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

County: San Benito County **Date: May 1, 2014**

☒ May 1st Submission (September 1st through February 28th Reporting Period)

☐ October 1st Submission (March 1st through August 31st Reporting Period)

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Name and Contact Information County Mental Health Department Representative					
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County: San Benito County **Date: May 1, 2014**

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	41	
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	2	
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.	0	All children who were referred to the MHP for a full mental health assessment received a mental health assessment.
4	Potential subclass members who were unknown to the MHP during the reporting period.	12	These 12 children and youth were unknown to the MHP. Some of these children received mental health services from therapists in the community. Others did not receive mental health services. We have initially focused our program on CPS children and youth who were placed in our county. We will expand the number of children served in the next six-month period, including children who are placed out-of-county.

County: San Benito County **Date: May 1, 2014**

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	21	
2	Receiving Intensive Care Coordination (ICC).	4	
3	Receiving Intensive Home Based Services (IHBS).	4	
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.*	1	
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*	6	
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).	7	
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	3	
8	Declined to receive ICC or IHBS.	2	

County: San Benito County **Date: May 1, 2014**

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

PART C: Projected Services			
Item #	**Service**	**Projected number of subclass members to be receiving services by August 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	15	We plan to continue identifying, referring, assessing, and enrolling additional children and youth in our Katie A program. We expect this number to be at least 15 children and youth by August 31. These children and youth will all receive ICC services as a component of the program.
1 (b)	IHBS	15	We plan to continue identifying, referring, assessing, and enrolling additional children and youth in our Katie A program. We expect this number to be at least 15 children and youth by August 31. These children and youth will all receive IHBS services as a component of the program.

Is your county experiencing the following implementation barriers?

Hiring	***Yes***	No
Training	Yes	***No***
Service Availability	Yes	***No***
County Contracting Process	Yes	***No***

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

We have had a number of staff leave our CWS program in the past few months. As a result, we are recruiting new staff. It is difficult to recruit new staff in this small, rural community.

County: San Benito County **Reporting Period:** September 1st through February 28th **Date Completed:** May 1, 2014

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the state is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county's child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Agency Leadership *Leadership's experience implementing family-centered services in a collaborative setting.*	Our leadership has a shared vision of family centered care. We are aligning with shared treatment goals and are open to what the family wants. The CFT listens closely to the family's voice and vision. Child Welfare has had trainings for staff two times a month to help develop skills in holding effective Family Team Meetings. We are still developing the process for having the families attend trainings and helping families have a meaningful role in oversight of services and quality improvement activities. We need assistance in helping to define the family's role in these activities. We are working together to discuss issues affecting access to services. For example, for families who need counseling, but are not eligible for Medi-Cal, are having difficulty paying for the fees required from Behavioral Health's sliding fee scale. As a result, they are not making timely payments and are getting invoices for the counseling services. This is causing the families stress and it may impact their access to services. Currently, CWS is not able to pay the family's co-pay share of cost. Leadership is discussing how to address this issue.	Y
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	We have held two Katie A trainings for both agencies combined. This was very effective in having staff learn together, hear questions from each agency, and help them gain a better understanding of the challenges and issues for each program. We have developed a shared Consent, Release of Information, and confidentiality forms and identified who can sign these forms (in each situation). We have also worked with our courts to have this issue addressed in court reports. We are implementing Safety Organized Practice which fully supports collaboration and coordination of services. We are working on identifying which	Y

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	court materials are most effective to share with mental health staff, to inform them of the child's history, and provide important information for developing the clinical Treatment Plan. Similarly, we are developing a methodology for providing ongoing, periodic status reports on the child and/or family's therapeutic progress in counseling so the CW staff are aware of progress in treatment.	
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	We have identified a Mental Health Screening Tool (MHST) which will be used to screen all CW children for possible mental health needs. We are planning on training CW staff to utilize this tool, and the process for making referrals to mental health services. Staff are trained on using the Core Practice Model and Safety Organized Practice, to help implement this Evidence-Based Practice. All six clinicians are scheduled to attend training on Trauma-Focused CBT in the next month. We have recently experienced reduced wages during in the labor negotiations. As a result, we have lost some newly hired and existing staff. We are a small county with low wages, and surrounded by bay area counties which have planned 3-year raises and improved benefits. CWS is finding it difficult to compete with the higher salary and benefit packages offered by surrounding counties. In child welfare, we have a high ratio of bi-lingual, bi-cultural staff. In mental health, we have been successful at hiring additional bilingual, bicultural clinical staff. This is especially important in this county with a population of 60% Hispanic.	Y
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.*	Our collaboration has been extremely effective at working together to identify alternatives to placement and utilizing lower levels of care. Our shared vision, teams talking together about every case, and shared collaboration and responsibility has created an important cultural shift for our children and families. We have scheduled staff to attend training on Trauma Focused CBT. We are also utilizing Safety Organized Practice and Family Team Meeting models to conduct our Child and Family Team (CFT) meetings. These promising practices help us to improve our services and achieve positive outcomes.	Y
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	We had an excellent training from Lake County on how to utilize Parent Partners in engaging and supporting families during the CPS process. We have also been working to have youth and family members involved in our system planning meetings. We have offered training to both family members and youth who are interested in being Peer Advocates/Parent Partners with our youth and families. Our youth are also involved in our ILP program and are setting their goals for their future. The ILP program is working with the youth to make their goals happen. We are also training staff to utilize Family Team Meetings and Child and Family Teams to shift the role of the family and youth to be the leaders and decision makers on the team. We hope to offer a Parent Support Group to bring families together, provide mentoring and support, to help families and youth become	Y

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	involved and support their role as informed decision makers.	
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	Cultural responsiveness has been a high priority for both CW and MH over the past 20 years. This community is 60% Hispanic and it is critical for our services to be culturally relevant and available in both English and Spanish. We have a number of bilingual, bi cultural CW and MH staff to deliver culturally competent services. We verbally translate CW court reports and court orders to the family members in Spanish. In addition, we translate all Case Plans for monolingual Spanish-speaking families. The mental health treatment plans are now also translated for Spanish-speaking family members.	Y
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	We are developing evaluation plans to define data elements needed to create measurable performance indicators. We collect data to measure key outcomes across time, including stability in living arrangement, length of time in out-of-home placement, number and percent of reunifications, placements with family, improved education and/or employment, and improved health. We utilize data to inform managers and use it to improve quality of services. Satisfaction surveys will be collected at least annually to help improve services.	Y
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	We are collaborating to develop shared fiscal agreements, commitment of funds to support the needs of children and families, and developing strategies for tracking the cost of mental health services for children in the CW system. We plan to develop this area of our system in the next year, after we have fully developed and implemented the Core Practice Model and related Medi-Cal funding categories.	Y