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

County: San Luis Obispo **Date: 9/27/14**

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: San Luis Obispo **Date: 9/27/14**

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	163	The information in this reporting section was gained in consultation with the DSS manager in charge of Katie A. We collaborated together in our monthly meetings and on the phone often to determine the numbers for all of part A and discuss the explanations. Out of 420 referrals since we started the data base (not just the reporting period), 106 are currently identified as subclass and 57 additional met one the criteria identified in the clarifications memo. In this reporting period the data base received 235 referrals and SW's are putting all DSS eligibility referrals into the data base including cases that are not asking for MH services so they can keep track and make sure all referrals have been screened. This was also to make sure that both agencies were able to look at the referrals and provide information to each other.
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	9	This information is communicated back to the DSS SW by phone or in person so that the MH therapist can also discuss recommended referrals if needed. The MH regional program supervisor also updates the data base and sends an email via the data base back to the referring SW. All SW's are encouraged to re-refer should there be a negative change in

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			their child's emotions/behaviors. If the child was recently assessed MH would do an assessment update to expedite services as needed.
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.	2	These clients were referred by DSS 8/18/14. MH's standard for routine referrals is to have an assessment within 14 days of when the SW contacts our Managed Care to set an assessment date. In this sibling case the parent choose to delay the appointment time. One sibling has been qualified for MHS however not Subclass at this time. The other sibling's case is pending.
4	Potential subclass members who were unknown to the MHP during the reporting period.	10	Child Welfare's procedure is to refer immediately if needed and no later than 2 weeks. As we were ramping up it was estimated that up to 20 new referrals came into the data base monthly. However now that we are established it is estimated that approximately 10 new referrals come into the shared data base monthly and not all of those are requesting a MH assessment and some may already be open to MH. Each time a referral is made by DSS the MH Program Supervisors receive an email stating that a referral is in so we can stay on top of the referrals.

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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	106	This comes from the joint data base.
2	Receiving Intensive Care Coordination (ICC).	84	This data represents that the MH staff has completed a progress note for ICC in our Electronic Health Record or our contractors have submitted their billing for ICC.
3	Receiving Intensive Home Based Services (IHBS).	56	This data represents what our contractor has submitted for their billing of IHBS.
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.*	8	This number is a hand counted and researched number. This number represents cases that are in Wrap Around. It is our intent that all Wrap Around cases will be receiving ICC and IHBS. As we were transitioning and formalizing our processes some cases were closing from DSS and Wrap Around and on these cases we did not do ICC These cases, however, were done consistent with the CPM. Our process is to notify our contract providers of a client's Katie A status and then they work to change their treatment plans to add ICC and IHBS in collaboration with the family. This is a coordination and training issue that we are working on.
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	This number is a hand counted and researched number. There are 2 Katie A clients that are in a group home and received TBS however we are not billing ICC as they are not in the discharge phase of their placement. 5 clients (plus 1 counted above) are placed in group home care and receiving Day Treatment Services MH provides case management and will not bill ICC until the client is in the 30 day

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			discharge period.
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).	6	This number is a hand counted and researched number. 3 clients are in a local RCL 12 that meet Katie A subclass and MH provides case management services to those clients and if needed medication support. MH will provide ICC 30 days prior to discharge from the group home. For the remaining 3 clients they are receiving MHS and staff are in process of adding ICC to the treatment plan and IHBS if needed.
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	0	It is possible that those families that declined to receive MHS may access other mental health services outside of Medi-Cal however we are unaware of any such case.
8	Declined to receive ICC or IHBS.	2	

PART C: Projected Services

Item #	Service	Projected number of subclass members to be receiving services by February 28th	Strategy/Timeline Description Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.

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

1 (a)	ICC	116	This number fluctuates because at anyone time we will have clients that end Katie A services if the Child Welfare case closes. Our estimate is based on what we have right now which we feel is fairly accurate as far as numbers of subclass. As a double check we receive a monthly email regarding when DSS closes cases and the expectation is this would be discussed as part of the Child Family Teams /ICC services
1 (b)	IHBS	60	This number fluctuates because at anyone time we will have clients that end Katie A services if the Child Welfare case closes and as services titrate off. Our estimate is based on what we have right now which we feel is fairly accurate as far as numbers of subclass. As a double check we receive a monthly email regarding when DSS closes cases and the expectation is this would be discussed as part of the Child Family Teams /ICC services.

Is your county experiencing the following implementation barriers?

