Education).

CARE PLAN DEVELOPMENT AND IMPLEMENTATION

The foundation for plan development begins with an assessment process*. This assessment occurs in concert with the standard intake and/or assessment process at the CMHA. At this point, the full array of Washington Medicaid State Plan Modalities* (which may include intensive services) *are authorized as needed.*

The CFT members engage in brainstorming options and identify creative and nontraditional approaches, including formal and natural supports, for meeting the needs of the youth and family. Careful consideration and weight are given to the youth and family's preferences,

strengths, culture and the parent's expert knowledge of their own child. Objectives that can be readily accomplished and celebrated within a short timeframe are identified to encourage early success and continued involvement and achievement.

THE CROSS SYSTEM CARE PLAN

The cross-system care plan will:

- Describe the youth and family's vision for the future (stated in their own language)
- Reflect the family's prioritization of needs and goals
- Identify the short-term objectives, interventions, supports and services that will address their identified and prioritized needs
- Incorporate pertinent, identified strengths and cultural considerations within its strategies to achieve successful outcomes;
- Be individualized and responsive to the youth and family's needs;
- Establish responsibility to CFT members for each strategy/intervention/task and establish timelines for implementation;
- Utilize both formal and informal/natural supports and services as indicated;
- Identify natural supports and connections to community supports which may need to be developed or re-energized;
- Identify outcomes, actions and strategies/interventions/tasks related to the family's vision for the future;
- Include measures by which the youth/family and CFT can monitor progress; and
- Be signed by the parent/guardian, and the child/youth (if developmentally and legally appropriate).

When the family has multi-agency involvement, every effort is made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. If a family member (e.g. parent and/or sibling) is also receiving behavioral health services, inclusion of the behavioral health goals and objectives for that family member may be incorporated into a Family Care Plan, when agreeable with the family.

Both the assessment and service planning are ongoing processes, which result in plans that are continually updated as needed to obtain desired results and meet the changing needs of the youth and family.

ONGOING CRISIS PLANNING

Effective crisis planning is a critical component of an effective care plan. The crisis plan:

- Anticipates crises based on knowledge of past behavior as an indicator of future behavior;
- Researches past crises to identify for each situation the preceding behaviors, impulsive behavioral responses (thought and action) and the consequent behaviors which follow as a natural result;
- Changes over time in response to what is known to be effective or ineffective interventions;

- Contains clear behavioral benchmarks that change over time to reflect progress, changing capacities and changes in the youth/family's expectations;
- Triages the intensity of response actions to align with the severity level of the crisis situation;
- Anticipates a 24 hour crisis response;
- Builds roles for family members and other natural support people as responders in crisis situations;
- Clearly defines roles of other CFT members and how they support the mission of the crisis plan;
- Utilizes input from the youth/family on what can go wrong with the plan and responds accordingly; and
- Evaluates the management of the crisis and effectiveness of the plan once the crisis has stabilized.

ROLES ON THE CFT

(Rules, responsibilities, competencies, skills, and assessment will be developed further)

THE FACILITATOR

Team facilitation can be done by a qualified and committed CFT facilitator. The facilitator maintains a committed team and is qualified with the necessary skills and persuasiveness to bring people and resources to the table in support of the youth and family.
The facilitator contributes knowledge and skills related to making sure that the meeting process is respectful and honors everyone's roles, responsibilities and perspective. While the responsibility of preparing family members and other participants may fall to others in some areas, it is the facilitator who will make sure that each participant is heard and given the same consideration as others during the meeting.

