

Reports are due April 1st and October 1st of each year. Please check the reporting period:

- May 15, 2013 – August 31, 2013 (Initial reporting period) October 18th
- April 1st
- October 1st

Katie A. Semi-Annual Progress Report Instructions

The Katie A. semi-annual progress reports are required by the Implementation Plan and should include information on the delivery of services occurring during the six months immediately preceding the report. The first of these reports is due on October 18, 2013, and includes information about services delivered May 15, 2013 through August 31, 2013. Enclosures 1 and 2 provide templates for the semi-annual report to be jointly prepared by Mental Health and Child Welfare Departments and submitted electronically.

Enclosure 1, Part A

The Mental Health Plans (MHPs) and Child Welfare Departments (CWDs) are to provide the total unduplicated numbers of subclass members, along with a breakdown of those subclass members grouped by the services being provided during the reporting period using the attached template. If the above numbers are not available, MHPs and CWDs are to provide an explanation of why they are not available and an estimated date of when the numbers will be available for each template item in Column 2 of Enclosure 1. This section (see Enclosure 1, Part A) of the progress report should build on the information counties provided in Section I of their Service Delivery Plans regarding identification of subclass members and the process used to determine their needs.

Enclosure 1, Part B

The MHPs and CWDs are to provide an estimated projection of the number of subclass members that will be provided with Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) by April 1, 2014, along with strategies and timelines to ensure access to ICC and IHBS, when medically necessary, and consistent with the Core Practice Model (CPM). In the column on Enclosure 1, Part B that reads "Strategy/Timeline Description," MHPs and CWDs should describe their plans for the identification of subclass children and youth who are identified in Enclosure 1, Part A, 4, 5, 6, 7 and 8 using the identifier and claiming codes for ICC and IHBS services.

Enclosure 2

The CWDs and MHPs should provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principles, and promote implementation of the ICC and IHBS using the CPM. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them. For each section, MHPs and CWDs should specify technical assistance or state support needed regarding implementation of CPM, ICC, and IHBS.

Submittal Instructions: Please submit electronically to the California Department of Health Care Services at: KatieA@dhcs.ca.gov, and the California Department of Social Services at: KatieA@dss.ca.gov. Reports are due on April 1st and October 1st of each year.

County:	San Bernardino	Date:	October 15, 2013
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Name and Contact Information County Child Welfare Department Representative					
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Name and Contact Information County Mental Health Department Representative					
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Name and Contact Information (other stakeholders)					
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Name and Contact Information (Other stakeholder)					
Name:	Holly Benton				
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County:	San Bernardino	Date:	October 15, 2013
PART A: Services Provided at Any Point Within the Reporting Period			
Item #	Information Requested	Column 1 10/18/13	Column 2 Timelines
Instruction	For subclass members, provide the numerical count for the following:	Provide the number of children/youth per category	If Column 1 is blank, provide an explanation why the number is unavailable and an estimated date the number will be available
1	In Subclass (unduplicated).	0	The Research Unit connected to Child & Family Services (CFS) has identified 550 potential subclass members based upon the criteria with corresponding data available in CWS/CMS. Efforts have been made to contact service providers involved with these identified youth, with some providers notifying CFS in September 2013 that an individual meets subclass membership; however, official subclass membership status is recognized when both MHP and CFS acknowledges subclass status. CFS has implemented a mechanism to process notifications of subclass membership which utilizes the benefits of one centralized contact for the MHP while soliciting input from the direct CFS caseworker. This process is now implemented, but all confirmations of subclass membership were made after 10/1/13 so are not included in this report.
2	Receiving Intensive Care Coordination (ICC).	0	ICC may only be provided to designated subclass members and there were no confirmations of subclass status from CFS prior to 10/1/13, so no services are listed. Additionally, the MHP provider must have ICC established within their potential array of services. There are currently 15 provider units sanctioned to provided ICC and efforts to add 10 more within the next two months. For an MHP Provider to have ICC added to their array of services a significant

			contract adjustment is needed which requires Board of Supervisor approval. This has caused a delay in approving these agencies/providers for ICC and IHBS.
3	Receiving Intensive Home Based Services (IHBS).	0	All MHP providers authorized to provide ICC are also being authorized to provide IHBS. Three of these providers are within a residential program, so utilization of IHBS will be limited to the 30 days prior to leaving the group home and during follow-up FSP activities.
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. <i>Do not include youth already counted in 2 or 3 above.</i>	134	The C-1 Component of our MHSA Plan is comprised of three distinct FSP programs, and collectively these are being identified as a primary continuum of programs for subclass members: (1) Children's Residential Intensive Services (CHRIS) is an MHP & CFS co-funded FSP program with RCL12 and RCL14 group homes; (2) California Wraparound is an MHP & CFS Co-funded FSP program serving high needs foster youth; (3) Success First/Early Wrap is an FSP designed to serve foster youth not eligible for California Wraparound. All providers in these programs will be authorized to provide ICC and IHBS; however, due to technical limitations billings for ICC only started after 10/1/13.
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC). <i>Do not include youth already counted in 2, 3, or 4</i>	26	The primary MHP programs included here are: (1) Therapeutic Behavioral Services (TBS), (2) Children's Intensive Services (CIS), and (3) Screening, Assessment, Referral, and Treatment (SART). SART is a transdisciplinary team program co-created by San Bernardino First 5 and the MHP. CFS has a policy of sending 100% of all foster children aged 0-5 to SART for screening and possible treatment. SART programs are authorized to provide ICC and IHBS and have started to do so after 10/1/13. In San Bernardino the ITFC

