

Katie A. Semi-Annual Progress Report

Enclosure 1

County: CalaverasDate: 5/15/14

- May 1st Submission (September 1st through February 28th Reporting Period)
- October 1st Submission (March 1st through August 31st Reporting Period)

Name and Contact Information County Child Welfare Department Representative

Name:	Mikey Habbestad				
Title:	Program Manager				
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City:	San Andreas	State:	CA.	Zip Code:	95249
Phone:	209-754-6615	E-mail:	MHabbestad@co.calaveras.ca.us		

Name and Contact Information County Mental Health Department Representative

Name:	Mark McCormick				
Title:	Clinician III, Children's Services Coordinator				
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If your answer below is blank or zero, please provide an explanation.

PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period			
Item #	Information Requested	Column 1 Beneficiary Count	Column 2 Timelines
1	Subclass Members	8	4 in county (1 just moved from grp
2	Receiving Intensive Care Coordination (ICC).	1 possibly	We had 1 CFT in 3/13, 2 in 4/14. V
3	Receiving Intensive Home Based Services (IHBS).	0	We only have 4 in county. Of those
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>	0	We have the same child as in 2 an
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>		We have 1 child in 4 and 5/14 that
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).	8	We were providing CSOC level ser
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	0	
8	Declined to receive ICC or IHBS.	0	

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1. 4 in county (1 just moved from grp. home), 4 out of county (3 in grp. homes and 2 in foster homes).
2. We had 1 CFT in 3/13, 2 in 4/14. We have 1 scheduled in 6/14 and are working on 3 others in 5 or 6/14. The 2 in group homes do not yet get ICC due to lock out as not moving out within several months.
3. We only have 4 in county. Of those 1 is getting IHBS as of 4 and 5/14. The 4 out of county have received quarterly case mgt. The 3 need the CFTs locally and we are pursuing that and will bill once started. Some case mgt. billing on another client will be changed to IBHS. Within 1 week one foster child is moving from home to a grp. home due to increased issues. He will get services at the grp. home so will be getting less IBHS. One foster child out of county does not need IBHS as he is getting additional services - case mgt. - through Creative Alt. Another may need to be able to receive through host county BHS.
4. We have the same child as in 2 and mentioned in 3 as well.
5. We have 1 child in 4 and 5/14 that was suddenly receiving extensive services until had his CFT and eventual addition of IBHS.
6. We were providing CSOC level services to 2 prior to them being removed by CWS during the period (1 became subclass and the other became after 2/28). Another was receiving services here despite being in an out-of-county foster home (now in grp. home and subclass). One had come in for assessment and tx. plan in fall 13, but not followed through until removal (grp. home, subclass now). One in foster care was getting managed care and another until he went into a grp home. One out-of county child in foster care has been getting case mgt. for several years (quarterly visits) and was getting managed care tx with host county. Several in-county children were starting or receiving therapy.

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Addendum to Pg. 4 service availability explanation (at the bottom of the pg.).

Though I mentioned it, the distance to trainings and client/family/agency meetings is at times a barrier. Out of county placements are a special dilemma in determining how best to provide services. If we need to do assessments and CFTs this will at times take part or all of a day or even more than a day if far enough away. We hope to use managed care, but can't predict whether another county BHS will be willing to provide IBHS. I believe they will be a part of a CFT meeting, but I see us as ultimately responsible for ICC as the host county. At this point we do not have new staff to do this, though may get some help from a new position in the near future. Our primary challenge is time to fit this in with everything else we do so that we can assist foster children and all our clients to have successful outcomes

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If your answer below is blank or zero, please provide an explanation.

PART A: Potential Subclass Members Identified During the Reporting Period				
Item #	Information Requested	Column 1 Beneficiary Count	Column 2 Next Steps/Timelines	
1	Potential Subclass Members	44		
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	0		1. Review Katie A MHST assessment and consult verbally with CPS as assess. - within 1 week of assess.2. Send Katie A MHST response with NOA and suggest referral to local rural Medi-Cal clinics within 2 weeks of assess..3. Return if new issues arise.
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.	In period up to 2/28/14 - 12		Of those 5 were assessed and MHST response returned to CWS in 3/14 and 7 in 4/14. The timelines include to schedule an assess. within 2 weeks of call, to complete response within 1 week of assess., and to get into ongoing services within 3 weeks of assess.
4	Potential subclass members who were unknown to the MHP during the reporting period.	My list may include new CPS cases between 3/1-5/1/14 - possibly 124.		Of this number some are young children, many are getting services through other providers, some are out-of-county. Of the number at least 14 have been assessed or are scheduled to be assessed. We are getting many more new referrals from CWS than prior to Katie A.

