

County: Calaveras

Date: 9/26/14

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, ACSW				
Title:	Program Manager				
Agency Name:	Calaveras Health and Human Services Agency (HHSA)				
Address:	509 E. St Charles St.				
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, LCSW				
Title:	Clinician III, Children's Services Coordinator				
Agency Name:	Calaveras County Behavioral Health Services, HHSA				
Address:	891 Mountain Ranch Rd.				
City:	San Andreas	State:	CA.	Zip Code:	95249
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County: Calaveras

Date: 9/26/14

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	11	
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	8 – open, class (2 out-of-co, 1 receives tx. here, 1 in another county) 3 screenings, out-of-county, approved managed care	
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.	3 open and receiving agency services in 9/14	
4	Potential subclass members who were unknown to the MHP during the reporting period.	0 known	

County: Calaveras

Date: 9/26/14

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	17 – 4 in county, 13 – out-of-co.	
2	Receiving Intensive Care Coordination (ICC).	8	
3	Receiving Intensive Home Based Services (IHBS).	0	
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>	1 in in out-of-county grp. home, receives CFTs, but ICC not billed	
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>	8 in out-of-county grp. homes, Possibly 1 other, local.	
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).	We have 29 class receiving services, the 7 receiving managed care ,	and the 11 closing – at least 3 received some services in the period.
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	Some of the 115 CWS foster children who do not see us	
8	Declined to receive ICC or IHBS.	1	

County: Calaveras

Date: 9/26/14

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

PART C: Projected Services			
Item #	Service	Projected number of subclass members to be receiving services by 2/28/14	Strategy/Timeline Description Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (a)	ICC	9	
1 (b)	IHBS	6	

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability XXXXXXXXXX	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.

Refer to the attached Addendum.

County: Calaveras

Date: 9/26/14

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

Katie A. Semi-Annual Report

Addendum 9/26 for Page 2/Part A

1. Column 1 - Calaveras County Child Welfare Services (CWS) had about 180 open clients in the 6 month period. Of that number, 55 were open to Calaveras County Behavioral Health Services (BHS), 28 were in-county, 15 were out-of-county, and 12 were either closed or in the process of being closed due to lack of medical necessity or successful completion by either BHS or CWS.

Of the 43 BHS clients receiving services, 17 were subclass, 12 others were potential subclass clients who, while lacking major subclass criteria, had enough high to moderate issues to move to subclass if further issues arose.

Of the 180 CWS clients, 3 were assessed by BHS on 9/14 and did not appear to be subclass, though one is a potential. Seven were out-of-county, receiving managed care therapy through the host county's BHS, of which 5 were potential subclass. Approximately 115 CWS clients were not seen by BHS for various reasons, including lack of necessity, receiving private services, or too young for services. This includes 45 local children, 40 out-of-county children, and 30 children age 0-2.

Column 2. BHS will continue to coordinate with CWS on client services and meet monthly to ensure client needs are being met and monitor client status. Continue to review whether clients meet any subclass criteria. Consider increasing services if needed.

2. Column 1. If potential subclass and new, all clients would be assessed and would meet service necessity.
Column 2. If any new clients do not meet service necessity we will keep them open the full 60 day assessment period in case behaviors escalate. We will review each Mental Health Screening Tool referral, and intake staff will also consult directly with the CWS worker if it appears that client does not meet medical necessity or we are determining subclass eligibility. BHS will continue the assessment process with prompt (within 3 working days from the authorization decision) feedback to CWS on the outcome of the assessment - issues, assignment, and status. We are to reopen or restart services if new issues arise.
3. Column 2. Continue the assessment process discussed above. We will continue to coordinate with and train CWS staff on the referral process so that forms are filled out correctly and there are no time barriers getting the assessment scheduled. In BHS we have a system whereby new assessments are scheduled within 2 weeks or we add intake slots. We need to work to consistently get client charts to the first authorization meeting within 1 week from intake. Workers also need to do the treatment plan within the week to make sure we can assign the

case for services. Then we need to follow through with the prompt decision on assignment and feedback to CWS. Continue coordination to improve the flow of that process.