The facilitator will:

- Guide the process of the meeting.
- Encourage each CFT member to identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of others involved in child-serving systems;
- Utilize consensus-building techniques and is expected to avoid any "positions" or predetermined solutions in meeting the needs of the family;
- Establish and sustains an effective team culture by inviting CFT members to propose, discuss and accept ground rules for working together.
- Engage all CFT members and identifies their needs for meeting agency mandates and the strengths that each person brings to the team. The facilitator is expected to identify their perspectives on the youth/family's strengths and needs, provide CFT members with an overview of CFT practice, and clarify their role and responsibilities as a team member in this process.
- Increase the "natural support" in CFT membership and the youth/*f*amily's integration into their community. This is accomplished by periodically inquiring whether there is

anyone else the family would like to invite to CFT meetings, (i.e. friends, extended family, neighbors, members of the family's faith community, co-workers).

- Identify family support, peer support or other "system" and community resources that can assist the youth/family with exercising their voice in the CFT process, if needed.
- Prepare for meetings:
  - Develop a meeting agenda with the youth, family, and other CFT members.
  - Schedule meetings at a place/time that is comfortable and convenient for all CFT members while giving special consideration to the preferences of the family.
  - Prepare visual aids or tools to facilitate the meeting process.
  - Inform all CFT members of the date, time and location of each meeting.
- Contact CFT members who are unable to attend a meeting, in advance, to elicit their input.
- Ensure all CFT members receive an updated copy of the care plan, documentation of progress, CFT meeting activities, discussions and task assignments within 7 days after the CFT meeting.
- Be sensitive to the needs of team members when working in rural areas where getting members together physically may be challenging. The facilitator must be creative in establishing a team that may meet via phone or through teleconferencing.
- When working with older youth, the facilitator and team must respect the young person's wishes around team formation.
- Inform the youth and family of their rights (including Due Process) and obtaining all necessary consents and releases of information.

THE COMMUNITY MENTAL HEALTH PROVIDER

The community mental health provider will:

- Contribute knowledge about agency and community resources and relay both the strengths that they see in the family system and the critical concerns that must be addressed in the family's care plan.
- Ensure that services and supports are provided in accordance with the WA State Children's Mental Health System principles and the Core Practice Model
- *May* use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the person but will not use these tools as criteria to deny or limit services.
- Coordinates the Medicaid reimbursable mental health services.
- Most behavioral health services do not require additional PIHP authorization. When it is determined that a person is in need of a behavioral health service requiring prior RSN authorization in order to correct or ameliorate a mental illness or condition (e.g. psychiatric inpatient, or CLIP), the community mental health provider initiates action for those services in accordance with RSN policy. A decision to authorize or deny a prior authorization request *must be made by the RSN*.

OTHER SERVICE PROVIDERS

Other service providers inside the agency and in the community also contribute knowledge about resources and relay both the strengths they see in the family system and concerns they may have for family members. They are encouraged to provide information and options for the

family to consider rather than make recommendations and insure all official service plans of each system emerge from the one cross system care plan.

MEDIATING CONFLICT

- It is expected that treatment provided through the public mental health system is medically necessary according to the following definition:

  "A requested service which is reasonably expected to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. Course of treatment may include mere observation, or where appropriate, no treatment at all.

  Additionally, the individual must be determined to 1) have a mental illness covered by Washington State public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support cannot address the individual's unmet need."
- Additional guidelines in determining whether a service is appropriate could include those that are (a) in accordance with generally accepted standards of practice; (b)clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the client's presentation; and (c) not primarily for the convenience of the client, family or care provider.
- The community mental health provider and other CFT members work together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and parent(s)/guardian(s).
- If agreement is not able to be reached regarding service planning at the CFT level, the community mental health provider and facilitator help unite the team in agreeing to try a particular service approach on an interim basis for a specified period of time during which the behavioral outcomes of the child are carefully monitored by the CFT.
- The team reconvenes to consider the outcomes in relation to the services that have been provided and to make needed adjustments over time.

APPENDIX A

WA State Children's Mental Health System Principles

RSNs agree to move as quickly as is practicable to develop a Medicaid funded behavioral health system that delivers services according to the Principles set forth below.

