

County: Glenn County

Date: September 30, 2014

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:	Bill Wathen				
Title:	Deputy Director				
Agency Name:	Glenn County Health & Human Services				
Address:	420 E. Laurel Street				
City:	Willows	State:	CA	Zip Code:	95988
Phone:	(530) 934-1468	E-mail:	bwathen@hra.co.glenn.ca.us		

Name and Contact Information County Mental Health Department Representative					
Name:	Amy Lindsey				
Title:	Deputy Director, Behavioral Health				
Agency Name:	Glenn County Health & Human Services				
Address:	242 N. Villa Avenue				
City:	Willows	State:	CA	Zip Code:	95988
Phone:	530-934-6582	E-mail:	alindsey@glenncountyhealth.net		

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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	76	
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	0	All children who received a mental health assessment met medical necessity criteria for SMHS.
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.	0	All children who were referred to the MHP for a full mental health assessment received a mental health assessment.
4	Potential subclass members who were unknown to the MHP during the reporting period.	7	

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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	39	
2	Receiving Intensive Care Coordination (ICC).	13	
3	Receiving Intensive Home Based Services (IHBS).	13	
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>	7	
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>	6	
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).	5	
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	7	
8	Declined to receive ICC or IHBS.	2	

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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 August 31 st	Strategy/Timeline Description
1 (a)	ICC	20	Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members. We plan to continue identifying, referring, assessing, and enrolling additional children and youth in our Katie A program. We expect this number to be at least 20 children and youth by February 28, 2015. These children and youth will all receive ICC services as a component of the program.
1 (b)	IHBS	20	We plan to continue identifying, referring, assessing, and enrolling additional children and youth in our Katie A program. We expect this number to be at least 20 children and youth by February 28, 2015. These children and youth will all receive IHBS services as a component of the program.

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	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 had a number of staff leave our CWS program in the past few months. As a result, we are recruiting new staff. It is difficult to recruit new staff in this small, rural community.

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Reporting Period: March 1, 2014 – August 31, 2014