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PART C: Projected Services			
Item #	Service	Projected number of subclass members to be receiving services by August 31 st	Strategy/Timeline/Description
1 (a)	ICC	all 8 from 2/28, 2 additional new since, Possibly 6 more new clients, but unclear if they would have a CFT by 8/31. - 16	Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members. 1 CFT scheduled in 6/14. Need to schedule 2 other CFTs locally in 5 or 6/14. Need to coordinate with another county on 1 now (3/14) subclass member as they are providing extensive services. Need to schedule 3 other 90 day CFTs before 8/31. 3 intakes in 5/14 - possible subclass - 1 completed and the others cancelled and need to be rescheduled. Need to complete tx. plan on a new referral who just moved from group home to relative placement (still out-of-county) - should need CFT by 8/31 unless we wait for school involvement in 9/14. Need to continually check on 3 grp home residents as to any move to lower level of care, etc., so would start ICC.
1 (b)	IHBS	1 and 2 - 5 3. - 2 Total with possibly new referrals -	1. All present subclass clients in county with CFT will receive CSOC case mgt. and case mgrs. will use IBHS for all community-based services by 7/1/14. 2. One local child who was receiving most IBHS in 4 and 5/14 will be moving to grp home so will have less IBHS, but will continue until then. 3. Coordinate with all non grp. home out of county kids BHS services, foster parents, and CPS workers to determine if that county needs to and is willing to provide IBHS for those clients. 4.

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	<input checked="" type="checkbox"/> Yes	No
County Contracting Process	Yes	No

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.

We have the issues of a small rural county. We have had recent turnover, but there is some staff increase which should help. I think we need to be able to use existing staff and increase their involvement with Katie A, but it will work better if some time for new staff can be dedicated to Katie A. rather than fitting Katie A into existing staff. That is not clear as yet. Since 1/1/14 I have been trying to fit Katie A into the many hats I wear. It is a struggle to complete requirements for Katie A (out-of-county - often 2+ hrs. - intakes and CFTs and trainings, Katie A responses, increased contacts with CWS both mgt. and with workers (a good thing) along with managed care, coordinating with non Katie A high level clients (CSOC, increase in acute, serious cases with more psych. hospitalizations recently more than the last 2-3 years), coordinating contracted therapists, child intakes, supervision of staff, coordination of TBS, and other mgt. duties. Barriers include a huge increase in CWS new cases (60 now removed children in 60 days in 9/13), lack of clinician or case mgt. time to be trained on and do CFTs (so I am doing them other than 1 other staff on 1 client). I hope to train 2-3 clinicians in facilitating CFTs and have some assistance with that, particularly the out-of-county. We need to keep exploring best ways to make this work such as dedicated staff, contracting, etc. We really like the idea of Katie A - more focus on foster kids with serious needs, more coordination with CWS, the goal to increase life and placement stability for foster children. Being one agency now has helped as well. I do think we keep moving forward and are providing some services for all subclass, but need to be able to move toward more Katie A services at least for our local clients.

County: Calaveras Reporting Period: 9-1-13 to 2/28/14

Date Completed: 5/15/14

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. (Note: I am using a separate sheet for the description sections.)

