

County: _____

Date: _____

- 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					
Name:					
Title:					
Agency Name:					
Address:					
City:		State:		Zip Code:	
Phone:		E-mail:			

Name and Contact Information County Mental Health Department Representative					
Name:					
Title:					
Agency Name:					
Address:					
City:		State:		Zip Code:	
Phone:		E-mail:			

County: _____

Date: _____

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		
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.		
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.		
4	Potential subclass members who were unknown to the MHP during the reporting period.		

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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		
2	Receiving Intensive Care Coordination (ICC).		
3	Receiving Intensive Home Based Services (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. <i>Do not include youth already counted in 2 or 3 above.</i>		
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). <i>Do not include youth already counted in 2, 3, or 4</i>		
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	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).		
8	Declined to receive ICC or IHBS.		

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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		
1 (b)	IHBS		

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.

County: Sonoma

Reporting Period: Sept 1, 2013 – February 28, 2014

Date Completed: April 28, 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)
<p>Agency Leadership <i>Leadership’s experience implementing family-centered services in a collaborative setting.</i></p>	<p>Inter Agency Leadership Human Service Division (HSD) and Behavioral Health Division (BHD) leadership continue to meet regularly as a steering group in order to accomplish:</p> <ul style="list-style-type: none"> • Continuous opportunity for collaboration across systems • To identify system barriers and remove obstacles to ensure timeliness to services and support family centered and client focused care • A new Memorandum of Understanding (MOU) that will further integrate MH and HSD by co-locating additional BHD staff at HSD • Cross-system information sharing and shared problem solving • Identify opportunities for families and other collaborative partners to meaningfully participate in the above activities • Explore alternative funding sources to support the provision of services 	<p>No</p>
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>	<p>Inter Agency Collaboration HSD and BHD have established additional workgroups made up of all levels of management and staff in order to:</p> <ul style="list-style-type: none"> • Create joint trainings in the Core Practice Model. To that end the Northern CA Training Academy has been in discussions with HSD and BHD to develop joint training for the HSD, MH and contract staff. 	<p>No</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<ul style="list-style-type: none"> • Develop structures to provide feedback from stakeholders to improve joint accountability • Develop opportunities for staff of both agencies to work together to decrease barriers for providing family focused care and to be responsive to family strengths and needs • Review current data systems to identify changes required of administrative practices in order to meet settlement obligations. <ul style="list-style-type: none"> ○ Tracking timeliness of referrals to services ○ Tracking barriers for families engaging in care ○ Developing a system wide communication process to ensure referrals are being made for all potential sub-class members • Review systems and address barriers in order to fully integrate the mental health team in the child welfare structures and teams at every level • Sonoma County has continued to co-locate BHD staff with key HSD programs and locations during this reporting period and will be adding additional co-located staff in the next reporting period: <p>Community Collaboration</p> <p>During this reporting period HSD and BHD has continued to leverage existing collaborations with community providers. Many of these collaborations are explained in detail in the Sonoma County Service Delivery Plan submitted to the Department of Health Care Services in June 2013. HSD and BHD meet regularly with the following groups to receive feedback and provide updates about the Katie A. settlement agreement:</p> <ul style="list-style-type: none"> • HSD and BHD coordinate Sonoma County Youth and Family Partnership (Partnership). Partnership meetings that bring together staff from agencies throughout Sonoma County, including Sonoma County Office of Education, mental health, child welfare and Juvenile Probation. • BHD brings together the Birth to Age 5 Collaborative. HSD is a major partner in this Collaborative. This group comes together as a result of Mental Health Services Act funding for mental health prevention and early intervention services and screening targeting children from birth to age 5 and their families. Participants in this group are service providers who specialize in services to this specific age group