

County: Orange

Date: 10/1/14

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

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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	901*	
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	182	
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.	103*	
4	Potential subclass members who were unknown to the MHP during the reporting period.	465*	

*See Attachment 1

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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	755	
2	Receiving Intensive Care Coordination (ICC).	226	
3	Receiving Intensive Home Based Services (IHBS).	81	
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>	25	
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>	24	
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).	477*	
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*	

*See Attachment 1

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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 February 28th	Strategy/Timeline Description
1 (a)	ICC	304*	Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (b)	IHBS	123*	

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.

Katie A. subclass youth are receiving a wide range of behavioral health services including ICC and IHBS services. Particularly, youth that are enrolled in Wraparound services are receiving IHBS; however, staff limitations have made it challenging to provide IHBS services in our outpatient mental health clinics. Additional funding is still needed to hire staff such as rehab workers, youth and parent partners in order to achieve the level of service provision the Core Practice Model had intended. There are many subclass youth who are not receiving ICC and IHBS services because they were residing in group homes at the time of the eligibility assessment was completed. Although these youth receive a variety of SMHS while residing in group homes, ICC and IHBS services cannot be billed. So, the lockout rule for ICC and IHBS continues to be a barrier to services availability for these subclass youth.

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

See Attachment 1

County: Orange

Reporting Period: March 1st through August 31st, 2014

Date Completed: 10/1/14

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)
<p>Agency Leadership <i>Leadership’s experience implementing family-centered services in a collaborative setting.</i></p>	<p><i>CW and MH continue to develop and partner to meet the needs of Orange County youth and families. We have many existing collaborative meetings and have explored ways to identify and meet the needs of families. These meetings include, but are not limited to the following: Orange County Children’s Partnership, Orange County Child Welfare Redesign Planning Council, Orange County Trauma Informed Practice Steering Committee, MHSA Steering Committee, HCA and SSA Quarterly meetings, Quality Assurance oversight and audits, MTFC Steering Committee, Wraparound Oversight Group, Wraparound Review and Intake Team, Parent Leadership, Orientations and Mentors, Foster Youth Outcomes, Education Equals Partnership, Eliminating Racial Disparity and Disproportionality, Acceptance through Compassionate Care, Empowerment and Positive Transformation, and Quality Parenting Initiative. The Executive Management teams from both CW and MH are regularly briefed and updated on the progress of Katie A. implementation in Orange County.</i></p>	
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>	<p><i>We have developed MOU’s between CW and MH as well as obtained Miscellaneous Orders from our Juvenile Court to assist in streamlining communication, the sharing of information, and the facilitation of case related communication. CW and MH have co-located staff. We have identified a method for sharing Katie A data and are adjusting this method to provide both CW and MH with more meaningful and accurate data. We also continue to explore more effective ways to share data that takes into account each agency’s responsibility to adhere to state and federal regulations regarding Protected Health Information (PHI). Since</i></p>	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p><i>the last progress reporting period CW and MH have also ramped up efforts in collaborating between agencies by adding additional on-going collaborative Katie A planning/implementation meetings to the monthly schedule. Katie A. implementation team members from each side have shared policy and procedure information so that CW and MH staff members are being trained in a coordinated manner that emphasized a unified and integrated approach towards service delivery. Joint CW and MW trainings are conducted regularly and to the extent that needs are identified and resources are available.</i></p>	
<p>Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i></p>	<p><i>We continue to project an increase in class and subclass youth as our understanding and methods of service provision develop and become more sophisticated; however, we believe we have adequate resources to meet the needs of existing and projected populations at this time. Youth enrolled in Wraparound are receiving IHBS, but ability to deliver this service in the MHP County and Contract clinics is limited due to the insufficient number of youth and parent partners to deliver IHBS. Funding is lacking at this time to increase staffing of youth and parent partners in these clinics.</i></p>	
<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><i>Available services are culturally responsive and staffs are regularly trained related to cultural competency across both agencies. We have a CW/MH/Community Stakeholders trauma informed systems collaborative and are one of the super communities working with the Chadwick Center as part of a SAMHSA grant. Our mental health providers have been trained and are using several EBPs including TF-CBT, MTFC, PCIT, and FFT. CW is in the process of receiving the CW Trauma Training Toolkit developed by the NTSN. MH and CW have implemented a robust Wraparound program.</i></p>	
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i></p>	<p><i>CW and MH continue to seek out and identify foster youth and parent representatives to participate in the planning and implementation process. This is reflected by participation of a former foster youth and parent representatives in all scheduled CW/MH planning and implementation meetings. The youth and parent representative were also invited to participate in the Regional Learning Collaborative scheduled for October 7th, 2014.</i></p>	
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></p>	<p><i>Both MH and CW have bi-lingual and bi-cultural staff and regularly train staff on cross cultural issues.</i></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><i>The Wraparound and MTFC programs capture outcome data. CW tracks out outcomes as part of the Child Welfare Redesign and self-assessment process. Mental Health is currently in the process of exploring methods to track outcome data. CW and MH continue to explore ways to improve data matching of information for outcome tracking and preparation of Katie A. Progress Report documents. The current process is very workload</i></p>	<p>YES</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p><i>intensive. Additional staffing and fiscal resources are being explored to address these challenges. MH utilizes EHR for data mining and analysis related to services delivered to the Katie A. Subclass. MH will bring on a psychologist to help develop and implement outcome measures to address the domains in the Katie A. Outcomes Matrix. Access domain questions will be addressed using data from EHR and Progress Report. Outcome measures for other domains in the matrix will be developed jointly with CW partners. Data sharing between CW and MH for cross-comparison of youth who have received, or not received, assessment/services has begun to occur on a regular basis.</i></p>	
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i></p>	<p><i>Our County collaborates on a number of fiscal strategies and braided funding strategies when possible, to support family centered services. Additional staffing and fiscal resources are being explored to enhance implementation of the Core Practice Model, data tracking and service delivery related workloads.</i></p>	

