Katie A. Semi-Annual Progress Report **Enclosure 1**

County: Riverside County **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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County: Riverside **Date: 10-1-14**

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

PART A: Potential Subclass Members Identified During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Next Steps/Timelines**
1	Potential Subclass Members	2660	This information is based on the instructions found in the state letter MHSUDS 14-012/ACL 14-29: Any Mental health services, 3+ placements within 24 months; Wraparound, Full Service Partnership services, specialized care rate; RCL 10+ group home; psychiatric hospitalizations. The Department of Mental Health (DMH) and Children's Services Division (CSD) data systems are utilized to confirm the potential subclass members.
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	1803	Consumers who have been screened and assessed and found to not meet medical necessity.
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.	1142	Consumers who have been screened and have not been assessed to determine disposition.
4	Potential subclass members who were unknown to the MHP during the reporting period.	412	Children identified by CSD as having 3+ placements within 24 months, specialized care rate and RCL 10+ group home, but have been unknown and therefore not served by MHP.

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	1933	Children identified as open to both CSD and DMH in the reporting time frame and received MH service or were identified as meeting subclass criteria.
2	Receiving Intensive Care Coordination (ICC).	260	ICC data was derived from service records with the ICC and IHBS service code.
3	Receiving Intensive Home Based Services (IHBS).	145	IHBS data was derived from service records with the ICC and IHBS service code.
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. *Do not include youth already counted in 2 or 3 above.*	52	Children receiving Wraparound or FSP services that were not claimed as ICC or IHBS.
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). *Do not include youth already counted in 2, 3, or 4*	82	Multi-Dimensional Treatment Foster Care numbers are considered part of our Full Service Partnership program and counted in PART B #4 above.

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).	1498	This line includes children receiving services that were not claimed as ICC, IHBS, Wraparound/Full Service Partnership, or ITFC/TBS. The type of services that they received includes mental health services which may not be claimed with the ICC or IHBS codes: • Trauma Focused Cognitive Behavioral Therapy, or other evidence based practices • Individual Therapy • Group Therapy • Psychiatric Medication Services • Targeted Case Management to children living in group homes
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	0	All of the children identified as subclass have begun receiving some type of mental health service including an assessment.
8	Declined to receive ICC or IHBS.	26	This is the children who were referred for services after MH assessment, but family declined services. Screening/Referral disposition after MH assessment is recorded in DMH data system.

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 28, 2015**	**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	1000	Although our county did not meet the initial target, the increasing collaboration for CSD and DMH staff at all levels has had a positive impact on our projected increase for children receiving ICC services from 90 during the last reporting period to 260 for this reporting period. The increase has also occurred for children receiving IHBS from 90 during last reporting period to 145 for this reporting period. DMH barriers from the last reporting period involved: • Training of providers to effectively utilize the ICC code. There was staff turnover and new hires which delayed the training, but is now resolved. During the next reporting period, DMH will coordinate follow up trainings to providers and insure that oversight on the use of these codes. We project that we will meet this new target by February 2015. **Action Step: identify and retrain providers by February 2015** • Small number of scheduled Child and Family Team meetings. Staff's original understanding was that billing of ICC and IHBS had to be done in conjunction with the Child and Family Team meetings. When it became clear that CSD could not schedule team meetings fast enough to accommodate the billing codes required by the state, DMH shifted their practices to begin billing these codes uncoupled by the team meetings. **Further clarification from our state partners on this issue would be helpful.** • Stalled contract negotiations of Wraparound providers and amendment of contracts in outlying areas of the county. The numbers here will be larger in February as these contractual issues have been resolved, but they were a barrier to billing ICC and IHBS in the past reporting period. **No action step needed; resolved.** • Significant 'no show' rate of children in foster care scheduled to receive mental health services. This is partially due to children moving before their appointment may be actualized. CSD has been working in collaboration with DMH to insure that foster parents and parents understand the need to bring children to appointments. CSD sent a letter to foster parents describing the process and has enlisted the help of 'AFA'. **Action step: CSD dedicating staff to support families and children in this process.** • Slow roll out process of the county. The county plan originally submitted and approved by the state afforded a year long process of implementation involving the switch to ICC and IHBS billing codes from targeted case management and mental health services. In order to comply with the settlement, Riverside County had to move the roll out process up considerably. Hence, our county's adaptation to the process, although expedited, started at a place of deficit. This deficit has been corrected and will be evident in our reporting numbers of February 2015 as the trainings and follow up occur. **No action step needed; resolved.**