- **Family and Youth Voice and Choice**: Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.
- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based**: Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the youth and family and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional**: A youth and family team's commitment to achieving its goals persists regardless of the youth's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

APPENDIX B

CORE PRACTICE MODEL

PURPOSE

The Washington State Division of Behavioral Health and Recovery core practice model is an overarching framework for providing comprehensive behavioral health services and supports for youth with complex emotional and behavioral issues. The practice model provides the broad principles that inform and guide the management and delivery of mental health services and supports; describes the treatment and support activities that providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and services quality; and ensures cost-effective use of resources.

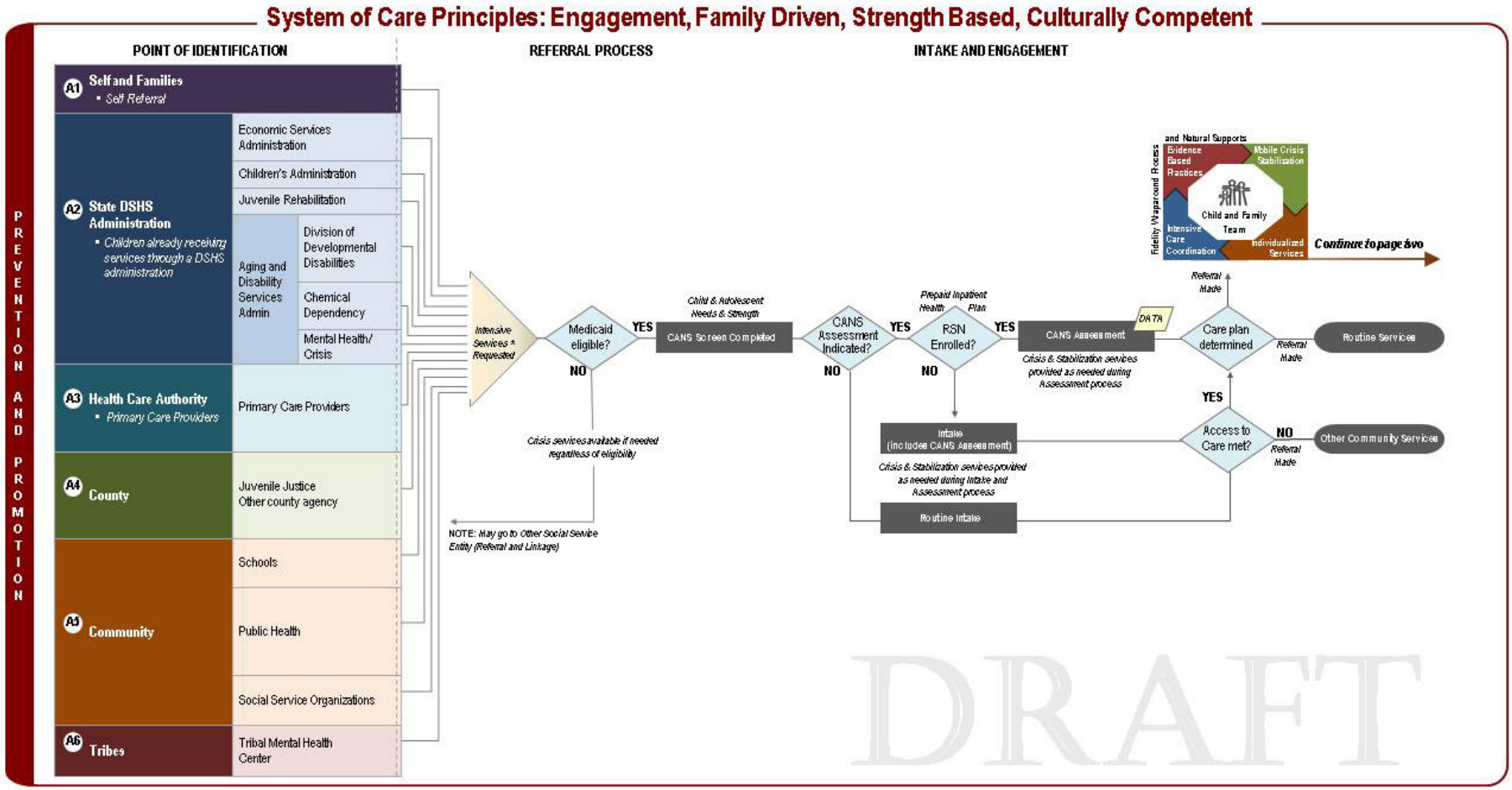
PRACTICE MODEL COMPONENTS

Practice components embrace Washington State Mental Health Principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the youth and family all of components 1-6 (below) over the course of treatment and transition.

1. ***Engagement*:** Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the youth and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
2. ***Assessing*:** Information gathering and assessing needs is the practice of gathering and evaluating information about the youth and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of youth.
3. ***Service Planning and Implementation***: Service planning is the practice of tailoring supports and services unique to each youth and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the youth, family, and caregivers.
4. ***Teaming:*** Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
5. ***Monitoring and Adapting*:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
6. ***Transition*:** The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