			program is a sole contract with CFS and youth are receiving mental health services through other programs.
6	Receiving services not reporting in 2, 3, 4, & 5 above.	133	The primary MHP programs included here are: (1) General Mental Health Clinics, (2) School Aged Treatment Services, and (3) private providers of the Fee-For-Service network.
7	Not receiving SMHS.	293	The foster children identified as potential subclass members, but not receiving specialty mental health services are a priority for our departments. The CFS caseworker for each child will be contacted by a DBH staff to discuss current difficulties and facilitate accessing services.
8	Declined ICC or IHBS.	0	At this early stage no families have declined ICC or IHBS.

County:	San Bernardino	Date:	October 15, 2013
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PART B: Projected Services

Item #	Service	Projected number of subclass members to be served by 4/1/14	Strategy/Timeline Description
1	ICC	300	<p>Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to:</p> <ol style="list-style-type: none"> 1. newly identified children/youth and 2. children/youth identified in Part A, Items 4, 5, 6, 7, and 8 as medically necessary <p>Provision of the Core Practice Model, including ICC and IHBS, is conceptualized as essential to the well-being of subclass members and therefore must be available to meet the different levels of need and circumstances present in this group of children. To address the possible broad range of circumstances and needs a continuum of care of ICC and IHBS providers has been develop throughout the current system of care. Programs authorized to provide and trained in the provision of ICC and IHBS are as follows:</p> <ol style="list-style-type: none"> I. Screening, Assessment, Referral, and Treatment (SART): A 0-5 program co-developed by First 5 and DBH serving children with a transdisciplinary team which includes a Public Health Nurse, Occupational Therapist, Pediatrician, Neuropsychologist, and Clinical Therapist. CFS policy has been to refer 100% of foster youth aged 0-5 to SART for screening and possible services. Contracted agencies will continue to screen 100% of CFS referrals and, when needed, assess for additional services and subclass membership.
2	IHBS	75	<ol style="list-style-type: none"> II. Full Service Partnership (FSP) programs within C-1 Component of MHSA: Children’s FSP programs designed to services to children and youth needing higher levels of care. <ol style="list-style-type: none"> a. Success First/Early Wrap: An FSP designed for children and youth who do not meet the requirements for admission to California Wraparound, but are still in need of both intensive in home services and the coordination of care included within wraparound. b. California Wraparound: A program coordinated by DBH and CFS to provide wraparound and intensive EPSDT Specialty Mental Health Services to foster youth. c. Children’s Residential Intensive Services (ChRIS): A newly implemented program coordinated by DBH and CFS which builds on lessons learned during Residential Based Services (RBS) pilot program and expands these resources to three provider agencies within RCL 14 and RCL 12 level group homes. FSP services are provided during residential and after discharge to facilitate successful growth and transitions.

III. DBH Collaborative Children’s Programs:

a. Healthy Homes: This unit consists of DBH clinicians co-located at CFS offices with the intention of providing screenings and assessments for foster children, attending Team Decision Meetings (TDM), and facilitating access to mental health services as needed. The primary focus of this team is the screening and, when warranted, assessing foster children. As such they will not be a primary provider of ICC, but may stay involved during early identification of a subclass member to ensure linkage to either SART or a C-1 FSP program.

b. Centralized Children’s Intensive Case Management (CCICMS): This unit provides services to children and youth with high level needs, often in collaboration with other programs and/or during transitions of care. Clinicians in this unit will serve as the ICC Coordinator for all foster youth who are placed at the Community Treatment Facility (CTF) to ensure smooth transitions back to the local community.

The above programs have all been trained on the provision of the Core Practice Model and will start billing ICC with the confirmation of subclass membership from CFS for each child. Since 10/1/13 CFS has confirmed six subclass members.

CFS is in process of developing a systematic training curriculum for case workers to become knowledgeable about the Core Practice Model. The initial stages of this process are completed and a complete training schedule is being developed. Initial stages included the director’s announcement within Monthly broadcast followed up with regional meetings led by the deputy directors to address any questions. These face-to-face efforts have been augmented by the utilization of computer based training created by the Public Child Welfare Training Academy. Until these trainings are broadly accessed by staff CFS has identified a centralized Core Practice Model expert to serve as a single point of entry for MHP providers/programs and work with regional Core Practice Model Regional Liaisons to ensure that any identified subclass member is properly served.

