

County: Placer

Date: _____ May 1, 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					
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Name and Contact Information County Mental Health Department Representative					
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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	189	As a System of Care, Placer County’s Child Welfare and Children’s mental health units are part of one agency, and are co-located in CSOC offices. Because of this infrastructure, staff can easily access information across each unit, as well as share databases. Consequently the identification of potential subclass members that remain placed within the county has not been cumbersome, and we are confident that the procedures developed are efficient. The identification and provision of mental health needs for children placed out of county is not as successful.
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	4	This system appears to be sufficient and requires no improvements.
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.	16	In creating the current Dependency Mental Health program policies County Counsel staff were consulted to assure legal parameters were followed. During this process Counsel examined the current law related to consent to treat and determined that the social worker or

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

			<p>caretaker could not provide consent to treat for mental health care; that those rights were retained by any parent who had custody rights prior to Departmental intervention. Placer has typically ensured a high number of dependents have received needed mental health treatment, however, this recent legal interpretation has provided an impediment to minors receiving assessment and/or treatment. Clinicians are making multiple appointments with parents in order to obtain signatures on the "consent to treat" documentation, with little success in frequent instances. When this occurs the Child Welfare social work staff must request the Court to order that they or the caretaker can consent to the treatment; occasionally this has required the preparation and filing of a separate petition if a Court hearing is not already on calendar.</p>
4	<p>Potential subclass members who were unknown to the MHP during the reporting period.</p>	190	<p>As a System of Care, Placer County's Child Welfare and Children's mental health units are part of one agency, and are co-located in CSOC offices. Because of this infrastructure, staff can easily access information across each unit, as well as share databases. Consequently the identification of potential subclass members who remain placed within Placer County has not been cumbersome, and we are confident that the procedures developed are efficient. However, approximately one half of all dependents placed out of the home are placed outside of Placer County. The mental health needs of those youth are unknown to</p>

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

			the children's mental health team.
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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	63	As a System of Care, Placer County’s Child Welfare and Children’s mental health units are part of one agency, and are co-located in CSOC offices. Because of this infrastructure, staff can easily access information across each unit, as well as share databases. We are confident that this allows us to efficiently identify subclass members, and provide appropriate services. We are awaiting further policy development from the State to assist in providing intensive services to minors placed in counties outside of Placer. Additionally, currently under development are procedures pertaining to providing mental health case management, to include monthly team meetings, to minors placed in group home care, level 10 or above. Placer County typically has less than 20 dependent youth in group home care at any one time.
2	Receiving Intensive Care Coordination (ICC).	16	As a System of Care, Placer County’s Child Welfare and Children’s mental health units are part of one agency, and are co-located in CSOC offices. Because of this infrastructure, staff can easily access information across each unit, as well as share databases. We are confident that this allows us to efficiently identify subclass members, and provide appropriate services. We are awaiting further policy development

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			<p>from the State to assist in providing intensive services to minors placed in counties outside of Placer. Additionally, we are in process of the development of procedures of how the mental health staff will provide mental health case management to youth placed in group homes level 10 or above; to include Child and Family Team meetings. These procedures must reflect the fact that the State of California medi-cal billing manual states that counties are prohibited from providing and billing ICC while minors are placed in group home care, except for 30 days prior to discharge from placement.</p>
<p>3</p>	<p>Receiving Intensive Home Based Services (IHBS).</p>	<p>6</p>	<p>As a System of Care, Placer County's Child Welfare and Children's mental health units are part of one agency, and are co-located in CSOC offices. Because of this infrastructure, staff can easily access information across each unit, as well as share databases. We are confident that this allows us to efficiently identify subclass members, and provide appropriate services. We are awaiting further policy development from the State to assist in providing intensive services to minors placed in counties outside of Placer. Additionally, we are in process of the development of procedures of how the mental health staff will provide mental health case management to youth placed in group homes level 10 or above; to include Child and Family Team meetings. These procedures must</p>

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			<p>reflect the fact that the State of California medi-cal billing manual has stated that counties are prohibited from providing and billing for IHBS while minors are placed in group home care, except to assist them in transitioning to a lower level of care just prior discharge from the placement.</p>
<p>4</p>	<p>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></p>	<p>13</p>	<p>Placer County operates a Wraparound program within the Children’s System of Care; the service is not contracted out. Because of this structure we are confident that, currently, all subclass members receiving Wraparound are also receiving ICC and IHBS. The Wraparound program was not trained on billing methodology related to ICC or IHBS until part-way through the reporting period. Placer county does have a small contract to provide intensive mental health “wrap like” services to children in placement when their placement may be at risk of ending due to the minor’s emotional/behavioral challenges. The service is also available to families if they have adopted a former Dependent of Placer County. The program provider was trained part-way through this reporting period on the provision of ICC and IHBS and their billing reports reflect the provision of said services.</p>