4. Column 2. Continue to coordinate with CWS on client services. We are discussing a model whereby CWS alerts us when children out-of-county are in therapy, with whom, etc. CWS uses private providers at times due to client's having previous services with the provider, faster connection to services, and out-of-county placement. Our local rural health provider (Dignity Health) has Medi-Cal counseling services in four towns, which is an additional resource. We hope that the improved communication process will increase BHS involvement with CWS clients.

For Page 3/Part B

1. We increased from 8 to 17.
2. We increased from 1 to 8 clients, some who have had 2-3. We cannot formally do ICC with out-of-county group home clients due to lock-out, but we do CFTS with one who is anticipated to return home in 4 more months. Increase ICC to 2 additional clients by 11/1/14 and to 4 additional clients by 12/1/14.
3. We have to improve on this, but it is difficult to do much beyond quarterly reviews and CFTs for the 9 foster children in out-of-county group homes. Also we cannot bill for those until a few months before the client reunifies or moves to a lower level. Even for the 4 out-of-county foster or relative-placed foster children, 3 are too far away. One child is only an hour away and there is potential, but all 4 are getting services through the host county BHS. We hope to coordinate more with those providers. Initiate IHBS with 3 clients by 11/1/14, and 1 additional client by 12/1/14.
4. This is again the group home residents. Since many are placed through one agency, we have been able to coordinate on them. If family is actively involved, we plan to do CFTs and include them in coordination. With one family we are planning to schedule family sessions at BHS with our therapist to start the transition process, but are unsure if we can bill. This service is very necessary. To check on all children in placement by 11/1/14 to determine if there is any move toward stepdown and to check monthly thereafter.
5. We have 1 child receiving Children's System of Care services, including case management, who will be reviewed for subclass eligibility. This child has been a potential subclass member for the 6 months he has been in treatment. I will meet with his therapist on that. This would also appear to include the group home clients. To make a decision on that at 10/14/14, which will be my first chance to confer with therapist due to schedules.
6. BHS is currently unclear about the number of CWS children receiving private services. They may have had an intake prior to collection of Katie A. data or no contact with BHS, so that data is unclear. Coordinate on this issue at the 10/14/14 meeting with CWS.
7. There are about 115 foster children who do not receive BHS services. Several have been discussed in Multi-Disciplinary Team meetings and determined to not need therapy currently, or they are very young. We need to get clear on specific numbers and reasons. Coordinate on this issue at the 10/14/14 meeting with CWS.

8. We have an 18 year-old client who, upon becoming subclass, is ambivalent about services, including case management. Continue to follow this client and confer with the therapist by 10/14/14.

Page 4/Part C

1(a). The plan includes determining if this client qualifies as Subclass and move to a CFT and case management services - 10/14/14. Consider this for a recent group home placement who had previous outpatient services, though we cannot bill. We would do a CFT, as she is new to the process and may need the support due to past psychiatric hospitalization and depression – to schedule by 11/1/14. Start reviewing local potential subclass members, local placements by 11/15/14 and out-of-county placements by 12/1/14, and monthly thereafter. Continue to assess new clients for subclass eligibility. Clearly notify case management staff when a person becomes Katie A subclass and is ready for ICC. Review this with the CSOC team by the 9/30/14 meeting and ongoing at our weekly CSOC meeting.

1(b) Push to increase Intensive Home-Based Services (IHBS). Clearly notify case management staff when a person becomes Katie A. subclass and is ready for IHBS. Review this with the CSOC team by the 9/30/14 meeting and ongoing at weekly CSOC team meeting. Determine if the one client qualifies as Subclass and plan a CFT and case management services by 10/14/14. Encourage IHBS by 11/1/14. Review with therapist whether one client would be accepting of case management by 11/1/14.

Implementation Barriers

Many of our Child Welfare Services (CWS) children do not qualify as Katie A subclass. The majority of subclass children are in out-of-county group homes or foster-home placements 2-3 hours away so that face-to-face contact involves extensive travel time. This is a barrier to ongoing Intensive Care Coordination (ICC) and any Intensive Home-Based Services (IHBS), even if billable.

Staff providing services need to remain aware of Katie A. status and bill appropriately using the Katie A. codes. More coordination with CWS is needed, along with work on both sides to increase timely access to services. We need clarity regarding those CWS clients not being seen by BHS, in order to assist CWS in reviews to prevent any major issues.