Additionally, a team of program and research staff (i.e., Children’s Programs, DBH Research & Evaluation, and Human Services Legislation & Research) has been created to develop a monthly system by which potential subclass members will be identified and connected to current providers for further review and evaluation. It is anticipated that monthly identification of foster children identified as potential subclass members will be coordinated by this team and follow-up actions will include: (1) notifying current MHP provider/program of potential subclass membership and requesting an evaluation, or (2) facilitating linkage to an appropriate MHP

			<p>provider/program if potential subclass member is not currently involved with an MHP provider/program.</p> <p>The providers are trained in the Core Practice Model, the systematic identification of potential subclass members is in place, and initial structure for collaboration between MHP programs and CFS is well established. It is expected that ICC will be provided to all subclass members enrolled in an appropriate program by 4/1/14. Those not enrolled in one of the identified programs will have help connecting to such a program, so the majority should receive ICC. The provision of IHBS will be established as well; however, the expected percentage of Subclass Members requiring IHBS is unknown. The expectation of number of children served reported here is based on the idea that 25% of the children and youth will need IHBS.</p>
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County: San Bernardino Reporting Period: May-August 2013 Date Completed: October 15, 2013

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the state is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county’s child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p>Agency Leadership <i>Leadership’s experience implementing family-centered services in a collaborative setting.</i></p>	<p>Children and Family Services and The Department of Behavioral Health are developing an elaborate MOU to solidify their mutual responsibilities, as a joint management group, to implement Katie A. Our agencies have developed numerous such agreements over the years and have had great success in implementing shared projects, including Wraparound, Residential Based Services, Healthy Moms and Babies, Interagency Youth Resiliency Teams, Interagency Placement Council, SART, Healthy Homes and Juvenile Court Behavioral Health review services. We are very confident in our ability to successfully implement projects as a collaborative.</p>	<p>N</p>
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>	<p>Currently, representatives from both agencies participate in numerous monthly meetings. Some meetings are specific to programs (such as SART, Wraparound, IPC and RBS) and are intended to address ongoing issues specific to those programs. There are also numerous regular meetings with representatives of the courts, public schools and other stakeholders. Further, the County holds a monthly Children’s Policy Council where all children’s service partners can meet, plan and review policy making throughout the continuum of care.</p>	<p>N</p>
<p>Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i></p>	<p>The Departments have very strong administrative structures and are able to manage complex change with relative finesse. During this past month the Director for Children and Family Services retired. In many counties this change would have created significant disorder, but our Departments have navigated this change with a clear focus and a commitment to keeping our momentum moving forward in multiple projects.</p>	<p>N</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p>Service Array <i>Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.</i></p>	<p>Our service array for children and families is quite extensive. We have a strong continuum of care that covers a wide range of prevention services through to a very high level of programming for children who require out of home placement. Staff throughout DBH and provider agencies is trained in Trauma Informed Management and other evidence based, promising practice based and unique and innovative programs. Our Residential Based Service model incorporates wraparound activities in high level group homes, while our Success First project incorporates those same principles for children who don't qualify for high level Wraparound. It is readily apparent that San Bernardino County is very committed to culturally astute processes throughout all Departments.</p>	<p>N</p>
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i></p>	<p>Our programs have instituted a family centered approach for many years. Wraparound theory has had a significant impact on how our Departments address treatment and service issues. Our Departments share contract and service responsibilities across numerous areas, including screening and review of psychiatric records for all foster children, which have existed in our county for years. Child Family Teams were an early important component of our Residential Based Services model started 6 years ago. SART is a project that involves foster children 0-5 and uses Parent Child Interactive Therapy as a key component for care.</p>	<p>N</p>
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></p>	<p>Our agencies work in an enormously challenging environment, with a richly diverse stakeholder group representing numerous religious, ethnic, and economic points of view. The ability to respond to these various groups is a continual requirement in moving the community forward toward achieving the countywide goals and visions of our Board of Directors. We continually train and challenge staff to develop the appropriate cultural humility when working with our community members.</p>	<p>N</p>
<p>Outcomes and Evaluation <i>The strength of current data collection practices, and how outcomes data is used to inform programs and practice.</i></p>	<p>We have been engaged in a system-wide roll-out of numerous performance outcome processes. DBH has incorporated the Child Adolescent Needs and Strengths Tool (CANS) in all of the provider contracts and has purchased complex software that will eventually allow us to congregate data across all programming for evaluating the effectiveness of treatment modalities by population. DBH and CFS have had a long-standing MOU for sharing data, the Katie A. demands are requiring us to review and revise our MOU to ensure we are meeting the requirements of the implementation plan.</p>	<p>N</p>
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i></p>	<p>Both Departments are fiscally prudent and this allows them to know precisely what is within their ability and what will have to be developed in order to meet new demands. DBH is able to expand contracting to specific targeted providers for increasing EPSDT services, for ICC and IHBS, however these programs are not a complete representation of the potential service providers. It is our plan to use the first year of implementation to determine the real costs of providing Katie A. services and identify funding to manage any subsequent expansion.</p>	<p>N</p>