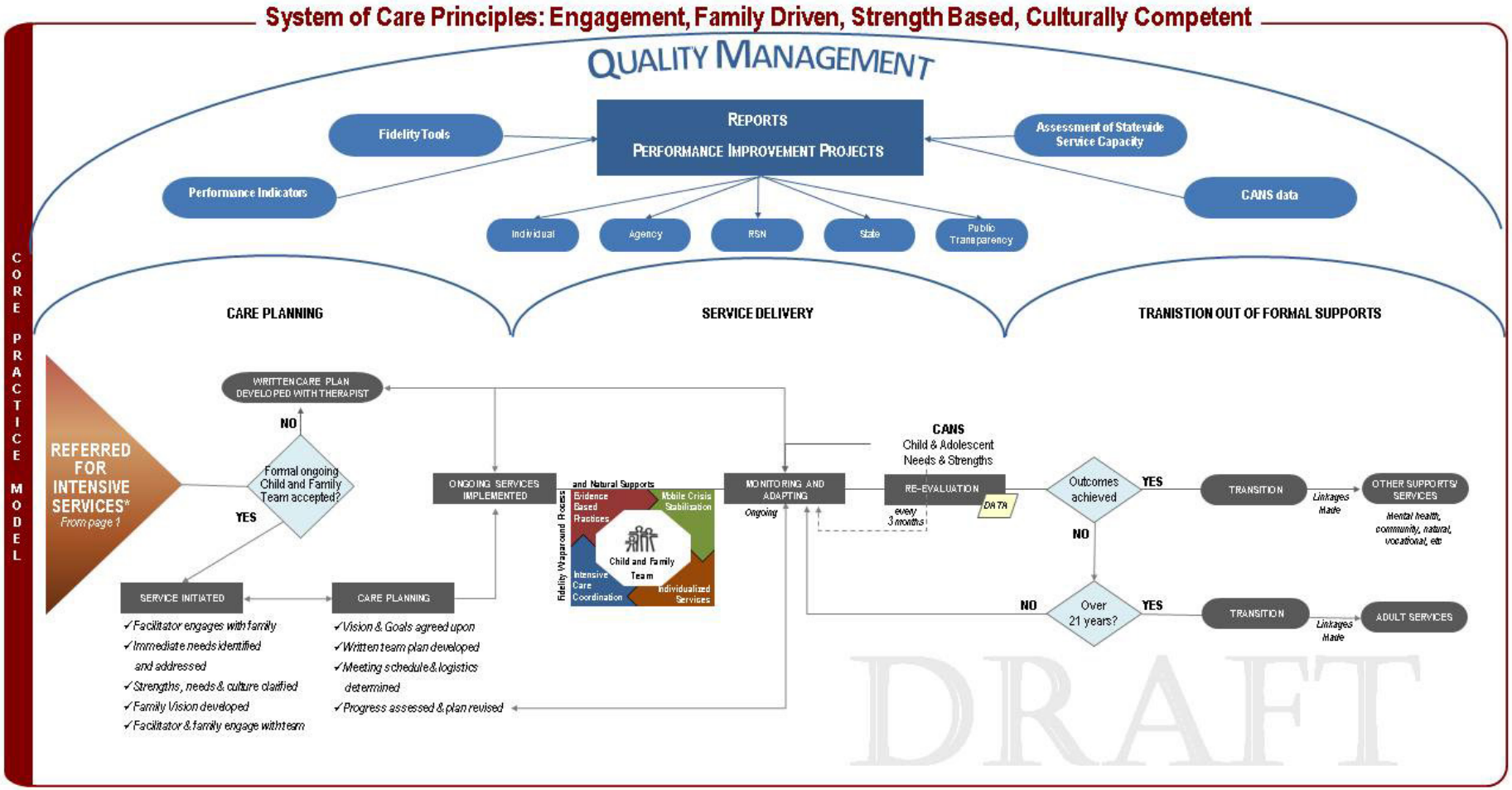
APPENDIX C

Access Model to Intensive Community Mental Health Services*



APPENDIX C

Access Model to Intensive Community Mental Health Services*



APPENDIX D
ACCESS MODEL NARRATIVE

POINT OF IDENTIFICATION

RSNs (Regional Support Networks), providers, and allied systems will identify children and youth who have functional indicators of a possible need for intensive mental health services and will recognize that screening for intensive services is essential when there is a:

1. request for out of home treatment or placement due to mental health needs;
2. step-down request from institutional or group care; or
3. RSN crisis intervention and the individual presents with past or current functional indicators of need for intensive mental health services.

REFERRAL PROCESS

1. Families, or their representative referral sources, will contact the RSN or an RSN contracted Community Mental Health Agency (CMHA) directly.
2. Medicaid eligibility will be determined. Clients not enrolled in any RSN will be referred to appropriate services, including crisis services as needed.
3. A Certified CANS Screener will interview the referral source utilizing the Child and Adolescent Needs and Strengths (CANS) Screen[2] to determine need for a full CANS Assessment.
4. Clients will be appropriately referred to a routine intake or an intake incorporating the CANS assessment based on this screening.

INTAKE AND ENGAGEMENT

- Clients being referred for a CANS Assessment who are not currently being served by an RSN provider will be scheduled for an intake[3] which will include the CANS Assessment. When needed, up to 14 days? of crisis and stabilization services may be provided whether or not Access to Care Standard is met.