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

<p>5</p>	<p>Receiving other intensive SMHS, but not receiving ICC or IHBS.</p> <p>Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC).</p> <p><i>Do not include youth already counted in 2, 3, or 4</i></p>	<p>30</p>	<p>As stated previously, we are confident that we have efficiently captured the identification of subclass members, and that subclass members are receiving ICC and/or IHBS. However, we are awaiting further policy development from the State to assist in providing intensive services to minors placed in counties outside of Placer. Additionally, currently under development are procedures pertaining to providing mental health case management, to include monthly team meetings, to minors placed in group home care, level 10 or above. Placer County typically has less than 20 dependent youth in group home care at any one time.</p>
<p>6</p>	<p>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).</p>	<p>0</p>	<p>As a System of Care, Placer County's Child Welfare and Children's mental health units are part of one agency, and are co-located in CSOC offices. Because of this infrastructure, staff can easily access information across each unit, as well as share databases. Consequently the identification of potential subclass members has not been cumbersome, and we are confident that the procedures developed are efficient. At this point there are no subclass members known to be receiving services outside of the Medi-cal mental health system.</p>
<p>7</p>	<p>Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).</p>	<p>Unknown</p>	<p>As stated previously, we are awaiting further policy development from the State to assist in providing intensive services to minors placed in counties outside of Placer. It is</p>

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

			very difficult to obtain needed mental health services in such instances due to the lack of mandates and consistency in county practices statewide, and there have been occasions wherein youth have lost placements prior to obtaining the needed treatment.
8	Declined to receive ICC or IHBS.	0	At this point all minors who have been assessed and identified as members of the sub- class have accepted services when offered them.

PART C: Projected Services			
Item #	Service	Projected number of subclass members to be receiving services by August 31st	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	37	As stated previously, because of the fact that Placer County is a System of Care and the mental health and Child Welfare units are integrated, we are confident that we are identifying the subclass members that remain placed in Placer County in a highly efficient manner. In progress are procedures to provide mental health case management to minor’s placed in group homes level 10 or above. It is anticipated that in the next reporting period any Placer County dependent placed in such a placement will receive mental health case management, to include monthly team meetings. Pursuant to the State medi-cal manual, those children will not receive ICC until 30 days prior to discharge. Typically Placer County only has up to 20 minors at any one time in group home care. Additionally, we are awaiting further policy development from the State to assist in providing intensive services to minors placed in counties outside of Placer which may impact the

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

			number of youth receiving ICC significantly as approximately one half of all youth placed out of home are in placements
1 (b)	IHBS	22	As stated previously, because of the fact that Placer County is a System of Care and the mental health and Child Welfare units are integrated, we are confident that we are identifying the subclass members in a highly efficient manner. In progress are procedures to provide mental health case management to minor's placed in group homes level 10 or above. It is anticipated that in the next reporting period any Placer County dependent placed in such a placement will receive mental health case management, to include monthly team meetings. Pursuant to the State medical manual, those children will not receive IHBS until just prior to discharge as they are transitioning to less intensive care, or home. Typically Placer County only has up to 20 minors at any one time in group home care. Additionally, we are awaiting further policy development from the State to assist in providing intensive services to minors placed in counties outside of Placer which may impact the number of youth receiving IHBS as approximately one half of all youth placed out of the home are in placements outside of Placer County.

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	Yes x	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.

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

Service Availability: When minors are placed out of county, especially non-contiguous counties, county or local agency staff are unable to provide in-depth assessments or intensive services. Currently there are no state mandates for “host counties” to complete in-depth mental health assessments to determine sub-class eligibility. Additionally, many intensive services are provided by agencies via contract; those contracts are limited and most counties are unable/unwilling to use valuable “slots” for dependents of other counties.

Other Barriers: In creating the current Dependency Mental Health program policies County Counsel staff were consulted to assure legal parameters were followed. During this process Counsel examined the current law around consent to treat and determined that the social worker or caretaker could not provide consent to treat for mental health care; that those rights were retained by any parent who retained custodial rights. Placer has typically ensured a high number of dependents have received needed treatment, however, this recent legal interpretation has provided an impediment to minors receiving assessments and/or treatment. Clinicians are making multiple appointments with parents in order to obtain signatures on the “consent to treat” documentation, with little success. When this occurs the Child Welfare social work staff must request the Court to order that they or the caretaker can consent to the treatment; occasionally this has required the preparation and filing of a separate petition if a Court hearing is not already on calendar.