Despite these issues, we are pleased with the benefits of increased coordination with Child Welfare Services (CWS), better understanding of each other's needs, and the improved understanding of the effects of trauma on foster children, and hopeful that services will continue to improve. We are pleased with the core practice philosophy and see the benefit of the core practice model in Child-Family Team (CFT) meetings, as we watch families leave the CFT feeling empowered.

County: Calaveras Reporting Period: 3/1/14-8/31/14

Date Completed: 9/26/14

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.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Agency Leadership <i>Leadership’s experience implementing family-centered services in a collaborative setting.</i>	See additional pages for all categories here, below, and on pg. 2.	Y
Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i>		Y
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

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i>		Y
Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i>		N
Outcomes and Evaluation <i>The strength of current data collection practices, and how outcomes data is used to inform programs and practice.</i>		Y
Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i>		N

Katie A. SEMI-ANNUAL REPORT

ADDENDUM for ENCLOSURE 2

Agency Leadership

Mark McCormick, LCSW is the supervisor of Calaveras County Behavioral Health Services (BHS) Children's Services. His responsibilities include supervision of staff, monitoring program caseload, interagency coordination, direct services to clients and families, managed care coordination (including Therapeutic Behavior Services (TBS)), facilitation of Child Family Team (CFT) meetings, Katie A. determinations and responses. Mr. McCormick has knowledge of and experience with Children's System of Care, Wraparound, Mental Health Recovery, Mental Health Services Act, Team Decision Making (TDM) and Family Unity, which assist in implementing of Katie A., core practice principles and training.

Mr. McCormick has now attended about 20 CFTs (facilitating five) and has attended 6 TDMs over the past 1-2 years. Mr. McCormick continues to participate in the UC Davis Katie A. trainings, including Core Practice Model, Engaging Families, and Facilitating a CFT in March, 2014. Mr. McCormick also attended two Katie A. Collaborative meetings, Fresno in May, 2014 and Sacramento in August, 2014. The latter was also attended by Mikey Habbestad, program manager of Child Welfare Services (CWS). Mr. McCormick often listens in on the Katie A. weekly technical assistance calls. Other trainings attended during this period include Law and Ethics, Cultural Competence with a focus on Latinos, and three trainings/discussions conducted with CWS Supervisor Alisa Gehrke for BHS CSOC staff focused on understanding trauma and emotional struggles particular to foster children.

Systems and Interagency Collaboration

Over the past six months, coordination and communication between BHS and CWS has continued to be at a higher level than before Katie A. One factor that has contributed to increased coordination is that BHS is now part of a larger Health and Human Services Agency created a year ago by combining Calaveras Works and Human Services Agency with the Health Services Agency (BHS and Public Health). As a result we are becoming one team under the same director. To better coordinate BHS and CWS staff meet weekly in multi-disciplinary team meetings and together at CFT meetings. CWS and BHS meet monthly to discuss implementation of Katie A. services and processes. Staff from both programs have an opportunity to discuss what is working and/or what can be improved. CWS now has a new Child Protective Services supervisor, Teresa Dominguez. She will also be a major part of our Katie A Team.

There have also been periodic trainings and discussions between BHS clinical staff and CWS Supervisor Alisa Gehrke which have resulted in better understanding of how trauma affects foster children and how each of our agencies work. Staff has received brief trainings on the Katie A. process, are encouraged to attend Multi-Disciplinary meetings and the monthly coordination meetings, and are collaborating more with CWS workers on individual cases. At the monthly meeting we have discussed the need for training again on the Katie A. referral process due to staff changes at CWS, who have hired new workers and a new supervisor during the past 6 months.

We also want to have the BHS CWS Liaison provide training and ongoing support for CWS staff to better maintain the quality of the referral process. Mr. McCormick meets periodically with Ms. Habbestad and plans to meet with other CWS management staff to discuss progress and issues. The CWS Liaison and

Mr. McCormick often coordinate with CWS social workers in various activities such as CFTs, MDTs, managed care, referrals, status/issue updates, responses, and crises. Time constraints and extensive responsibilities continue to be a barrier, but the amount of coordination has greatly increased through the Katie A. implementation process.

