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

County: San Diego **Date: 04-01-2015**

X April 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 Diego **Date: 04-01-2015**

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	1353	CWS data is pulled and compared to MHP data on an ongoing basis to identify children/youth not otherwise captured and in need of screening and possible assessment.
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	389	Youth who have been assessed by the MHP to meet criteria for "Class" and are receiving appropriate mental health services. These clients will be reassessed for Katie A subclass eligibility throughout their mental health treatment.
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	During this past reporting period, the MHP has had capacity to assess all CWS youth referred for mental health services.
4	Potential subclass members who were unknown to the MHP during the reporting period.	166	Case review, screening and assessment for the children/youth identified for this reporting period is underway.

County: San Diego **Date: 04-01-2015**

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	798	Includes 76 members who received Care Coordination by CWS.
2	Receiving Intensive Care Coordination (ICC).	630	Includes 76 members who received Care Coordination by CWS. MHP continues to train and monitor contracted providers to ensure that all subclass members are offered ICC.
3	Receiving Intensive Home Based Services (IHBS).	166	Approximately 20% of subclass members received IHBS. MHP is working with contracted providers to ensure that IHBS is provided to youth outside of a group home that are transitioning to a permanent home environment.
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.*	4	BHS has been working with Wraparound and FSP providers to ensure subclass members receive the appropriate services resulting in a decreased number of subclass members who are identified in this category from prior reporting period.
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*	65	The youth are primarily receiving mental health services in a group home setting where ICC claims are a lockout. However, these subclass members are receiving Care Coordination and are participating in CFTs. Claims are only available with 30 day discharge planning timelines. MHP will continue to provide training and technical assistance support to contracted providers on 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).	89	These youth are receiving mental health services through programs which are lockout situations such as Polinsky Children's Center. These youth are receiving care coordination and CFTs.

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

7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	0	All identified Subclass members receive mental health services unless they decline.
8	Declined to receive ICC or IHBS.	10	Monthly logs collected by BHS and CWS are reviewed to collect this data

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	700	As implementation continues regionally, projections have been made regarding the total number of anticipated referrals. As more youth are screened by CWS for possible mental health issues, it is anticipated that there will be an increase in the identification of potential Subclass youth leading to an increase in the provision of ICC. Roughly 80% of subclass members are actively receiving ICC within a reporting period. Our goal is to continue to improve and have set a stretch goal of approximately 85% of subclass members receiving ICC in the next reporting period. Of course, this is contingent upon the total number of subclass members. Additionally, based on reporting timelines, a subclass member may be in early assessment phase and ICC claims will follow.
1 (b)	IHBS	200	In the 18 full-day trainings scheduled for January – June 2015, additional information has been added to the curriculum regarding IHBS. At this time our baseline of IHBS appears to be roughly 20% of subclass members. A higher rate of IHBS is projected with full implementation with an identified increase to approximately 25% as a projected stretch goal for the next reporting period.

Is your county experiencing the following implementation barriers?

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

County: San Diego **Reporting Period:** 09/01/2014 – 02/28/2015 **Date Completed: 04-01-2015**

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.*	Behavioral Health Services (BHS) and Child Welfare Services (CWS) along with Probation leadership and the Family Youth Roundtable (FYRT) continue to meet regularly regarding implementation of the Core Practice Model (CPM) which in San Diego County is our Pathways to Well-Being initiative. This collaboration extends to all programs contracted to provide services to our CWS and Probation youth and families. A Memorandum of Understanding (MOU) between BHS and CWS has been drafted to outline our shared responsibilities with regards to Pathways to Well-Being.	N
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	CWS, BHS, and FYRT along with the Academy for Professional Excellence continue to meet regularly. BHS Pathways to Well-Being staff are co-located in the various CWS regions in the county with CWS Pathways staff. BHS and CWS staff conduct joint staff meetings to ensure open communication, collaborate, and participate in case consultations to determine eligibility and begin the CFT process if indicated.	N
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	Beginning in July 2014 clinical staff were added to a number of regional behavioral health clinics to assist with the increase capacity projections. The services provided include: early screening and comprehensive assessment; provision of trauma-informed care. CWS has dedicated staff within the Residential Services program to support Pathways services for youth eligible for enhanced services. CWS has added dedicated staff to Regional operations to implement screening and support initial Child and Family Team development.	N

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.*	BHS Organizational Providers offering Pathways services have been trained in ICC, IHBS, and CFTs. Technical assistance is being provided to BHS providers by BHS Pathways staff to further their understanding and practice of teaming and CFT facilitation. Providers are also offered ongoing Trauma Informed training in order to create a trauma-informed environment and reduce the risk of re-traumatizing clients.	N
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	Families and youth continue to be integrated into the planning and the provision of ongoing trainings for our workforce. The training provided to all CWS and BHS staff is delivered by training triads that include one trainer from each key team stakeholder (CWS, BHS, and parent/youth partner). On a service level, family partners are part of the workforce and continue to be an integral part of the service delivery system	N
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	As we train county staff and contracted behavioral providers on our Pathways to Well-Being initiative, the concept and practice of cultural humility has been embedded in our training modules. All behavioral health providers' are required to develop a cultural competency plan. In addition, all clinical staff is required to complete a minimum of four cultural competency training hours per fiscal year. The County as the Mental Health Plan has a robust and multifaceted Cultural Competency Plan that serves as a foundation for culturally responsive services.	N
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	We continue to use a data matching process between CWS and BHS to ensure the identification of all class and subclass youth. This gives us critical information regarding youth, assists in validating the information that is put into the tracking and billing systems, and provides a way to examine program and system trends. CWS is completing mental health screening with all children/youth in a new CWS open case and capturing data regarding screening outcome, teaming, assessment and class/subclass designation.	N
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	BHS and CWS operate under the general oversight of the County of San Diego's Health and Human Services Agency (HHSA). While budgets are separately managed; there is collaboration during budget development for programs requiring shared governance such as with Pathways to Well-Being to ensure best use of resources. As previously addressed, the County of San Diego successfully manages funds and blends allocations from federal, state and local resources to maximize meeting the needs of children, youth and families.	N