1 (b)	IHBS	500	Although our county did not meet the initial target, increasing collaboration for CSD and DMH staff at all levels has had a positive impact on our projected increase for children receiving IHBS from 90 during last reporting period to 145 for this reporting period. The barriers to utilizing this billing code are the same ones as listed under 1 (a) for ICC. They are listed below for your convenience: • Training of providers to effectively utilize the ICC code. There was staff turnover and new hires which delayed the training, but is now resolved. During the next reporting period, DMH will coordinate follow up trainings to providers and insure that oversight on the use of these codes. We project that we will meet this new target by February 2015. **Action Step: identify and retrain providers by February 2015** • Small number of scheduled Child and Family Team meetings. Staff's original understanding was that billing of ICC and IHBS had to be done in conjunction with the Child and Family Team meetings. When it became clear that CSD could not schedule team meetings fast enough to accommodate the billing codes required by the state, DMH shifted their practices to begin billing these codes uncoupled by the team meetings. **Further clarification from our state partners on this issue would be helpful.** • Stalled contract negotiations of Wraparound providers and amendment of contracts in outlying areas of the county. The numbers here will be larger in February as these contractual issues have been resolved, but they were a barrier to billing ICC and IHBS in the past reporting period. **No action step needed; resolved.** • Significant 'no show' rate of children in foster care scheduled to receive mental health services. This is partially due to children moving before their appointment may be actualized. CSD has been working in collaboration with DMH to insure that foster parents and parents understand the need to bring children to appointments. CSD sent a letter to foster parents describing the process and has enlisted the help of 'AFA'. **Action plan: CSD to provide a dedicated staff person whose responsibilities will include identifying and addressing barriers to subclass children receiving appropriate mental health services.** • Slow roll out process of the county. The county plan originally submitted and approved by the state afforded a year long process of implementation involving the switch to ICC and IHBS billing codes from targeted case management and mental health services. In order to comply with the settlement, Riverside County had to move the roll out process up considerably. Hence, our county's adaptation to the process, although expedited, started at a place of deficit. This deficit has been corrected and will be evident in our reporting numbers of February 2015 as the trainings and follow up occur. **No action step needed; resolved**

Is your county experiencing the following implementation barriers?

Hiring	Yes
Training	Yes
Service Availability	Yes
County Contracting Process	Yes

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

Please note, the below had an impact on our county's ability to implement ICC and IHBS and some barriers have been described above in Part C.

Hiring:
Although we have made great strides in our hiring related to the Katie A vs. Bonta Settlement requirements, the Department of Mental Health continues to strive toward making our hiring practices for Master of Social Work and Master of Family Therapy candidates effective in this current competitive environment. Our efforts here include partnering with local universities for both interns and graduate linkage, attending regional job fairs, and conducting mass hiring fairs of our own.

Training:
A few training needs have arisen within the last reporting period. First, some of the managed care contractors and clinicians who missed the first round of training on the ICC and IHBS training codes need to be addressed. Second, there are employees who would benefit from a more comprehensive training on the concepts presented in the Core Practice Model. Although ongoing training for Child and Family Team meeting processes continue, a CFT meeting example video would be welcomed by our state partners to assist in this training effort.

Service Availability:
Throughout the county, there are limitations for culturally specific services such as bilingual accessibility African American populations, Asian American, and LGBTQ populations. The Departments of Public Social Services and Mental Health continue to evaluate the service needs of the children in order to determine if the current expansion efforts have been sufficient.

County Contracting Process:
There have been some delays in the processing of some of the contracts which have been resolved.

Facilities:
Teams have been working on creative ways to house the expansion of staff: sharing with other departments and doubling up offices. However, there continues to be a challenge with enough physical space to house the additional staff.