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Reporting Period: 9/1/13-2/28/14

Date Completed: 4/7/14

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?
<p>Agency Leadership <i>Leadership’s experience implementing family - centered services in a collaborative setting .</i></p>	<p><i>CW and MH leadership have an articulated strategy for collaborating across systems to ensure family-centered practices have system-wide support.</i> UPDATE: Previous Readiness Assessment rating - 3. Placer's integrated system of care, which has a joint mission, vision and values statement created by the partners in the collaborative effort, including the juvenile judiciary, child welfare, probation, mental health, education, public health, and family and youth advocacy.</p> <p><i>CW and MH leadership create and support opportunities for collaborative projects between agencies.</i> UPDATE 10/13: This is an integrated system of care which continues its 20 plus year history of delivering services collaboratively.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>CW and MH leaders have a shared vision of family-centered care.</i> UPDATE 10/13: Continuing focus of our system of care, to keep children, adults, and families self-sufficient in keeping themselves Safe, Healthy, At Home, In School/Employed, Out of Trouble, and Economically Stable.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>CW and MH leaders share responsibility and accountability for implementing timely services.</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

(Timely is defined according to local practices).

UPDATE 10/13: Readiness Assessment previous rating –2. This is an area of focus for us to deliver effective mental health services in a more timely way, in the era of decreasing resources and increasing needs. Tracking systems for timeliness has been challenging due to the different data sets in mental health and child welfare systems in use (CWS/CMS, and Avatar) and lack of a bridge between systems. However, due to integrated management structures, the solutions are integrated as well.

UPDATE 4/14: The System of Care continues to focus on timeliness of services and has instituted a tracking system outside of Avatar and CWS/CMS for this purpose.

Forums exist for information sharing and cross-system problem solving that include families and other community partners.

UPDATE 10/13: Family and Youth Advocates, as well as leaders from other constituents such as representatives from the Native and Latino communities, are a part of the CSOC management team and provide input into planning, policy development and other leadership efforts.

UPDATE 4/14: No additional updates for this reporting period.

Families and other community members have a meaningful role in oversight of services and quality improvement activities.

UPDATE 10/13: Family Advocates and Family and Friends Coordinators are members of the Quality Improvement Committee, the Cultural and Linguistic Competency Committee, and are workgroup members planning and implementing area of the System Improvement Plan activities for CWS.

UPDATE 4/14: No additional updates for this reporting period.

Interagency and Community Committees are in place to ensure policies and practices are consistent with family-centered principles of care.

UPDATE 10/13: See above answers. Youth and Family member advocates who responded to the original readiness assessment felt this was a strength area for Placer's system of care.

UPDATE 4/14: No additional updates for this reporting period.

CW and MH leaders regularly discuss issues affecting access to services.

UPDATE 10/13: This is a system of care, so integrated leadership discusses all areas of functioning and as stated above, timeliness is a regular item of focus.

	<p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>CW and MH leaders regularly discuss issues affecting quality of services.</i></p> <p>UPDATE 10/13: This is a system of care, and quality of services is reviewed routinely. We review reports and satisfaction surveys as well, from the state derived Consumer Perception Surveys, and an additional county administered satisfaction survey conducted in English and Spanish with all narrative notes captured for more qualitative information. We also use evidenced based practices and routinely discuss the results from Functional Family Therapy, Incredible Years, Nurtured Heart, Structured Decision Making, Family Team Meetings, etc.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p>	
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>	<p><i>Collaboration is supported through formal agreements, such as memorandums of understanding, joint training plans, or interagency strategic plans that articulate strategies and mechanisms for meeting the needs of children and families.</i></p> <p>UPDATE 10/14: Previous Readiness Assessment – 3, rated as such since we have an integrated system of care.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Agencies have a shared approach to addressing issues related to consent and confidentiality.</i></p> <p>UPDATE 10/13: This was also rated as a 3 given our joint integrated system of care.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Agencies provide opportunities for joint training to staff and families.</i></p> <p>UPDATE 10/13: Area rated as a 3 due to integrated system of care. All training can be and are offered jointly with both perspectives given.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Agencies have an established process for reviewing, changing, and implementing policies and procedures that support family-centered practices.</i></p> <p>UPDATE 10/13: Rated as a 3 and there are no changes to the previous report.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Agencies have structures and processes in place that support collaboration with other organizations that are interested in children’s issues such as, primary care, schools, libraries, local</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