Readiness Assessment Section	Readiness Activities	Training or Technical Assistance Needed
Agency Leadership <i>Leadership's experience implementing family-centered services in a collaborative setting.</i>		Y
Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i>		N
Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i>		Y
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>		Y

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Enclosure 2

<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i></p>	<p>N</p>
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></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>Y</p>
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i></p>	<p>N</p>

ADDENDUM For ENCLOSURE 2 Of KATIE A REPORT

Agency Leadership –

Mikey Habestadd of CWS and coordinator Mark McCormick are attending the Central Region Learning collaborative 5/19 in Fresno. Mark has attended 2 UC Davis Katie A Trainings – Facilitating a CFT (Santa Clara) and The Core Practice Model: Engaging Families (Davis). Mark has listened in on various Katie A. Wed. weekly technical calls. Mark is involved with all aspects of coordination – CFT meetings, intakes, TDM meetings with CWS, MDT weekly CWS case meetings, trainings, coordination with CWS supervisors and workers on case coordination, Katie A. determinations and responses, developing child assessments and tx, plans, staff coordination, weekly staff case reviews and review of new assessments, managed care coordination with CWS foster children placed out of county, case mgt. on occasions, diagnosis, crisis intervention, discharge planning from psychiatric hospitalizations, etc. Mark has an awareness of and experience a variety of models – CSOC, Wraparound, recovery, MHSA, Team Decision – Making and Family Unity models from where it came that assist in awareness of Katie A and core practice principles.

Systems and Interagency Collaboration

Coordination and communication between MH and CWS has increased significantly over the last 6 months. In efforts to better coordinate the Child, Family Team, MH and CWS use the multi-disciplinary team meetings to accomplish the task. CWS and MH have been successful meeting 1x per month to discuss Katie A implementation of services and ongoing processes. Staff from both programs have an opportunity to discuss what is working and/or what can be improved. There have been 2 meetings between our clinical staff and the CWS supervisor Alisa Gehrke in better understanding issues and trauma for foster children and how our agencies work. Staff have received various brief trainings on the Katie A. process, are being encouraged to attend Multi-Disciplinary meeting, and to collaborate more with CWS workers. Joint trainings are being scheduled and attended between agencies, including Trauma Informed Treatment

Systems Capacity

Calaveras County Health and Human Services plans to increase the Mental Health Program children's team staffing to ensure quality and timely services to our Katie A population. Hopefully, the staff changes are successful in allowing enough time to cover Katie A requirements and other job duties and expectations. Administration meets with the clinical service staff on an ongoing basis to discuss system needs and identify shortfalls that need to be addressed. Supervision and trainings available to all staff that integrates with the Katie A population.

Service Array

CWS and MH staff have been trained on cultural responsiveness, trauma-informed care, Wraparound and CSOC principles which are very similar to Katie A and the core practice model, family and client driven services. Staff are experienced in targeted case management, including linking clients to community resources, support, rehab training, advocacy, We are linking Katie A clients to these services as well as community-based therapy and medication services.

Involvement of Children, Youth and Family

Services are based on individualized needs, are strength-based, community based, delivered in the least restrictive environment, and in the client's and parent's own language. Services focus on prevention and early intervention. MH staff have been trained in trauma-informed care. Joint trainings with Human Services and other key partners will be provided on trauma-informed care, Core Practice Manual, family-centered principles, and practice topics.

Cultural Responsiveness

Mental Health has provided both Hispanic and Consumer Cultured trainings. MH staff are trained on cultural competency issues several times a year. Trainings in the past year have included Latino-Americans, family members of consumers with mental illness, and adult consumers. I would like to have parents of children and teens give the next years' training. CWS staff will be invited to attend these trainings in the future. Consumer Service Liaisons are an integral part of the Behavioral Health team, particularly with our Latino population. We need a parent partner CSL for CSOC and Katie A.

Outcomes and Evaluation

MH is in the process of developing data collection related to Katie A. services. Current outcome measure models are being reviewed for implementation. Cross-system data collection and capacity analysis will be developed during the integration of CWS and MH service agencies proceeds. This is a growing trend and we have competent staff who are versed in this area and add much in the areas of outcomes and evaluation. Mark and 3 other staff (both Katie A therapists) a training on CANS and we have discussed in Leadership. We have heard that our electronic records system Anasazi is looking into getting CANS into their system. We will be working on developing policy and procedures in order to be able to use CANS by fall 2014, if possible.

Fiscal Resources

A joint fiscal team has been developed that meets on a monthly basis and current system needs are being reviewed. We have top fiscal staff who are able to look at best ways to use finances to assist with Children's staff, including how to use any staff increase to assist with Katie A services. This is hopeful.