Intensive Treatment Foster Care:
Preparations for the development and expansion of this program have begun during the last reporting period. A supervisor has been hired, staffing levels increased, and children are being accepted into the program. Our county will welcome further assistance from our state partners on this program as we move toward expansion of the program.

Recruitment of Foster Care Homes:
This need continues to be a challenge. While CSD has identified community based partners motivated to assist in the recruitment, support and retention of needed foster homes, Community Care Licensing delays have been a barrier to expanding needed county licensed homes for children in need of out of home placement.

Child Welfare Data Entry:
The release of the ACL clarifying data entry in CWS/CMS would be helpful for child welfare.

Medi-Cal Claim Status:
The Department of Mental Health has worked diligently to insure that all of the child welfare children served by their department are KTA indicated and billed. In this regard, our department respectfully requests that the DHCS auto correct the children already billed without the KTA indicator instead of directing our department to utilize the “void and replace” method. This would assist both of our departments in meeting the court mandates more efficiently and quickly prior to the December court date.

Please see the following page for detailed information regarding the claim status from DMH.

Katie A Medi-Cal Claim Status
as of 9/11/2014

The County continues to work through system and business process challenges regarding the implementation of Katie A. but has made significant progress in recent weeks around the submission of claims data for services provided since October 1, 2013. From a month ago, our claims are up 477%, clients are up 184%, and units of service are up 437%. One major challenge the County still has is working with the DHCS - Med CCC Unit to clean up claims that were submitted without the Katie A. indicator. In hopes of minimizing the growth of this problem and more timely submission of claims data, an improved process is being put into place to identify and flag all Katie A clients based on DPSS eligibility and MH medical necessity.

Current Katie A. claiming information for our County:

Katie A. Claims as of 9/11/14			
	Claim Amount	Clients	Units of Service
County Services through 8/31/14	$859K	428	355K
Contractor Services through 8/31/14	$2.56M	941	1.58M
Department Total Services	$3.42M	1,369	1.94M

Katie A. claiming data from approximately one month ago:

Katie A. Claims as of 8/1/14			
	Claim Amount	Clients	Units of Service
County Services through 5/31/14	$393K	353	162K
Contractor Services through 3/31/14	$322K	128	199K
Department Total Services	$715K	481	361K

Estimate of the claims that have been submitted without the Katie A. indicator and will require coordination with DHCS - Med CCC Unit to resolve:

Claimed Services Missing Katie A. Indicator			
	Claim Amount	Clients	Units of Service
Department Total Services	$3.35M	571	1.9M