	<p><i>parks and recreation, or others.</i></p> <p>UPDATE 10/13: Previous Readiness Assessment Report – 2. This continues to be an area of focus. The Placer SMART collaborative is a longstanding effort with many partners, including the Placer County Office of Education, the local SELPA, and public health, but it does not always include local parks, and libraries.</p> <p>UPDATE 4/14: No substantial changes in this area have been noted through this reporting period.</p> <p><i>Agencies have co-located office space or staff.</i></p> <p>UPDATE 10/13: This continues as a 3 and a strength area. CWS, MH, Probation officers, Public Health Foster Care Nurses, Foster Youth services workers, Family and Youth Advocates, ILP Services, etc. are all co-located in our Children's System of Care locations.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Agencies have information systems that support sharing of child welfare and mental health data.</i></p> <p>UPDATE 10/13: While this area was rated as a 3 for Placer and on the local level we have a waiver supporting this sharing of data, it is recognized that this is still a major barrier to systemic efficiency for our families and processes and work at the state and federal level to change the laws around sharing of information to benefit children and families would be a huge improvement for our efforts in the dependency mental health arena.</p> <p>UPDATE 4/14: Placer County continues to share information on the local level as stated in the last report, but would desire a solution at the state level.</p> <p><i>Processes are in place to share and receive feedback at the practice, program, and system levels in order to solve problems and enhance success.</i></p> <p>UPDATE 10/13: This is another area of strength for Placer, rated as a 3, in part due to our longstanding SMART collaborative and supported system of care.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p>	
<p>Systems Capacity <i>The collective strength of administrative structures, work force capacity , staff skills & abilities, and operating resources.</i></p>	<p><i>Children and youth in the CW system are screened for possible mental health needs.</i></p> <p>UPDATE 10/13: At the date of our readiness assessment in May, this area was rated as a 2 since we already did identify and deliver mental health services for some of our dependents, but we did not conduct a screening of all dependents. Since that time, we have instituted our screening process for all dependents who meet the class specifications.</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

UPDATE 4/14: Screening continues to be conducted. Some issues around consents have arisen which are explained in the data section of this report.

Children and youth in the CW system who are referred to mental health receive a timely full mental health assessment. Timely is defined according to local practices.

UPDATE 10/13: This is an area we are working on in part due to system impacts coming from multiple areas at once, including MH service need from the education system which has increased after the repeal of SB 26.5. We are seeing increasing referrals from schools, principals, hospitals, and directly from families for children formerly on IEPs. We are also ramping up for the Healthy Families rollover to medi-cal and have seen new referrals impacting our system already even though we are a Phase 4 B county. We also have increased mental health assessment needs for CWS parents from increased detentions in child welfare which is the responsibility of the MH component of our system of care. We have prioritized Dependency Mental Health assessments before general CWS assessments and on-going mental health assessments to be completed first by our in house clinicians, and are increasing our referrals out to Network Providers to keep timely assessment flowing.

UPDATE 4/14: Screenings are being conducted and timely referrals are made to the mental health team within the system of care. There are some challenges due to CWS parents' sometimes refusing to give consent for care and treatment. Additionally, we are working with county counsel to identify solutions to their interpretation of case law as it relates to consent authority by County Social Work staff. Presently some delays are occurring when consent must be obtained from the court.

Policies in place support an effective referral process and linkage to services in multiple systems.

UPDATE 10/13: These practices are already in place since we have historically linked dependents with in county and out of county services.

UPDATE 4/14: No additional updates for this reporting period.

There are effective processes and sufficient supports in place to recruit, hire, and train personnel. Factors may include timeliness to hire, expertise of human resources staff, written training materials.

UPDATE 10/13: Placer County is not unique in having rather laborious hiring processes which are dependent on recruitment lists and rules governed by a civil service commission. This continues to be a barrier to timely and efficient hiring.

UPDATE 4/14: No additional updates for this reporting period.

Staff receive ongoing training, and are mentored and coached by experienced managers to ensure

staff maintain high quality skills and abilities.

UPDATE 10/13: Coaching is in place and effective, and many core training modules which are required by child welfare services are delivered through our UC Davis training program. Many mental health training requirements are in place, occurring, and effective as well.

UPDATE 4/14: No additional updates for this reporting period.

Agencies utilize partnerships with other public agencies and community-based organizations to ensure that children and families can access a variety of services and supports in multiple settings.

UPDATE 10/13: This was, and continues to be a strength area for our system of care. Our core collaboration and system of care assumes no wrong door and services from all sectors being added to families as the need becomes evident.

UPDATE 4/14: No additional updates for this reporting period.

Agencies engage the local community through activities that may include partnering with community-based organizations and hosting public meetings or community forums.

UPDATE 10/13: This area is developed in part, but continuing efforts to improve our visibility within and collaboration with the community are always at the forefront.

UPDATE 4/14: Placer County has a very active MHSA community stakeholder group, the Campaign for Community Wellness, which has been in place and functioning since the passage of Proposition 63. The CCW group is comprised of county representatives, provider agencies, community members, youth and consumers and has a very active role in shaping the services of the SOC and learning about and fostering many of these community services and support groups. In addition, Placer County partners with the local CAPC for quarterly educational forums to engage and inform the community of services to prevent child abuse and address mental health needs.