Hiring	Yes	xNo
Training	Yes	xNo
Service Availability	Yes	xNo
County Contracting Process	Yes	xNo

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

County: San Luis Obispo **Reporting Period: March 1 – Aug 31st 2014** **Date Completed: 9/27/14**

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.*	Children's System of Care, Wrap around, the SAFE (Systems Affirming Family Empowerment) System of Care, and MHSA FSP (Full Service Partnership) promotes trauma informed, client driven, strength based, family empowerment, multiagency inclusion in the development of a client/family plan. This reporting period we have been meeting regularly with our multiagency partners as part of a "Management Support Team" exploring and gathering commitments in the form of MOU's to continue to provide a wide range of family driven services. There have been continued efforts to align the different areas of our county (North, Central, Coast, and South County) in an effort to serve families with the philosophy of the "Core Practice Model". Mental Health has provided two staff (one added in the beginning of Katie A) to coordinate with the agencies in the North, Central and Coast areas in an effort to bring consistency in service mirroring a well established program in our South County. The Department of Social Services "DSS" has also commented staff to each area of the county to be a part of these interagency teams and is a consistent member and voice at the table. Mental Health has our 3 regional Katie A teams co-located with Child Welfare Social Workers and during this reporting period it was discovered that our North County had more need than originally thought and the Central region had less need. MH reassigned the Central team to cover the North County half of their time to meet the demand of referrals. The Department of Social Services, Probation's Juvenile Placement Services and our community prevention providers put on four forums though out our community as part of their Child and Family Review process. Several Mental Health Supervisors and staff participated in these forums as stakeholders and as part of seeking input from partner agencies, parents and youth. The	N

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	focus of the forums were to look at the current services provided to families and youth in the community, receive feedback and use the information to guide decisions regarding funding of programs. DSS is in the process of training social workers on how to incorporate Safety Organized Practice into the Child and Family Team by discussing the Harm and Danger statements along with generating the case plan with the family to be submitted at the dispositional hearing. Mental Health has recently completed a "GAP" survey of staff and community in an effort to guide decisions of future planning, results are currently being compiled.	
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	Mental Health, Department or Social Services management, Family Care Network, Inc. "FCNI" (contractor) and supervisory staff have continued to meet monthly for this reporting period to continue to refine our processes and receive feedback from each other as to any barriers that are coming up in providing services to families. At the start of our implementation of Katie A we had identified our SAFE System of Care site meetings as an option for CFT's with Katie A identified subclass clients however this has not been utilized in this way. SAFE meetings are aligned with the values of the "Core Practice Model" and continue to be an option where families can access multiagency members of the community (social workers, therapists, teachers, probation officers, family advocates, etc.) to have strength based discussion of their needs. SAFE meetings are utilized more as a preventative effort to provide services that the family needs in an effort to avoid a family entering the system. Wrap, FSP, the Katie A teams and clinic based Mental Health therapists continue to provide ICC. Wrap, FSP and the Katie A teams have staff as part of their team that provide IHBS and are seen as the resource for clients/families that have the most intensive needs. Coming from a trauma informed approach that not all clients should be switched to an intensive team, all Mental Health therapists can provide ICC and access IHBS for their clients/families and this process has been established during this period.	N
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	As stated previously, the Department of Social Services has created a joint data base that has been approved by county counsel that allows for DSS to initiate a KA eligibility assessment which triggers a mental health assessment and the collaborative process. The Department of Social Services continues to refine this data base to meet both MH and DSS needs such as adding fields to make it easier to identify geographical areas that clients are located to assist in quicker identification of K A subclass. Mental Health hired 3 new staff at the time of implementation and reassigned a therapist and part of a program supervisor to implement KA. The Mental Health Program Supervisor was previously the supervisor that had created the county's FSP program based in the philosophy of "Wellness, Recovery and Resiliency" and was a natural choice to implement KA. The reassigned staff has a history of working in collaborative settings providing home and school based therapy services and now is the SAFE Coordinator as well as facilitator of CFT's. All KA team staff elected to change to the K A team. The KA team has provided trainings to the different Mental Health Clinics and to Social Workers regarding the "Core Practice Model". All regional MH Program Supervisors and our	Y