County: Riverside County **Reporting Period: February 28, 2014 – August 31, 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)
Agency Leadership *Leadership's experience implementing family-centered services in a collaborative setting.*	On August 13, 2014, Children's Services Division (CSD) and The Department of Mental Health (DMH) conducted a Pathways to Wellness (Katie A.) Stakeholders' Meeting. The focus of this bi-annual meeting was to once again update our stakeholders on the progress of the Pathways to Wellness implementation in Riverside County and to elicit feedback to update the Readiness Assessment. This meeting was well attended by 108 stakeholders. Stakeholders included participants from Education, Probation, Regional Center, Community Based Organizations, Parent Partners, Youth Partners, African American Coalition, Latino Organizations, Foster Family Agencies, Group Home Agencies, Child Welfare staff and Mental Health staff. The information that follows includes feedback provided by the stakeholders. Of the stakeholders who voted on Agency Leadership progress and needs, 62.7% indicated that CSD and DMH Agency Leadership efforts are working and 37.25% of the stakeholders who voted indicated that Agency Leadership needs are continuing to develop. None of the voting stakeholders indicated that our joint Agency Leadership efforts were not working. Pathways to Wellness is supported by the executive and management staff of both CSD and DMH. The implementation structure, to include the Steering Committee, Core Committee and Subcommittees are comprised of both CSD and DMH executive, management, supervisory, lines staff, Parent Partners and Youth Partners. Outreach and training to county licensed caregivers (FFH), FFA and group home directors is occurring	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	through regional caregiver quarterly meetings and the FFA and group home directors' quarterly meetings. CSD and DMH staff are collaborating around grant opportunities to support our shared vision of family centered practice. During this reporting period, CSD and DMH leadership, along with a Parent Partner and Youth Partner, attended the Southern Regions Collaborative Meeting, held in San Bernardino and the State Convening, held in Sacramento. During the upcoming reporting period, efforts will include maintaining the progress noted in this section, early engagement and collaboration with parents, working to resolving any identified barriers to effective and timely services for children and families, continued outreach and training for caregivers, and collaboration with educational partners.	
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	Of the stakeholders who voted on Systems & Interagency Collaboration, 48.14% of the stakeholders indicated that CSD and DMH are continuing to develop in this area. Only 6.48% indicated that CSD and DMH are experiencing challenges in this area. The challenges identified by the stakeholders included: • More inclusion of school districts; through formal agreements • Increase collaboration with Parent Partners in all county regions • Provide a parent orientation prior to assessment • Notify families that they will be contacted by Mental Health prior to families being contacted to schedule a child assessment • Include collaboration with faith based organizations Joint agency bi-monthly planning meetings continue to be held following the State technical calls and monthly subcommittee meetings continue for identification of implementation barriers and recommendations for effective resolution of any barriers. Additionally, policy development continues. The Pathways to Wellness training curriculum was developed by training staff from both CSD and DMH and all child welfare social workers and mental health clinicians trained together in a collaborative training environment. A total of 631 social workers and 107 mental health clinicians have completed training. During this reporting period, the screening of children for mental health needs and the implementation of Child and Family Team Meetings (CFTs) have increased collaboration between CSD social workers and DMH mental health staff on behalf of children and families jointly served. CFT meetings will be operational in all seven (7) CSD regions by October 2014. CSD social workers and DMH mental health clinicians have reported the CFT meetings to be beneficial not only for the child and the family, but also for staff. CSD and DMH staff are describing CFT meetings as "non-adversarial",	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	productive and collaborative, and CSD social worker can be overheard sharing their positive experiences with other social workers following CFT meetings. The increasing collaboration for CSD and DMH staff at all levels has had a positive impact on our projected increase for children receiving ICC services from 90 during the last reporting period to 260 for this reporting period. The increase has also occurred for children receiving IHBS from 90 during last reporting period to 145 for this reporting period. Exciting has also been the resolution of confidentiality barriers that existed for child assessments and service planning. As a result of action by CSD County Counsel, Orders and Findings are now in place that allow for the Judicial Officers to order the sharing of information between CSD and DMH for the purpose of a child's mental health assessment and treatment needs.	
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	Of the stakeholders who voted on Systems Capacity progress and needs, 1.78% of the stakeholders indicated that CSD and DMH efforts are fully working in this area. 98.18% of stakeholders indicated that CSD and DMH efforts are continuing to develop in this area. None of the voting stakeholders indicated that our joint System Capacity efforts were not working. The collective strength of our administrative structure has been addressed in the sections above. Our workforce capacity is developing and progress has been made. During this report period, DMH Human Resources improvements have occurred, additional mental health clinicians have been hired and contracting with community providers has continued. During this reporting period, CSD has hired an additional 34 child welfare social workers and three Induction Trainings have been completed for social workers hired during the end of the October – April 2014 reporting period and this current reporting period. As of October 2014, all dependent children in child welfare will have a completed screening using the Mental Health Screening Tool (MHST). New children entering child welfare services will have a completed screening following the Detention Hearing. Mental health assessments and treatment services for children meeting subclass criteria are continuing to increase in all areas of the county, including the hard to serve Desert Region, where joint office space is being utilized. Outreach to caregivers will be an ongoing effort to ensure all children receive timely assessment and treatment services. During this review period, county licensed caregivers (FFH) where provided with an initial training for Pathways to Wellness at regional Quarterly Caregiver Meetings. Additionally, a Pathways to Wellness informing letter was sent to over 4,200 FFH, FFA and group home caregivers. This letter outlined for caregivers their roles and responsibilities to ensure that children and youth are participating in scheduled mental health assessments and any further identified mental health services, based on the outcome of the child's/youth's mental health assessment.	Yes. Funding needs and opportunities. Yes. Out of county service barriers that impact all counties.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	Outreach to our faith based community has resulted in an increase in 24 licensed county foster homes (FFH) during this reporting period. Joint agency outreach efforts will continue during the upcoming reporting period and efforts will include the recruitment of Intensive Treatment Foster Homes. Staffing needs for the implementation and long term success of Pathways to Wellness continues to be an ongoing challenge for both CSD and DMH. Additional facilitators will be needed to meet the demands of the increasing need for CFT meetings and additional clinicians will be needed to meet the increasing need for child and youth assessments and treatment services. During this reporting period, DMH claiming barriers were identified and resolved. Work continues to resolve any outstanding claims to be resubmitted.	