There is a sufficient child welfare workforce in place.

UPDATE 10/13: This is a challenge area due in part to the hard hiring freeze from the past several years. Although hiring is now allowed, it has been difficult to keep up with the past openings, current retirements, and lateral movement within the county. While we always maintain case ratios, it is often managed through extra help personnel, and supervisory staff managing cases as well.

UPDATE 4/14: Placer County has successfully recruited and hired a 6 child welfare practitioners, which represents a restoration of 11% of the pre-recession workforce.

	<p><i>There is an adequate network of qualified mental health service providers available.</i></p> <p>UPDATE 10/13: There are approximately 70 Network Providers consisting of LCSWs, MFTs, Psychologists, and MDs who report around 20 to 25 openings each month. These providers seem adequate at times for the number of clients, but we continue to struggle to keep bilingual providers who move out of the area or become habitually full, and providers who are willing to work in the Tahoe area. Active recruitment efforts continue.</p> <p>UPDATE 4/14: Placer County continues to recruit for bilingual providers capable of delivery of culturally specific services. One new LCSW was added during this time frame who provides Native American services to add to several others in our Network. Several new bilingual, bicultural Latino county social workers were hired into the System of Care.</p> <p><i>Administrative processes and organizational infrastructure are sufficient to meet business and procurement needs.</i></p> <p>UPDATE 10/13: We sometimes do not always feel we have the human resources need to complete some tasks (i.e. hiring within civil service rules), and our IT resources are challenged in some areas.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</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>Children and families are assessed for immediate safety, stabilization, and crisis support needs.</i></p> <p>UPDATE 10/13: This is an area that we all believe we are doing in a thorough fashion within our system of care, be it from child welfare, mental health or the probation sides of our integrated system. Education used to be more firmly represented as well, and is still through our FRCC process; however, we have seen some gaps appear as a result of the repealing of SB 26.5.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Services are tailored to meet specific, individual needs and build on individual strengths.</i></p> <p>UPDATE 10/13: This is always a goal of our system which we derive through family team meetings in child welfare, strengths assessments through the wraparound process, and plan to do more of through dependency mental health.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Services are community-based, delivered in the least restrictive environment, and in the child and family's own language.</i></p> <p>UPDATE 10/13: This is a continued goal to strive for in our integrated system. We do have very low numbers of children placed in out of home care and high levels of care compared to the state average. We continually strive to hold as many family team meetings as possible and FRCC</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

is never held without the family in attendance.

UPDATE 4/14: Specific to Katie A, the only FTMs not being held currently are for those children placed in groups homes. This is an area of focus to develop, but due to the very low numbers placed historically, we have chosen to implement others areas first.

Available services support transitions to the community, independence, and the adult system of care.

UPDATE 10/13: Since the passage of AB 12, transition services for foster care youth has been utilized in a more comprehensive manner in part due to the services and financial resources that are available through this law. We also have a TAY full service partnership through MHSA funds which helps another segment of our youth population being supported with their mental health challenges. TAY outreach services are also available through MHSA which assists in linking youth to services in the community. Placer's collaborative includes YES, the Youth Empowerment Support, which is run and staffed by former system involved youth and others to provide direct support and linkage for youth in all aspects of their adult transition. We have also improved our youth to adult services transition for the more severely challenged youth through a direct referral and warm hand off in terms of medication support and psychiatric services.

UPDATE 4/14: No additional updates for this reporting period.

Available services include the use of evidence-based practices.

UPDATE: Placer has a number of evidenced based or promising practices in the service array including Incredible Years, Functional Family Therapy, Wraparound, Nurtured Heart, and others.

UPDATE 4/14: No additional updates for this reporting period.

Families have access to services that focus on prevention and early intervention.

UPDATE 10/13: Placer County has a robust network of providers, community agencies, faith based organizations, other governmental agencies, and others who deliver prevention and early intervention services though PEI funding. Please see the public MHSA Annual Reports for details on the myriad services and programs offered. In addition, educationally based prevention services such as Positive Behavioral Services and Supports (PBIS), and early intervention Wraparound services are implemented by our education partners in many of the school districts in Placer County.

UPDATE 4/14: No additional updates for this reporting period.

Services are sufficient to meet the mental health needs of the community.

UPDATE 10/13: This area is sufficient for the moment, but is always being re-assessed within the framework of increased needs and new challenges such as Katie A., Healthy Families transition to medi-cal, affordable care act, and dependency mental health.