Date Completed: September 30, 2014

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>Glenn County Human and Human Services Agency (HHS) is a combined agency that includes both the Human Resource Agency and Health Services Agency. All child-serving programs work together to collaborate on developing a comprehensive service delivery system to meet the needs of children and youth who meet the criteria for the Katie A. subclass. The HHS director provides leadership and oversight to the process and helps promote a strong vision to support collaboration and coordination across all Child Welfare Services (CSW) and Behavioral Health (BH) programs.</p> <p>Glenn County has been designated as one of the pilot counties, to work with the state to implement Katie A. early and to serve as mentors for other small counties. We also have been working together over the past three years to improve our coordination and collaboration in linking children in the CWS system to receive mental health services quickly and efficiently. We have meetings between the two agencies every two weeks, to identify children and youth, coordinate services, and address areas for improving services.</p> <p>CWS and MH have attended several trainings together, in Redding and Sacramento, for the Regional Learning Collaborative as well as holding shared training for staff on implementing the Child and Family Team Model, Core Practice Model, and delivering Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Safety Organized Practice (SOP) is being used to implement the Core Practice Model (CPM). We are also using the same tools for facilitating each Child and Family Team (CFT) meeting. Staff from the mental health program who are</p>	<p>N</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>involved in implementing Katie A. are also being trained to use SOP, so that we can all use the same language. We have also found it valuable to have shared co-facilitation on the CFT – this approach helps to ensure that concerns and strengths for the family and child are represented. This strategy also helps to support family voice and youth voice during these meetings.</p> <p>We have one young adult who was a foster youth who works closely with our Katie A. Team. She helps the team identify opportunities to enhance our system to promote youth voice. We also have Youth Peer Mentors, who work closely with some of our Katie A. youth. While we still have opportunities to improve our youth and family voice, we have made a lot of progress. We continue to identify ways to change our culture to promote youth and parent involvement throughout our systems of care.</p> <p>In the next six months, we will work together to make sure our policies and practices are consistent with family-centered principles of care across both agencies. We are also working on revising our existing Memorandum of Understanding to outline how we will share resources and staff to promote collaboration of services.</p>	
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>	<p>Glenn County has strong systems and interagency collaboration. We have a Multi-Disciplinary Team (MDT) that meets twice monthly, once in Willows and then in Orland. The MDT membership includes CWS, mental health, schools, law enforcement, and probation staff. The MDT is facilitated by a CWS supervisor and the Children’s Interagency Coordinating Council (CICC) Coordinator. In addition, our CICC includes all child-serving agencies in the county, including education, probation, Child Abuse Treatment (CHAT), network providers, mental health, substance abuse, CWS, law enforcement, tribes and Migrant Education Programs. We also have a Management and Planning Team (MAP) that serves as the county’s Interagency Placement Team. This group includes deputy to mid-level managers from the schools CWS, mental health, probation, and Far Northern Regional Center to coordinate services and approve placements for children at risk of group home placement RCL 10 and above.</p> <p>We have an activity on Friday nights, where all foster families can bring their children. This activity is a team building opportunity for the foster parents, where they can provide support to each other, and the foster children/youth can spend time together and also support each other.</p> <p>In the past six months, we revised our shared Release of Information Form. The HHS</p>	<p>Y</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>has created a new Forms Committee; all policies and procedures are reviewed by this committee, which ensure that there is consistency across agencies.</p> <p>We are also in the process of implementing a One-Stop program, where multiple agencies offer services in one location. While this is initially developed to serve AB 109 persons released from the prisons/jails, this is a good illustration of our system collaboration. We have also co-located a mental health clinician at CalWORKs, to provide mental health screening and linkage to services.</p> <p>In the next six months we will continue to utilize these interagency teams to review and implement policies and procedures to support family-centered practices. We will continue to develop strategies to share information across child welfare and mental health information technology systems. It is our goal to have a shared computer system by the end of 2016.</p>	
<p>Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i></p>	<p>We have had a number of changes in leadership positions in the past six months. We have hired a new CWS Program Manager, who had been active in developing Katie A. services during the past year and has been able to transition easily into this leadership role. We have also hired two new supervisors for CSW. One of our key CWS Katie A Team members has moved from CWS to Mental Health. This provides continuity to the Katie A Team, but creates a vacancy at CWS. Mental Health has also hired a number of new clinicians and case managers. This helps to strengthen our mental health services team and supports the Katie A Team.</p> <p>We co-located a mental health clinician at CWS to provide early screening for CWS and to deliver counseling and referrals for children who do not have Medi-Cal. We have been working to improve the timeliness of referrals to mental health services for the past two years, and are now able to link children and youth to services within a short period of time, typically in less than two weeks.</p> <p>We are working to develop policies to support an effective referral process and linkage to service across multiple systems. We continue to develop strategies for recruiting and hiring staff, including bilingual Spanish and Hmong speakers, our two primary languages.</p> <p>We continually offer training to CWS staff to help them learn all aspects of their job. We are also including mental health staff in any CWS training, to help ‘cross-train’ staff and promote collaboration, integration, and consistency across services.</p>	<p>Y</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>Glenn County delivers culturally responsive services. Our mental health staff have the capacity to deliver services in English and Spanish. We are also translating CFT Agendas into Spanish and developing the capacity to translate core CWS and MH documents into Spanish, including Family Case Plans and Treatment Plans</p> <p>Staff have been trained in evidence-based services including Parent Child Interactive Therapy (PCIT), Cognitive Behavior Therapy (CBT), and trauma-informed CBT. Services are available at home, in the schools, in the clinic, and in other community locations, depending upon the needs of the child, youth, and/or family. Service activities support family-centered principles and promote implementation of ICC and IHBS services and are consistent with the Core Practice Manual (CPM). CWS uses Family to Family and Safety Organized Practice tools and processes that have been found to increase family engagement, promote client voice in decision making, and be culturally sensitive.</p> <p>Each month at our Katie A Steering Committee, we review data on the number of ICC and IHBS services delivered, along with all services offered to Katie A individuals. We are pleased that our documentation shows that we have tripled the number of ICC and IHBS services in the past few months, by providing additional documentation training to staff to ensure they are correctly coding all services delivered to Katie A individuals.</p> <p>We are also increasing our services to children and youth who are placed in out-of-county foster and/or group homes. We now attend Child and Family Team meetings that are held in surrounding counties (Butte, Tehama, Colusa) as well as attending their TDM meetings. This greatly helps to support the families and children/youth in supporting them to achieve positive outcomes.</p> <p>We attended training by the Chadwick Center on Trauma-Informed Care, as part of the Learning Collaborative in Redding. We also attended a Learning Collaborative training in Sacramento. As a result of this training, we are identifying additional training opportunities for staff to learn more and develop skills in offering services that help reduce trauma for our children, youth, and families. CWS Staff have also attended training in understanding domestic violence and develop skills in reducing the re-occurrence of domestic violence with our families. Staff have also attended</p>	<p>Y</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>training on Parent Child Interactive Therapy (PCIT) and Anger Management.</p> <p>We have also initiated a quality patenting initiative, to identify family members who can offer services to our Katie A families. We have identified a team of family members, parents, staff, and agency representatives, including a representative from ICWA, to help expand our Parent Advocate positions. We are also looking for opportunities cross-training family members and strengthen our Katie A Collaborative.</p> <p>We have discussed the need to share information about trainings across CWS and MH. We are developing a system to notify staff at both agencies when training is offered. This system will help “cross-train” staff and expand the skills of our coordinated service delivery team.</p>	
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i></p>	<p>We have a strong commitment to involve and hire youth and families to work within our children’s service delivery system and to deliver services that are consistent with the Core Practice Model and family-centered principles. We have a young adult involved in our Katie A Steering Committee as well as supporting our foster youth during CFT meetings and at court. This individual is employed by the school district and was also a foster youth. She brings a wide range of skills to our Katie A planning and service delivery.</p> <p>We also have four part-time Youth Peer Mentor positions with Mental Health, to work at our Transition Age Youth (TAY) Center. These youth provide advocacy and mentoring to other youth receiving mental health services. We plan to continue to expand our capacity to involve youth in the Katie A. services, and participate in ICC and IHBS services, as appropriate.</p> <p>Our TAY Peer Mentors also offer training on promoting youth voice. This training will be available to CWS youth and provide them a way to have a voice and be effective at advocating for their needs. We are also planning on offering training on promoting Youth Voice to CWS and MH staff. We will have a panel of CWS youth to tell about their experience, and invite the TAY Peer Mentors to help support the CWS youth in sharing their experiences. This training will provide an opportunity for staff to talk about what they hear and develop strategies for promoting youth voice.</p>	<p>Y</p>