- Clients currently being served by the RSN will be provided a full assessment utilizing the CANS Assessment Tool. Medically necessary services will be provided by the contracted CMHA during the assessment process.
- Providers will recognize functional impairments commonly associated with the functional indicators of a possible need for intensive mental health services and evaluate if they amount to a high risk behavior, as defined under 1915(b) Waiver Access to Care Standards, and exist due to the presence of a mental health condition (Diagnosis B “Additional Criteria”)
- Based on this assessment, clients will be referred to intensive or routine mental health services. Clients not meeting Access to Care Standard will be referred to other appropriate community services.

CARE PLANNING

1. Upon referral to Intensive Services, clients involved with two or more child servicing systems will be encouraged to engage in the Child and Family Team (CFT) Process for the development of a cross system care plan.

---

[2] Prior to the availability of the CANS tools, local RSNs will utilize current methods of screening and assessment to determine eligibility for intensive services.

[3] The purpose of an intake evaluation is to gather information to determine if a mental illness exists which is a covered diagnosis under Washington state's section 1915(b) capitated waiver program, and if there are medically necessary state plan services to address the individual's needs.

2. A service plan will be developed and services implemented. Families, CFTs and mental health providers will be empowered to present their service recommendations to the entity responsible for funding and providing that service and will understand the process to handle disagreements or difficulties.

