County: San Francisco **Date: 10/23/2014**

☐ 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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County: San Francisco **Date: 10/23/2014**

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	224	This is our new batch of potential subclass members that need to be assessed for SMS. Currently 130 of them are already receiving some Mental Health Services. They are currently being reassessed to see if they need additional services like ICC and IHBS
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.		See above
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.		See above
4	Potential subclass members who were unknown to the MHP during the reporting period.	38	

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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	220	
2	Receiving Intensive Care Coordination (ICC).	185	
3	Receiving Intensive Home Based Services (IHBS).	179	
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.*	0	
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*	0	A number of our subclass clients also receive TBS with ICC and IHBS
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).	35	This is our residential level 12 and 14 subclass members that we cannot bill ICC and IHBS for
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	0	Don't have this information
8	Declined to receive ICC or IHBS.	15	This is mostly our TAY population.

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

PART C: Projected Services			
Item #	**Service**	**Projected number of subclass members to be receiving services by August 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	200	
1 (b)	IHBS	200	

Is your county experiencing the following implementation barriers?

Hiring	Yesx	No
Training	Yes	Nox
Service Availability	Yes	Nox
County Contracting Process	Yes	Nox

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

Hi we continue to experience some difficulty in hiring. This is because our civil service system moves very slowly. We have managed to get some positions approved and are trying to staff them

County: San Francisco **Reporting Period:** 3/1/14-8/31/14 **Date Completed:** October 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 county has strong leadership experience in implementing family centered services and an engaged executive leadership team involved with the Katie A. implementation specifically. Both CBHS and HSA have strong commitments to family centered services. We are currently cross training in Safety Organized Practices and Trauma Informed Systems of Care.	N
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	HSA and CBHS as well as parent partners from both agencies are involved in the Child and Family Team meetings. We currently have a workgroup composed of members from both agencies and a consultant to work on designing a shared care plan.	N
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	HSA and Behavioral Health have collaborated for many years to fund the Foster Care Mental Health Program, which operates as the managed care mental health program for children involved with child welfare. With the initiation of Katie A. (IASC) programming we have expanded our capacity dramatically. This has improved our ability to screen and assess children and youth in a timely manner for medical necessity. We have been working on increasing this capacity; however, due to the civil service system we continue to have some ongoing challenges re timely hiring of staff. Foster care mental health unit has been redesigned to build capacity, increase effectiveness and provide better oversight to the quality of care for children and youth. Together SFHSA and CBHS have: • Established three mental health care coordinators who will follow clients throughout their time in the system. One coordinator is hired and the other two positions are yet to be filled.	N

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	• Given the unique nature of San Francisco's foster care population, as over 60% are placed out of county, CBHS has expanded some of our contracts with CBOs who provide services to allow for greater geographic reach and flexibility to our child welfare population. • SFHSA hired a program analyst to help support the cross system programming and data analysis necessary for full implementation of Katie A.; this position was filled in mid-September.	
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.*	San Francisco is a leader in providing Trauma Informed Care. Trainings are regularly being held across all child serving agencies in the county. Child Welfare uses Safety Organized Practices and CBHS is currently being trained in this model. CBHS has a wide array of evidence based practices, and culturally adapted practices to meet the needs of our youth and families. We are always seeking to improve our service array and will continue to look at practices that have been or could be effective. Both agencies have a strong commitment to culturally responsive service delivery.	N
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	Parent partners attend all CFTs. Families are also encouraged to invite whomever they would like as to bring as natural supports to CFTs.	N
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	San Francisco has a strong commitment to cultural competence and humility. There is a continuous effort to hire staff that reflect the communities we work in. In addition there are ongoing trainings to address cultural competence, awareness and humility. We acknowledge that it is impossible to be completely competent in someone else's culture. San Francisco therefore focuses on training in Cultural Humility and the importance of curiosity, conversation, relationship and understanding. It is always a challenge to make sure that our work force best reflects the population we serve, a challenge San Francisco takes seriously. SFHSA's extensive implementation of Safety Organized Practice (SOP) will help ensure cultural responsiveness, as the heart of this approach is a focus on collaboratively created goals that describe what child welfare needs to see to close the case AND the family's ideas and ways of creating safety. In addition to joint child welfare and mental health trainings on SOP, the iASC (Katie A) pilot team is currently drafting shared mental health and child welfare care/case plans which will reflect an SOP framework in the CFTs.	N

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	San Francisco is challenged in data collection and data sharing between the two county systems. We have improved the cross system data collection and developed specific plans to continue to work towards greater integration and access to data. At this point we rely on manual methodologies to insure we are on track. In the future we hope to improve our electronic capacity to share and use data across systems. As described above, SFHSA recently hired a program analyst to assist with this given the extensive time required to correctly identify and analyze the data.	Yes if there are some experts familiar with our data systems and challenges (CWS/CMS, CalWIN and Avatar).
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	Behavioral Health and Human Services Agency have worked together to ensure transparency about our resources and to share responsibility for fiscal decisions. Thus far we have effectively and collaboratively managed the resources necessary for expansion of mental health services through joint planning and work orders from SFHSA to CBHS. At the same time it is unclear if more epsdt realignment will fully support the required capacity. San Francisco has signed the MOU to become a IV-E waiver county, which will help with funding flexibility.	N