Service Array *Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.*	Of the stakeholders who voted on Service Array progress and needs, 5.66% indicated that CSD and DMH Service Array efforts are working and 94.33% of the stakeholders who voted indicated that Service Array efforts are continuing to develop. None of the voting stakeholders indicated that our joint Service Array efforts were not working. Services for African American families are available in the three primary areas of Riverside County, the west, mid and east county areas. Effective Black Parenting Services and service locations were presented to the stakeholders at the August 13, 2014, Stakeholders' Meeting. Stakeholders were responsive and positive regarding this service resource. Members of the African American Coalition offered their assistance with further community development and service efforts for African American families as we continue our Pathways to Wellness implementation efforts. Collaboration meetings will be planned for this upcoming reporting period. Riverside County has 12 Federally recognized Tribes in our county area. The Spirit Program is offered for Native American families who may come to the attention of either or both CSD and DMH. The Spirit Program is a promising practice based on the parenting program, Incredible Years. The Spirit Program is culturally relevant and designed to meet the needs of Native American families. Tribal partners have had limited participation in the bi-annual Stakeholders' Meetings. Therefore, outreach has been initiated and meetings with our Tribal partners will be set for October 2014 and continue through the next reporting period. Additionally, CSD and DMH staff will be provided the opportunity to present Pathways to Wellness implementation and progress at an upcoming Tribal Alliance Meeting. The Tribal Alliance is a joint meeting of Tribal leaders, Tribal members, Judicial officers, Law Enforcement, Probations, CSD, DMH, and other community partners. DMH continues to expand trauma informed services for children and youth, and both CSD and DMH continue to participate in the joint Wrap Around meetings with Wrap Around providers. During this reporting period, Wrap Around services have increased from 180 to 230 available slots and further expansion is expected during next reporting period.	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	Of the stakeholders who voted regarding efforts for Involvement of Children, Youth and Families, 2.08% indicated that CSD and DMH efforts to involve children, youth and families are working and 93.75% of the stakeholders who voted indicated that efforts to involve children, youth and families are continuing to develop. Only 4.16% of the stakeholders indicated that CSD and DMH are experiencing challenges in this area. The challenges identified by the stakeholders Included: • Continue to involve parents • Increase family voice and choice • Clear communication As noted in previous sections of this report, during this reporting period CSD and DMH have increased capacity to service children and parents through Wrap Around Services and TBS continues to serve the children and youth in a family setting. As Intensive Home Based Services increase, Parent Partners are a resource to provide these services to child, youth and families. DMH Parent Partners are now available to participate in CFTs to support the voice and choice of parents and CSD Youth Partners are available to participate in CFTs to support the voice and choice of the child or youth. Both, Youth and Parent Partners are available to meet with parents and youth for additional support when needed. Parent Parents and Youth Partners are members of the Pathways to Wellness implementation committees and they are actively involved in planning and training. Additionally, both a Parent Partner and a Youth Partner have attended Katie A. State and South Regions conferences. As CSD social workers and DMH clinicians are participating In CFTs and collaboratively engaging with families, staff are increasingly describing their awareness of parents as experts on their children and that parents are able to actively engage in planning for their child's needs. The increase in communication between staff, parents and children is promising for better reunification outcomes. During this upcoming reporting period, CSD and DMH will be working together to increase communication with children, youth and families at all junctures of the Pathways to Wellness process. A goal is to develop a survey for use with parents, youth and caregivers that includes both a quantitative and qualitative gathering of data to help ensure that the voice and choice of parents, youth and caregivers are incorporated and that needs are addressed at all levels of the Pathways to Wellness process.	
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	Of the stakeholders who voted on Cultural Responsiveness progress and needs, none of the stakeholders indicated that CSD and DMH efforts in this area are fully working yet. However, 95.55% of the stakeholders who voted indicated that Cultural Responsiveness efforts are continuing to develop and only 4.44% of the stakeholders indicated that CSD and DMH are experiencing challenges in this area. The challenges identified by the stakeholders Included: • Need to focus on the LGBTQ community	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	As noted in previous sections, during this reporting period, CSD and DMH joint efforts have included educating stakeholders on Effective Black Parenting as a service resource for African American families in our west, mid and east county areas. Additional outreach to African American community leaders is planned for this upcoming reporting period. Additionally, as already noted, outreach to Tribal leaders is also planned. Training is provided for all new CSD and DMH staff regarding cultural competency and there is planning for Cultural Humility training for social workers in the new year. CSD social workers are provided Native American and ICWA training during Induction Training. CSD has established ICWA designated social workers in all county regions and there is an ICWA unit to ensure collaborative efforts with local Tribal partners. DMH has established a Cultural Competency division to work within the community on behalf of children, families and other community members. In the upcoming reporting period, CSD and DMH will include outreach efforts to the LGBTQ community and to continue to development Pathways to Wellness materials in languages to meet the needs of our county's population.	
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	Of the stakeholders who voted on Outcomes and Evaluation progress and needs, none of the stakeholders indicated that CSD and DMH efforts in this section are not working. 95.55% of the stakeholders who voted indicated that Outcomes and Evaluation efforts are continuing to develop and only 4.44% of the stakeholders indicated that CSD and DMH are experiencing challenges in this area. Stakeholders did not provide any additional written feedback regarding what they would like to see further develop or change regarding joint Outcomes and Evaluation efforts. The CSD Data Analysis Unit and DMH Research and Evaluation have continued to work collaboratively during this reporting period. Data matching queries developed continued to allow for the joint sharing of data. Data is exchanged on a weekly basis. A matching process is used to identify those children currently open in both systems. This allows both departments to identify those children currently receiving mental health services. New mental health screens/referrals are documented in the RCDMH electronic system including the disposition of those referrals. This data is then used to monitor the new referrals for mental health assessments and the final disposition of those referrals. A monthly summary report has been developed to monitor the number of screens/referrals received, the number of referrals pending disposition, the number referred for treatment services and the number of children newly opened into mental health services. Currently in service and the service array is also included in the monthly summary. Additional reporting will include timeliness of entry into service from start of referral and outcomes of service.	Yes

