## TARGETED CASE MANAGEMENT/INTENSIVE CARE COORDINATION (T1017)

**P - (Purpose):** Targeted case management services to help with housing and medical care

**I - (Intervention):** Helped Janine organize information regarding her stay at Mary Isaak Center and determine if she needed to do anything regarding her financial or community-service responsibilities. Helped Janine phone Petaluma Health Center to schedule neuropsych testing. Offered to help schedule a neurosurgery follow-up at UCSF, but Janine said she would follow up on that. Helped Janine identify needed next steps to update her EBT and Medi-Cal cards with her current legal name. Encouraged Janine to continue working with her COTS case manager on any issues she was having at MIC.

**R - (Response):** Janine said that her COTS stay has been extended for 30 days, and that COTS has said that they can "work with her" to provide support if she has her knee-replacement surgery. Janine vented at length about the other people at the shelter, but she said that she has made friends there. She also said she is "getting more vocal" and speaking up when there are problems, as well as doing community service. She said she will also start attending CODA meetings, saying, "Someone told me it was for weenies who can't say 'no.'" Janine was oriented and engaged but struggled to make decisions and seemed easily distracted.

**PL - (Plan):** Janine said she will follow up with UCSF for neurosurgery follow-up. Her neuropsych testing appointment is scheduled for 7/28. Janine agreed to attend next DBT Skills Group.

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**P - (Purpose):** To assist John's mother in supporting his housing needs
**I - (Intervention):** Received phone call from John's mother. Provided active listening about her concerns about John's behavior and worries that he will lose housing at the Mary Isaak Center (MIC). Provided basic information regarding MIC rules and encouraged her to contact his MIC/COTS case manager with her concerns or for more information. Reminded her that John has lived at shelters in the past and likely understands how far he can bend the shelter rules, and also that MIC is likely used to clients who attempt to bend the rules.
**R - (Response):** John's mother reported that she is most concerned about John being homeless while she and his father are out of town for seven weeks. She seemed to calm down when hearing that John's behavior would not be automatically considered out of bounds for MIC and that COTS staff would be likely to try to work with him. She agreed to encourage John to follow MIC rules but not panic and "blow up at him" if he does not. She also expressed concern over transportation to and from medical appts and to pick up medications, as John has been struggling to utilize public transportation (related to anxiety) and mom has been providing all transportation.
**PL - (Plan):** Clinician will ask John's PSC to work with John on maintaining his current housing at MIC and on finding longer-term housing. Discuss transportation issues with John and determine if there is a goal that John has to be more independent with transportation (if yes, create TCM Plan), and add transportation issues to the problem list.

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## COORDINATION WITH EXISTING CONTRACTED PROVIDER/CBO

**P - (Purpose):** Targeted case management services to coordinate with Matthew's therapist
**I - (Intervention):** Contacted Matthew's therapist Jane Smith to discuss whether Matthew was benefitting from or attending therapy, given family's recent lapse in Medi-Cal and his recent no-show for his psychiatric appointment.
**R - (Response):** Jane said that Matthew attends therapy regularly and seems to be benefitting from the service. She also said that she can continue to provide services during the Medi-Cal lapse.
**PL - (Plan):** Jane will follow up with Matthew's family and refer them to a Medi-Cal eligibility worker. She will also encourage Matthew's mother to reschedule his missed YFS appointment.

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## PARTICIPATING IN CFT MEETING

**P - (Purpose):** To participate in CFT meeting at Human Services Department with Sara and supports.
**I - (Intervention):** I introduced self to team and agreed to confidentiality statements from facilitator. I provided overview of Sara's current services, strengths and needs based on IPCANS completed in 10/2023. I highlighted Sara's support system and Sara's and bio mom's resiliency. I gathered information around case plan for Sara and family to inform treatment and provide support and services.
**R - (Response):** Meeting attendees included: Sara and resource parent (by phone), Melissa -CPS facilitator, Rachel - CPS SW, Jenny - CPS SW, Desteney- Ct sister, Carmen- bio mom (with baby brother), Dorothy - bio mom mentor, Dago - SCBH adults. Nicky-Catholic charities case manager, Catherine- DAAC. Team discussed protective factors including bio mom sobriety, support network, faith, gaining knowledge on generational trauma, Sara excelling in school, and family's plan to reunify. Concerns include effects of family separation, trauma, continued support and tutoring for Sara and siblings. Sara's mom and team requested family therapy, CPI parenting services, and assistance with obtaining furniture and house items due to mom getting a new 2 bed apt. Team discussed plan for Sara to reunify with bio mom in coming weeks.
**PL - (Plan):** Continue to monitor Sara/family needs and provide support and case management. Before next meeting with Sara/family, I will discuss family therapy options with treatment team, as well as resources for assisting family in obtaining needed resources.