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	<p>We are collaborating to identify a family member who has had experience with CWS, to participate in our planning meetings and support families as they enter the CWS system. We have identified a youth who has had experience with CWS to participate in our Katie A. planning meetings as well as support youth who are involved with CWS, to provide mentoring and advocacy.</p> <p>CWS and the Katie A Steering Committee is developing a parent satisfaction survey to help obtain feedback about the quality and effectiveness of Katie A services. We will review the data as a group and implement the survey in the next few months, as well as administer it at least annually. We will also develop training and written information to help families learn how to become informed decision makers and support them identifying opportunities to make choices to achieve their goals. We have a parent who co-facilitates our Parents Anonymous group with one of our CWS staff. We plan to expand the number of parents who attend this group.</p>	
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></p>	<p>Glenn County strives to work effectively in cross-cultural settings. Our threshold language is Spanish. We also have a few Hmong/Laos families who receive mental health services. We have an active Cultural Competence Committee, which meets monthly and identifies opportunities to strengthen services and meet the needs of our Hispanic, Native American, and Hmong communities. We have several staff at HRA and HSA who are bicultural and bilingual Spanish. We also have a mental health intern who speaks Hmong. Our written materials are available in Spanish, as well as all brochures and documents.</p> <p>We are also discussing different methods for expanding our outreach to our local Native American community, Grindstone. We have three foster parents located at the tribe. We will develop ways to involve them in services and support them. In addition, we are looking at different ways that we can partner with North Valley Indian Health to promote health a wellness. We will help the tribe to develop a calendar that will help identify opportunities to support them in their activities.</p> <p>We also provide ongoing training to staff to strengthen their skills and develop an understanding how to deliver services to persons from these different cultures and be respectful of the cultural differences in customs and beliefs. We will continue to offer training and partner with culturally-based community groups to ensure programs and services are culturally appropriate to meet the community's needs.</p>	<p>Y</p>

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<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 a comprehensive evaluation system for measuring outcomes for children, youth, and families. The Mental Health program measures key mental health outcomes, including: length of time in out-of-home placement, stability of living situation, education, and social connections. CWS has well defined outcomes for safety, permanency, and well-being, with about 15 years of data to define trends and patterns common to Glenn County. The county meets quarterly with stakeholders and the state to review the outcomes as quarterly reports are released.</p> <p>We write a five-year System Improvement Plan and an annual report to adjust or add goals as needed. These outcomes are sufficient to use for the Katie A. subclass and have been approved by the California Department of Social Services and the Federal Government. We will work to increase stakeholder involvement in this process, as it has been challenging to implement and sustain. We will learn to merge both mental health and child welfare outcomes to make decisions and determine how to change our systems and practices. We will identify training to support this effort.</p>	<p>Y</p>
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i></p>	<p>Our shared leadership across HRA and HSA builds the foundation for strengthening opportunities to share fiscal resources as we develop our Katie A. family-centered services. In the past six months, we have merged the two separate fiscal units into one. Trainings will be offered on fiscal strategies for staff at HRA and HSA. Our interagency teams will include persons with fiscal expertise, to maximize our ability to share resources and promote healthy outcomes.</p>	<p>Y</p>