and work with families and children in foster care. Participating community organizations include, California Parenting Institute, Early Learning Institute, Petaluma People Services Centers, Jewish Family and Children’s Services, as well as HSD and BHD, First 5 Sonoma County, Department of Health Services Maternal, Child, and Adolescent Health, and foster parents to these young children 	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p>Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i></p>	<p>During this reporting period:</p> <ul style="list-style-type: none"> MH and HSD staff will be trained in Trauma Informed Care, receive further training in Core Practice Model concepts, including improved implementation strategies of ICC and IHBS services; All trainings will be guided by culturally relevant values and strength based family involvement. An additional model that is being considered is Attachment, Self-Regulation, and Competency (ARC). ARC which is evidence based, cost effective practice that can be used for children and youth. BHD is continuing to explore implementation of ARC in a manner that would make it sustainable through the use of a train-the-trainer model. BHD and HSD leadership is discussing funding for this training with First 5 Sonoma County. BHD continues to co-locate licensed Mental Health Liaisons at HSD and Valley of the Moon to screen and assess children and youth to determine whether a foster child is part of the sub class. As noted above a Human Services Mental Health team is being established that will house additional MH staff at HSD and enable staff to provide better coordinated and collaborative services for the youth and their families. HSD and MH staff continued to work closely with Early Learning Institute to ensure children from birth to 5 years of age receive screening and appropriate services. 	<p>NO</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>Sonoma County services are built on a foundation of being culturally responsive and responsive to the strengths and needs of children and families.</p> <ul style="list-style-type: none"> BHD has used Evidenced Based screening tools and assessments for some time. Specifically, BHD uses evidence based screenings and assessments to identify sub-class members and their level of care. Ages and Stages Questionnaire- Social Emotional (ASQ-SE) is used for children age 5 years and younger; Child & Adolescent Needs and Strengths Assessment (CANS) for children and youth age 5 to 18, and the Adult Needs and Strengths Assessment (ANSA) for transition age youth ages 18 through 21 years. HSD is in the planning stages of implementing training for HSD staff in the use of the CANS screening tool. Having the same screening tool will increase clearer communication, improve understanding and the ability to respond collaboratively to each child’s unique needs. BHD staff provides mental health services, including individual and rehab therapy that is culturally responsive, community based and inclusive of family, siblings and other supports. In addition they provide parent education and training. BHD is exploring the implementation of Evidence Based Practices that will more specifically address the needs of the children and their families 	<p>NO</p>
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered</i></p>	<p>Family Centered Practices Prior to this reporting period HSD implemented an evidence based “access-linkage” model</p>	<p>No</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p><i>principles are reflected in current systems.</i></p>	<p>identified to be effective in the delivery of services to families who present with multiple co-occurring problems: <i>Together to Engage, Act and Motivate - (TEAM)</i>. TEAM staff employs effective strategies including facilitating multi-disciplinary, family-involved, team meetings, outreach to families, advocacy, and service coordination with all youth coming into the foster care system.</p> <ul style="list-style-type: none"> • Since June 2013, there have been 240 Child and Family teams, attended by mental health after a screening that has determined the need for further mental health assessment. • Family and children are involved in every point of the decision making and engaged in the design of every aspect of the service plan. • Members of the CFT have included clergy, family elders, ILP coordinators, friends and anyone else of the child or family’s choosing. • During this reporting period BHD continued to provide “like” services, including Wrap Around, collateral services with families; assertive , to sub-class members, these services embody the principles of the Core Practice Model and are family centered, individualized, culturally relevant and strength based, designed to ameliorate mental health conditions that interfere with a child’s successful functioning in the home and community. Services are administered by a team in a community based setting, and rely on natural community supports to develop a child and family services plan. 	