SERVICE DELIVERY

1. Individual care plans and level of care decisions will continue to be informed by the CFT, CANS assessment, clinical evaluation, medical necessity and individual need.
2. Clients receiving intensive services prior to CANS implementation will be assessed utilizing the CANS tool (when it becomes available) during their regularly scheduled re-authorization.
3. Intensive service providers (contracted CMHAs and Children's Long-term Inpatient Providers) will utilize the CANS tool every three months to further evaluate and modify the care plan.

TRANSITION OUT OF FORMAL SUPPORTS

1. Discharge and transition planning will be an integral part of the ongoing review process of the CFT and/or treatment process.
2. As outcomes are achieved, the transition plan will be accelerated and linkages made for ongoing more normalized, age appropriate support and services as needed.

QUALITY MANAGEMENT

A quality management process will integrate quality management goals, objectives, tools, and resources to inform and improve the provision of mental health services at multiple levels:

1. at the individual level to assess and meet the youth's needs;
2. at the agency level to monitor the provision of services and ensure adequate capacity and quality; and
3. at the regional and state levels to establish and maintain accountability within the system and monitor systemic improvements.

APPENDIX E
SERVICE ENCOUNTER REPORTING INSTRUMENT

Child and Family Team Meeting

<table>
<tr><th>DESCRIPTION</th><th>GUIDELINES (INCLUSIONS/EXCLUSIONS)</th></tr>
<tr><td>Purpose: Child & Family Team (CFT) Meetings are for the development, evaluation or modification of a cross system care plan In accordance with WA Children's Mental Health System Principles, care planning is family driven, youth guided and focused on strengths and needs. The CFT facilitates cross system coordination to support outcomes in the restoration of a higher level of functioning for the youth and family. The cross-system care plan is maintained in the official mental health provider client record and each participating member receives a copy. The cross-system care plan includes 1. A statement of treatment and service goals, 2. Clinical interventions, 3. Supports designed to achieve those goals and 4. An evaluation of progress.
Population Served: This service is designed for children and youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more systems.
Membership on the CFT is determined by the family and youth in collaboration with service providers and includes natural supports that the family / youth designate as well as representatives of involved providers and systems.
Facilitation: The CFT is facilitated by a member identified by the team that is able to maintain a consistent presence, guide the team process, coordinate planning efforts, and be responsible for sign-in sheets and meeting minutes that document efforts, agreements and progress.
Frequency: The team meets with sufficient regularity to assess progress and maintain clear and coordinated communication in order to carry out the Plan.</td><td>Inclusions:
See description. All meetings where the family and other members of an established CFT are participating as part of the care plan.

Exclusions:
• Meetings without the youth or family present (i.e. one or the other or both must be present).
• Meetings for a primarily clinical purpose such as Individual or family treatment services that do not involve other CFT members.

Cross- System Care Plan: An individualized, comprehensive plan created by a Child/Family Team that reflects treatment services and supports relating to all systems or agents with whom the child is involved and who are participating on the CFT. This plan does not supplant, but may supplement the official treatment plan that each system maintains in the client record.</td></tr>
<tr><td>REPORTING: Encounter time is based on client time. In the case of a CFT "client" refers to the time of the youth or family, either or both of whom must be present. One CFT meeting may be reported by the RSN to the state as only one encounter.

Report encounter with one of the following mental health system provider types who are present in the CFT :
ARNP / PA — RN/LPN
MA/PhD — Below Master Degree
Mental Health Professional — Certified Peer Counselor
MH Specialist</td><td>STAFF QUALIFICATIONS: Mental Health Professional (MHP) or staff supervised by a MHP will utilize this code.

NOTE:
Information on this page is intended as an overview. Refer to the PIHP contract, WA State Children's Mental Health System Principles and WA State Children's Mental Health Child and Family Team Practice Expectations.</td></tr>
<tr><td colspan="2">REPORT CODE: H0032: Mental Health Service Plan development without Physician
With Modifier: HT Multidisciplinary Team</td></tr>
</table>