Attachment 1

Below are explanations of the rationale used for the numbers entered in “Column 1” for any particular category. For some numbers, an expanded explanation was provided in order to reduce the potential for a misinterpretation of the data reported by CW and MH.

Enclosure 1, Part A:

1. Potential Subclass members are comprised of all children and youth who came to the attention of the Orange County Social Services Agency (SSA) Children and Family Services (CFS/CW) during the reporting period and who met at least one of the following criteria: a) placed in residential placement, RCL 10 or higher; b) participated in Wraparound, Full Service Partnership services or qualified for specialized care rates; c) placed in a psychiatric hospital or 24-hour mental health facility and/or experienced three (3) or more placements in 24 months; or d) were screened and referred by CFS to Orange County Health Care Agency (HCA/MH) for a mental health assessment and/or treatment
3. Our system of data sharing between CW and MH has just now been able to run a report on this number. The accuracy of this data report will be further refined prior to the next semi-annual report. MH has not yet been able to verify if indeed each one of these 103 youth were actually referred. In addition, MH's assessment period is 60 days. A portion of the youth accounted for in this number may be currently in the assessment process. MH and CW will continue to work together to ensure greater accuracy of data sharing.
4. The number in this category was determined by identifying children/youth in CWS/CMS during the reporting period who received Medi-Cal Services and were identified as potential subclass members, although MH did not receive a referral for assessment. For future reporting periods, CW will continue to ensure each child is screened and referred if indicated. Further, CW is exploring the possibility of including the Subclass Assessment Form in each child/youth's Health and Education Passport (HEP) in CWS/CMS, which would add an additional opportunity to ensure every child/youth is screened and referred as may be required..

Enclosure 1, Part B:

6. There are a significant number of children identified as subclass members who are receiving SMHS, through Medi-Cal providers, but the services are not being billed to ICC or IHBS because the youth are residing in group homes. They are receiving a variety of SMHS such as targeted case management and rehab services along with individual therapy, family therapy, group therapy, medication management, and crisis services through the Core Practice Model and goals are being formed through the CFT. In addition, there are some (not many) subclass youth who are receiving SMHS but ICC and IHBS services were not properly documented in their service plans and could not be billed. MH views this as a training/monitoring issue that has been identified and will be addressed appropriately.
7. Every identified subclass member is receiving some form of SMHS.
8. No subclass members declined ICC or IHBS services.

Enclosure 1, Part C:

- 1a. The methodology used to determine the number in Item **1a.** took into account the number of actual and projected subclass members who received ICC provided in the previous Semi-Annual Progress Report, the number of subclass members who are currently receiving ICC, the percentage of increase in subclass members noted during this reporting period, and the increase in training and monitoring that will occur in the next reporting period. In addition, HCA electronic billing system reports will be run on a monthly basis to determine number of subclass members that are receiving ICC and providers will be provided on-going monitoring, feedback, and training related to the use of ICC. In addition to the data provided in this enclosure by the MH electronic health record, CW has begun utilizing Special Project Codes in the State's Child Welfare Services Case Management System (CWS/CMS) to assist with tracking and progress reporting on youth who have been screened, assessed, identified in the subclass, and/or are receiving mental health services. Several sources are being explored to ensure the most efficient and accurate data-entry method for updating all existing and new subclass member cases with these special project codes. CW is also exploring the possibility of inputting data directly into the Health and Education Passport.
- 1b. The methodology used to determine the number in Item **1b.** took into account the number of actual and projected subclass members who received IHBS provided in the

previous Semi-Annual Progress Report, the number of subclass members who are currently receiving IHBS, the percentage of increase in subclass members noted during this reporting period, and the increase in training and monitoring that will occur in the next reporting period. In addition, MH electronic billing system reports will continue to be run on a monthly basis to determine number of subclass clients that are receiving IHBS and providers will be provided on-going monitoring, feedback, and training related to the use of IHBS.