UPDATE 4/14: This is an area of extreme focus during this past reporting period due to the Healthy Families transition to medi-cal in November of 2013, and the transition of Placer County physical health and non-specialty mental health services from fee for service to two managed care companies, California Health and Wellness and Anthem Blue Cross. Neither of the managed care companies were prepared, nor did the law dictate, that they provide non-specialty mental health services as of November, 2013 when the HF transition occurred. Accordingly, Placer County MHP was left to bridge the gap until January 1, 2014 when the law changed to require the managed care companies to provide non-specialty mental health services. However, as of January 1, neither health plan appeared to have networks in place to carry out that service provision. This has been a strain on the capacity of Placer’s delivery system.

Where service gaps exist, alternative strategies, such as cultural healing practices or other non-traditional services and supports, are explored.

UPDATE 10/13: We have many culturally and community supported services in Placer County including Promotora/es sponsored by the Latino Leadership Council, Parent Project held in English and Spanish, White Bison, Positive Indian Parenting, and Warrior Down from the Sierra Native Alliance, Youth services through YES, and many others (please see MHSA Annual Plan for additional details).

UPDATE 4/14: As stated above, at least one new culturally specific service provider has been added during this reporting period.

Services for children and families include trauma informed care.

UPDATE 10/13: This is a priority area for the system of care. We are making active efforts to include training in this area, and have trainings in all other clinical areas delivered from a trauma informed perspective. Placer is also leading a regional effort to create a trauma focused intensive services site based center to work with very young children.

Update 4/14: An RFP process is currently open, and the trauma focused intensive services site for 3 to 6 year olds is anticipated to commence July 1, 2014.

Readiness Assessment Section	Description of Activities	Training or TA Needed?
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family -centered Principles are reflected in current systems.</i></p>	<p><i>Families have a high level of decision-making power in all aspects of planning, delivery, and evaluation of services and supports, which is reflected in organizational policies.</i></p> <p>UPDATE 10/13: Our readiness assessment reflected the belief that this is a strength area for our system. As stated in other areas, youth and families are well represented in our SOC planning, leadership, and evaluation meetings, input is incorporated into policies and practices, and youth and family advocates are co-located in our buildings and are a vital part of our treatment and service teams.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Children and families have access to an ongoing community stakeholder process.</i></p> <p>UPDATE 10/13: While children and families have a number of direct avenues to provider input into the system of care, including through advocates, the Campaign for Community Wellness is an on-going community stakeholder process that was formed as an MHSA stakeholder group back in 2004, and has continued to the present as a community led group that provides input into all areas of functioning for the system of care. The CCW meets monthly, is facilitated by consumer family members, and has robust attendance from agencies, providers, community groups, youth, consumers, and other stakeholders. This continues to be rated as a strength area for our system.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Services are tailored to meet individual child and family needs and reflect the child and family’s values, culture, and preferences.</i></p> <p>UPDATE 10/13: This is an area of continual focus for us as services can often be driven by court processes and deliverables. Family Team Meetings are held throughout our child welfare system, and they will be expanded for dependency mental health. Our Wraparound services continue to have a strong family focus on individualized care, and Functional Family Therapy has at its core delivering individualized services through a structured evidenced based sequencing process.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Children and families have multiple opportunities to share feedback about quality and effectiveness of services.</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

UPDATE 10/13: Satisfaction surveys are held once a year through the state process, another time per year through the internal process, and through other mechanisms, including an exit survey that is conducted by the YES group for youth satisfaction. Input is also gathered in other areas, including through the Welcome Center where adult consumers and anyone who wishes to drop in can attend and give input into service functioning through their monthly Consumer Council. Representatives are also present at the Quality Improvement Committee, CLC, WET Advisory Group, SIP workgroups, and are members of the CSOC Leadership Teams. However, this was rated as a 1 for our system so efforts continue in this area.

UPDATE 4/14: No additional updates for this reporting period, although discussion is continuing in this area.

Peer support networks are available for children, youth, and caregivers.

UPDATE 10/13: This is an area that is continuing to grow, with YES providing a major area of support for youth through their peers and those who have direct experience with the system. For families, peer advocates and family advocates provide the majority of peer support, and this is known to be helpful, but more are needed to assist families with support.

UPDATE 4/14: No additional updates for this reporting period.

Training and written information is available for families in order to support their role as informed decision makers.

UPDATE 10/13: This is an area of need. While some documents exist, such as a youth rights booklet which has won accolades on a national level spearheaded by a former foster youth, the other documents are not easily understood while youth and families are in crisis. We have added a video loop in our offices that offers information on providers and services in the community. It is possible that this venue could be used to focus more on how families can drive their own care and be informed about their rights.

UPDATE 4/14: A formal workgroup has been formed to focus on the development of a parent orientation to include a written manual for parents/guardians about the system, how to navigate it and understand it, and how to effectively be even more active in decision making processes.

Families are involved in defining, selecting, and measuring quality indicators of services and programs.