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	Data collection has met the initial implementation needs, and a goal for the upcoming reporting period is to design and implement data collection and outcome measures to more fully inform practice. Purposed outcomes measures will focus on child access to services, child and family engagement in services, services appropriate to meet the needs of the child and within the family's community, effectiveness of services, and linkage for coordination of care.	
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	Stakeholders attending the August 13, 2014, Stakeholders' Meeting did not vote or provide written feedback regarding Pathways to Wellness Fiscal Resources. As noted in previous sections, approval was granted for additional Wrap Around services during this reporting period. Funding for Youth Partners continued and funding for additional facilitators has been identified. Additional CSD social workers and DMH clinicians have been hired and DMH provider contracting has continued. DMH staffing resources have also been reallocated to allow for identification and elimination of claiming barriers and data analysis. Both, CSD and DMH have fully committed to and invested in our joint Pathways to Wellness efforts through the use of fiscal resources for staff time, product development and training to ensure greater family centered practice and services. The fiscal resources follow the needs of the family. **Pathways to Wellness Stakeholders have been an important asset to our county's implementation process. Stakeholders have been consistent in their participation at Stakeholder Meeting, as reflected in attendance numbers of over 100 stakeholders per meeting. Stakeholder feedback has been invaluable and it has helped to hold us accountable in the areas of family centered practice, family voice and choice and cultural responsiveness. At the August 13, 2014, Stakeholders' Meeting, stakeholders not only shared with us the feedback noted in the sections of this report, but also provided us the with following positive regard: • Great Job! • A lot of work has been done and it shows • I really appreciate the participation of all of us • Coming together to receive feedback helps to see where I can contribute more • Although I did not contribute, I believe I would have been heard	