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></p>	<p>Cultural Diversity and Responsiveness</p> <ul style="list-style-type: none"> • All services and Child Family Teams are provided in the families preferred language. • BHD has added additional Spanish speaking staff since the last progress report. The goal for the Division is to hire a behavioral health workforce that matches the diversity of Sonoma County’s population for staff to be responsive to and reflect the makeup of the community and clients. To that end, BHD continues to actively recruit, hire, train, and support staff to meet this goal. • As a behavioral health organization, BHD has various regulatory requirements to provide services that are responsive to the diverse cultures within our community. These regulations are promulgated as part of the Mental Health Plan and the administration of substance use disorders services, as well as through the Guiding Principles that direct services in the Mental Health Services Act. BHD works from a fully developed comprehensive cultural competency plan in order to meet the cultural specific needs that exist in the community. • As noted above, the training of ARC - Attachment, Self-Regulation, and Competency – is still in the planning phase. However this model is under consideration because of how it outlines cultural considerations vis a vis engagement, language, symptom expression, 	<p>NO</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>assessment measures, cultural adaptations, intervention delivery method/transportability, and outreach, and training issues.</p> <p>Partnering</p> <ul style="list-style-type: none"> • HSD continues its ongoing bi-monthly Indian Child Welfare Act meeting with local tribes. • BHD and HSD staff meets monthly at the Latino Services Providers network meeting. • HSD and BHD works closely with VOICES (a peer run drop in center serving transition-aged youth emancipating from foster care) at meetings . 	
<p>Outcomes and Evaluation</p> <p><i>The strength of current data collection practices, and how outcomes data is used to inform programs and practice.</i></p>	<p>Data Collection</p> <ul style="list-style-type: none"> • During this reporting period BHD and FY&C used EXCEL spreadsheets to track service delivery for dependents. • BHD is currently mid-process for implementation of an electronic health record, AVATAR. AVATAR is currently testing a Katie A tracking and claiming • Screening of all new dependents was completed by December 2013 and is continuing. • Tracking continues of the number of youth from HSD who are screened; dates of assessments; level of care recommendations; whether services were received and barriers if services weren't received, for Katie A class and subclass youth. • TEAM participation , invitation, reasons for non-attendance and barriers for family, youth or support systems are tracked by HSD • A workgroup comprised of leadership from HSD and BHD has been initiated to create improved structures for compiling data 	<p>NO</p>
<p>Fiscal Resources</p> <p><i>How fiscal policies, practices, and expertise support family-centered services.</i></p>	<p>Funding</p> <ul style="list-style-type: none"> • Despite lack of state funding the county agencies are creatively using available resources to implement new and promising practices and explore evidence based practices • BHD and FY&C leadership is expert at leveraging multiple funding sources to launch settlement agreement services. Currently: <ul style="list-style-type: none"> • BHD leverages Mental Health Services Act – Prevention and Early Intervention funding blended with First 5 dollars to fund Early Learning Institute administration of the evidence based ASQ-SE screenings. • BHD uses Behavioral Health Account to fund the cost for co-location of staff at FY&C to provide evidence based screening to all foster youth between the ages of 5 and 18. • While these funding sources have worked to implement Katie A settlement agreement services, more funding may be need to be allocated to Sonoma County's 	

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	<p>Behavioral Health Account. BHD looks to Department of Health Care Services (DHCS) to provide stable ongoing funding for these non-MediCal billable services.</p> <ul style="list-style-type: none"> • During this reporting period, HSD and BHD continues to work with First 5 Sonoma County to fund a sustainable, evidence based practice that will support family centered, trauma- informed services. • Immediately prior to this reporting period (July 1, 2013) BHD began claiming for “like” services through Avatar. In order to claim Katie A services through AVATAR, Sonoma County will need purchase the Enhancement. To make this purchase of this unanticipated expense, more funds will need to be allocated to the Behavioral Health Account. <p>Workforce</p> <p>BHD assessed workforce need based upon projected numbers of sub-class members. As a result of these projections, BHD will need to hire up to 4 additional new staff to meet the obligation of providing the services with fidelity to the Core Practice Model. Additional funds may need to be allocated to the Behavioral Health Account to pay for these new staff, particularly to provide the services that are not MediCal reimbursable.</p>	