UPDATE 10/13: To the extent that these representatives are present and participate in meetings such as the QI and CLC committees, SIP meetings, leadership meetings, and the CCW, input does drive the refinement of services and quality indicators. SIP goals are largely driven

	<p>by system needs, but they do have extensive stakeholder involvement in the crafting of indicators and methods of improvement. Initial dependency mental health planning and the readiness assessment involved youth and family advocates. Subsequent implementation efforts will strive for this continued involvement.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p>	
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings</i></p>	<p><i>The cultural identity of children and families is valued, and reflected in service planning and delivery.</i></p> <p>UPDATE 10/13: This area was rated as a 1 on the readiness assessment and continues to be a focus for our system. Value is placed on identified culture and cultural practices of the family, but not by everyone. Training on culture and diversity issues continues, but that has not always been reflected back in service planning and delivery. For instance, we created a Native Services Team to identify Native families as they enter in the child welfare system to hold family team meetings facilitated with a Native expert in a more culturally relevant manner, in order to also provide more culturally informed mental health and other services. However, not all families are identified at intake in part due to staff practices. This is part of our CWS System Improvement Plan.</p> <p>UPDATE 4/14: A Cultural Broker Dialogue Series was commenced 24 months ago to address needs in this area. Many staff and some leaders attended the four day series over a number of months to create awareness, make recommendations for change, and incorporate those changes. The trainer was brought back again this spring to re-energize the system of care and community, and train those who did not participate before. This is an area of continued focus.</p> <p><i>Diversity and language among agency staff reflects that of the community.</i></p> <p>UPDATE 10/13: This is an area that Placer County struggles with as the county service sector is made up of primarily Caucasian employees, with limited methods to recruit and retain specific diverse cultures. Conversations with county personnel are being held to alter hiring practices to attract diverse cultures to serve the needs of the various ethnic groups in Placer, particularly the growing Latino community.</p> <p>UPDATE 4/14: The CSOC has been successful in recruiting and hiring several new bilingual/bicultural staff in the past few months in part due to agreement by county personnel department to add language preference as a scored item on targeted applications. In addition, we have also added experience and interest in working with the Native American population as two application questions. These enhancements were made possible through leadership tenacity and through community partners requesting the changes at the county level.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>

Staff are respectful of cultural differences in customs and beliefs.
UPDATE 10/13: Again, this is an area of need as some staff celebrate and embrace differences and alter their behavior to explore and honor this factor, while others do not.

UPDATE 4/14: See update above on the Cultural Broker Dialogue Series.

Training is provided to staff regarding diversity and culturally competent practices.
UPDATE 10/13: Training continues to be offered to staff, community providers and members, but impact on behavior has often been slow for certain individuals, and within certain service sectors.

UPDATE 4/14: See update above on the Cultural Broker Dialogue Series.

Published materials such as informational brochures and forms are translated into languages that reflect the diversity of the local community.
UPDATE 10/13: This area is slowly improving. While the mandated forms have been translated in the past (e.g. informed consents, grievance/appeals, beneficiary protection manuals, etc.) other forms that are vital to families have been slower to be translated such as the terms and conditions of probation and other court documents. Strides have been made in this area over the past several months and will continue to be a focus.

UPDATE 4/14: Progress has been made in this area with probation translating terms and conditions in certain instances for mono-lingual Spanish speaking families, and some MH treatment plans are routinely translated. In addition, the court has moved all Spanish speaking court cases to Mondays on the court calendar to aid the use of translators and family support.

Children and families have access to services delivered in their own language.
UPDATE 10/13: While the system has some bilingual staff, interpreters are often used, which of course is not the ideal situation. We also actively have and recruit for bilingual/bicultural providers, but their caseloads always become full quickly. This is an area in which other ideas or assistance could be helpful.

UPDATE 4/14: No additional updates for this reporting period. This is still an area of need and technical assistance.

Service plans are translated into the family's native language and discussed to ensure understanding.
UPDATE 10/13: Our Tahoe service provider does an excellent job of translating service plans into Spanish as needed, as well as informed consents, releases, and other documents.