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	Managed Care team have been trained in how to utilize the data base for identifying KA subclass and a procedure created for all DSS referrals to Mental Health to come through the data base. This facilitates greater and quicker access to assessments at regional clinics. Mental Health and it's contractor has also modeled the access to IHBS similar to our TBS procedure to assist in easy access for staff so as not to create a barrier for families in need of this service. Behavioral Health and coordination with our Public Health staff recently started a new on boarding process for new Health Agency staff. This on boarding is currently a one day process however is planned to grow to include training in trauma informed care, cultural competence and other agency specific areas of training.	
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.*	DSS in collaboration with FCN provided on opportunity for selected Social Workers, FCNI staff and Mental Health staff to participate in a 3 day trauma informed train the trainer training in 2011. Since that time the County has had a multiagency team who has provided "Trauma Informed Care" trainings to different agency partners (schools, probation, Behavioral Health staff, foster parents, etc.). The Mental Health staff coordinator of this team, K A Supervisor and CWS SW's attended the "Fostering Trauma-Informed Care in Child Welfare and Behavioral Health: Training for Trainers" held in May of 2014. This provided helpful input regarding the structuring of trainings. This team is in the process of scheduling trainings where all agencies can attend to support collaboration amongst agencies. Behavioral Health, DSS and our partner agencies utilize a number of evidenced based practices dealing with trauma, attachment, family systems, school based services, etc. Some practices that are used (Trauma Focused Cognitive Behavioral Treatment, Love & Logic, Seven Challenges, Theraplay, Positive Behavior intervention and Supports and Restorative Justice). DSS, Mental Health and our agency partners in the community make it a priority to function effectively within the context of the cultural beliefs, behaviors and needs presented by our clients/families and community. We emphasize cultural humility and providing culturally appropriate services and work to infuse cultural competency in all areas of our organizations including meetings, client services, and interagency discussions. DSS, MH, Probation and the court emphasize community based treatment and continue to focus on reducing even further the number of out of home placements. DSS workers do a good job of referring to MH and coordinating efforts to keep children in the community.	Y
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	Our county has been providing Wrap around, FSP, Treatment Foster Care, and the SAFE system of care for many years which are all family centered systems and had a CFT process in place. As well as MH therapists in the clinics, in collaboration with the family, had meetings that also would be considered CFT's on an as needed basis. In the last year DSS has added Safety Organized Practice and, with MH, Katie A which has formalized these processes and the structure of the CFT. Providing culturally competent, strength based,	Y

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	client and family centered intervention is a core value within our Multiagency Children's System of Care. Mental Health's treatment planning process requires client family driven treatment planning, decision making about how services are delivered and opportunities to provide feedback and modify plans as needed. DSS has also had this in place as our partner in SAFE and now they have added another component with Safety Organized Practice.	
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	DSS and MH have placed a major emphasis on cultural competency. Both agencies believe the family is the expert on the needs of their family. Our job is to listen using the concept of cultural humility, respect and facilitate the help they are requesting. We have bilingual capacity in several areas and programs if our county (Wrap Around, Day Treatment, SAFE, Clinics) but we do need more. Our hiring practice is to recruit bilingual preferred staff and we have had some limited success. Each year San Luis Obispo has at least 2 Cultural Competence trainings that are open to the community of service providers and consumers. From our last Cultural Competence training we have a plan to get interpreters, possibly using promontories and providing training to them. We have also met with our Latino Outreach program and Cal Poly University, discussing county opportunities for graduates in the masters program. We have also wanted to pursue potential training curriculum at our local community college. We welcome technical support re: recruitment and retention of bilingual/bicultural staff. Also, any community colleges that may have a curriculum that they would be willing share or contacts would be helpful.	Y
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	DSS has a robust data collection system. The DSS net is the data base that all DSS referrals for Mental Health now go through and together we have refined the system to gather the information we need each of our agencies. MH is continuing to improve our data collection system utilizing our Cerner Electronic Health Record. We will continue to use the System of Care outcomes of reduction of group home placement and incarcerations, school attendance, and reduced psychiatric hospitalizations until we receive further guidance from the state. At the same time however we are in conversation with John Lyons to set a train the trainer training for CANS/ANSA in December 2014. We continue to use data to inform our decisions about staff deployment, program effectiveness, productivity and access.	Y
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	Our County has a long standing history of collaborative relationships with multiple agencies; DSS, Probation, County Office of Education, Individual School Districts, and other service providers such as Child Development Resource Center. In our interagency Placement Committee meetings family-centered services are the focus of all the agencies. Mental Health has contracted for many years with Family Care Network to deliver Medi-Cal/MHS for Wrap, THP, Foster care, TBS and rehabilitation specialists in school programs. DSS just held their Child and Family Review Process which is used to make fiscal decisions	N

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	that support family-centered services. DSS has helped expand services by paying the Medi-Cal match to expand Wrap Around slots, enhance assessment capacity and service capacity for some mental health programs. Our Board of Supervisors have supported the multiagency in service expansion due to our positive outcomes of reducing reliance on group home care and providing community based services that help keep children in their home, school and in the community. Mental Health fiscal decisions are done with input from our management team keeping our goal of supporting family-centered services on the forefront of our decision making.	