# TARGETED CASE MANAGEMENT/INTENSIVE CARE COORDINATION (T1017) – REFERRALS & STEP-DOWNS

## NEW REFERRAL TO CONTRACTED PROVIDER/CBO

**P - (Purpose):** Targeted case management services to link Aisha to Lifeworks for family therapy
**I - (Intervention):** Spoke with Aisha's mother to provide information about Lifeworks and their services. Completed referral packet with mother, including current diagnoses, psychosocial history and current factors, and treatment goals. [Photocopying/clerical tasks not included in direct service time.]
**R - (Response):** Aisha's mother agreed with Lifeworks referral and assisted in completing the referral paperwork.
**PL - (Plan):** Clinician will send the referral packet to Lifeworks and follow up as needed.

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## LINKAGE REFERRAL FORM FOR TEAM TRANSFER/CONTRACTOR
***If no direct contact with other provider/client/family – all time goes in documentation box.**

**P - (Purpose):** Targeted case management services to refer Carlos to a team for treatment of Schizophrenia
**I - (Intervention):** Using clinical knowledge of client, completed referral packet, including detailing his service needs, current providers, living situation, and pertinent psychosocial history.
**R - (Response):** Referral packet completed.
**PL - (Plan):** Clinician will send the referral packet to next Linkage meeting and follow up as needed.

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## COMPLETING BENEFICIARY REQUEST FOR SERVICE

**P - (Purpose):** Targeted case management services to link Stefan to eating-disorder services
**I - (Intervention):** Spoke with Stefan and his family to provide information about therapists specializing in eating-disorder treatment in the community and the process for requesting those services. Consulted with Dr. Iversen regarding treatment request. Completed Beneficiary Request for Service, including current impairments, treatment team's recommendation, and clinical urgency of request [time spent completing BRS form not included in Direct Service time].
**R - (Response):** Stefan is ambivalent but willing to pursue eating-disorder treatment, and his family very much wants these services. Dr. Iversen reported that she is concerned about Stefan's physical health and would like him to begin eating-disorder treatment quickly.
**PL - (Plan):** Clinician will submit completed BRS form to program manager for review and approval.

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**STEP DOWN OF CLIENT NOT MEETING ASSESSMENT CRITERIA FOR SMHS**
*** If no direct contact with other provider/client/family – all time goes in documentation box.**

**P - (Purpose):** Targeted case management services to link Barnaby with the appropriate level of care for treatment of adjustment disorder
**I - (Intervention):** Completed Beacon bi-directional form, including Barnaby's current treatment goals and diagnosis. Faxed completed form to Beacon Called Sonoma 4Cs and confirmed Barnaby's enrollment in their program. [Time spent completing and submitting forms not included in Direct Service time].
**R - (Response):** N/A
**PL - (Plan):** After ensuring that transition is complete, clinician will close Barnaby to SCBH services.

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**WRITING DISCHARGE SUMMARY (INCLUDING MDs)**
*** If no direct contact with other provider/client/family – all time goes in documentation box.**

**P - (Purpose):** To link Benny with PCP to assure continuity of care for treatment of Schizophrenia.
**I - (Intervention):** Reviewed Benny's records. Based on chart review and clinical knowledge of client, wrote summary for client's PCP of treatment history, current challenges, strengths, and laboratory findings to assist PCP with continuity of care as client steps down management of their psychiatric condition to their primary care provider.
**R - (Response):** [Brief overview of treatment history and challenges.]
**PL - (Plan):** Benny's PSC will complete process of transferring client's care to PCP.

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**COMPLETING THE TRANISTION OF CARE TOOL**
*** If no direct contact with other provider/client/family – all time goes in documentation box.**

**P - (Purpose):** Complete Transition of Care tool to move Becky to appropriate level of care.
**I - (Intervention):** Reviewed client chart and completed transition of care tool. Faxed form to [name agency]. Called client and left voicemail that form was sent to [name agency].
**R - (Response):** N/A
**PL - (Plan):** Close client to SCBH services.