	<p>Wraparound plans have been translated upon need, as well as others. This area could be more systematic however.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Agencies partner with culturally based community groups to ensure programs and services are culturally appropriate to meet the community's needs.</i></p> <p>UPDATE 10/13: Because the SOC recognizes our cultural and language limitations, we have cultivated and maintained very strong collaborative relationships with our community partners to provide just this sort of input into system functioning, which is not always positive, and to actively partner with us to find solutions for the system limitations. We often partner with agencies and providers in the community to develop and/or provide the culturally relevant services that we know we lack. This is how many of the above listed services and practices become available for our multi-cultural families and individuals.</p> <p>UPDATE 4/14: Please see response on recruitment strategies as these changes to our formal recruiting system were due to influence from our community partners.</p>	
<p>Outcomes and Evaluation <i>The strength of current data collection practices, and how outcomes data is used to inform programs and practices</i></p>	<p><i>Agencies have a defined process that includes participation of families, direct service providers, agency staff, and other key stakeholders to define, select, and measure quality indicators at the program, service, and community levels.</i></p> <p>UPDATE 10/13: As noted above, the SIP process is very well defined and includes many stakeholders, providers, family member, consumer and youth representatives in the creation and implementation process.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Evaluation plans define specific goals and objectives, as well as measurable performance indicators.</i></p> <p>UPDATE 10/13: CWS SIP strategies include measurable goals and performance indicators. The MH Quality Management Plan also includes many specific goals and objectives including inclusion of family and youth members in leadership functions, input into development of goals, etc.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Evaluation plan describes how data informs quality improvement processes.</i></p> <p>UPDATE 10/13: The reader is directed to both the Child Welfare County Readiness Assessment and System Improvement Plan, and the Mental Health Plan External Quality Review</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

	<p>Organizational Annual reports for detailed reviews of the use of data in the Placer System of Care to make meaningful decisions and systemic improvements.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Data collection occurs for measures of administrative, fiscal, program, service, and individual child and family outcomes.</i></p> <p>UPDATE 10/13: There are a variety of reports used in the system of care to track, measure, and monitor outcomes in all of the above areas. One example, the monthly managers' report, has sections on child welfare immediate and 10-day response percentages; AB 636 Safe Measures; re-occurrence of maltreatment; foster care placement rates; social worker visit percentages; mental health number of persons served and amount billed; mental health services over 2 years; SDM safety assessment, etc. Other reports cover behavioral health clinical outcomes pre-mid-and post services, client satisfaction with services, and network provider satisfaction with the county.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Data collection relates to process indicators, functional outcomes for children and families, satisfaction surveys from children and families, and fiscal measures.</i></p> <p>UPDATE 10/13: See above. Several satisfaction surveys are conducted each year including the state Consumer Perception Survey, and the Placer County client satisfaction survey. Outcomes are tracked pre-mid-and post treatment and an annual summary report is created for system review and learning. Individual outcome comparisons are available to the clinician immediately upon completion of the Outcomes Tool and the Child and Adolescent Needs and Strengths (CANS).</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p>	
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family centered services.</i></p>	<p><i>Agencies have a basic understanding of what needs to be funded and what the approximate cost will be.</i></p> <p>UPDATE 10/13: This has been a strength area for Placer, although the realities of realignment in the MH and CWS areas are still unfolding with experience. Katie A not being addressed in the MHP Contract is an area of concern.</p> <p>UPDATE 4/14: No additional updates for this reporting period.</p> <p><i>Fiscal agreements that include commitment of funds are in place to support the needs of children, youth, and families.</i></p> <p>UPDATE 10/13: Placer has a waiver that allows for blending of funding which allows us to</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

address youth and family needs with a greater degree of flexibility and creativity.

UPDATE 4/14: No additional updates for this reporting period.

Agencies track expenses for the cost of mental health services for children and youth in the CW system.

UPDATE 10/13: Since Placer is an integrated system, we have been authorizing and providing mental health services to dependents for many years, and this is tracked in a variety of systems, including the type of service and expense of services.

UPDATE 4/14: No additional updates for this reporting period.

Agencies utilize multiple funding streams to support the mental health needs of children and youth in the CW system.

UPDATE: As stated above, this is a strength area for Placer in part due to our waiver which allows for this blending of funding streams from child welfare, social services, probation, education (in the past), foster care, mental health, etc.

Staff receives training on the time study process.

UPDATE 10/13: This is an important method of allocating funds accurately, and fiscal staff attend meetings with leadership and attend team meetings to train staff on time studies. This occurs at least annually and more frequently as needed or as changes occur. Clarification on what to use for components of dependency mental health start up and continuing activities would be helpful.

UPDATE 4/14: No additional updates for this reporting period.

Cross-systems training include fiscal strategies and funding requirements.

UPDATE 10/13: With our integrated system, all training in the fiscal arena is cross systems by definition.

UPDATE 4/14: No additional updates for this reporting period.

Policies and procedures describe strategies to blend funds from federal, state, and local sources to maximize ability to meet the needs of children and families.

UPDATE 10/13: Official policies and procedures do not exist as we rely on our waiver for this process.

UPDATE 4/14: No additional updates for this reporting period.

Interagency teams and collaborative projects include fiscal expertise.

UPDATE 10/13: All teams have access to fiscal representation, and leadership meetings, MHSA planning meetings, and managed care meetings include fiscal representation routinely.

UPDATE 4/14: No additional updates for this reporting period.