Systems Capacity

Calaveras County Behavioral Health Services (BHS) has increased Children's Services capacity by hiring two clinicians who carry a partial caseload of children. This increase, along with our present Children's System of Care staff (including 2 case managers and 1 therapist), children's staff (2.5 with new workers), and contracted community providers has assisted BHS with keeping up with the demand for children's services and specifically Katie A. We continue to have capacity issues as an agency in a small, rural county where administrative, supervisory and clinical staff all have a variety of job duties that compete for time. Other barriers affecting Katie A. services include a chronic shortage of local foster homes, leading to many, if not most, Katie A. subclass children in out-of-county group homes or foster or relative placements. This leads to time consuming trips of 4-6+ hours round trip. This will be mitigated somewhat by additional new staff who can assist with some of responsibilities for out-of-county children.

Service Array

CWS and BHS staff have been trained on cultural humility, trauma-informed care, Wraparound, recovery and CSOC principles, which are congruent with the Katie A. Core Practice Model of family and client-driven services. Staff have experience providing targeted case management, including linking clients to community resources, support, rehab training and advocacy. BHS is also linking Katie A. children and families to community-based therapy, parenting classes, medication services and supports such as equine therapy, martial arts classes, music classes, informal summer adventures, and art groups. This is particularly helpful for children with limited access to these services and activities due to issues associated with life in a small, rural county. Staff are committed to advocacy, assisting with life issues, encouraging recovery, team development, and the "whatever it takes" philosophy.

Our four local subclass children will soon decrease to three, as one has been successfully returned to the parent with dependency successfully ended. The parent has allowed BHS to continue extensive services. One dilemma is that with two-thirds of CWS children placed out-of-county, our county is dependent on group homes and other host county BHS staff to provide the ongoing treatment in most cases. We work to coordinate and include those providers (and school staff) when possible in Child Family Teams and in the quarterly meetings. BHS plans to seek out an evidenced-based practice such as Parent Child Interactive Therapy for training Children's Services staff. BHS staff have had several trainings on trauma-informed care and trauma treatment during the past five years, and need to continue this due to topic importance and staff turnover.

Involvement of Children, Youth and Family

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

treatment and trauma-informed treatment this fall, which follow a continuum of training over the last 5 years. Our staff does extensive work with families at all levels of need and Katie A. has simply extended that process. The Child family Teams (CFTs) offer a family-driven, recovery-oriented, and strength-based approach that guides the services we provide in Children's System of Care. The CFT model has been very helpful for families.

Cultural Responsiveness

The Health and Human Services Agency has had an agency-wide training on Latino culture this year, while BHS has provided a training on families of mentally ill consumers. BHS staff is trained on cultural competency issues several times a year. Trainings in the past year include the NAMI "In Our Own Voice" presentation in which adult consumers share their life issues. BHS is going to pursue having parents of children and teens give the next years' training and CWS staff will be invited to attend these trainings in the future. Consumer Service Liaisons (CSL) are an integral part of the Behavioral Health team, particularly with our Latino population. Our Latino Spanish-speaking (CSL) has greatly improved connection with and services to Latinos. BHS needs a parent partner CSL for CSOC and Katie A. We try to be aware of and respectful toward the variety of subcultures and unique characteristics of persons in our rural setting. For example, we have a large senior and retired population and a number of them are taking on relative placements. Through MHSF funds, BHS has been a part of developing Grandparent Support Groups in the community.

Outcomes and Evaluation

BHS is in the process of developing data collection related to Katie A. services. Current outcome measures are being reviewed for implementation. Cross-system data collection and capacity analysis will be developed as the integration of Child Welfare Services (CWS) and BHS proceeds. The Health and Human Services Agency has competent staff that are versed in this area and add much in the areas of outcomes and evaluation. BHS has chosen to use the CANS evaluation tool for children's outcomes and continue to discuss and plan for implementation once it is added into our electronic health record. We will be working on developing policy and procedures in order to implement the CANS in early 2015.

Fiscal Resources

A joint fiscal team has been developed that meets on a monthly basis and current system needs are being reviewed. They are able to identify the best ways to use finances to assist with BHS Children's staff, including how to use newly hired or established positions to assist with Katie A. services. Our local subclass clients and some in placement may benefit from additional financial resources similar to our Full Service Partner and Children's System of Care clients.