



**Glenn County Human Resource Agency and
Health Services Agency
Behavioral Health Services**

**Katie A. Subclass
Service Delivery Plan:
Intensive Care Coordination (ICC) and
Intensive Home-Based Services (IHBS)**

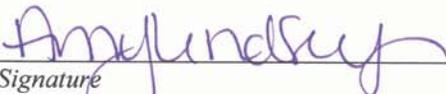
May 20, 2013

Glenn County Behavioral Health Services
Katie A. Service Delivery Plan:
Intensive Care Coordination (ICC) and Intensive Home-Based Services

This service delivery plan is consistent with current quality assurance and utilization management program activities, as specified in the Mental Health Plan contract with the Department of Health Care Services.

Submitted By:

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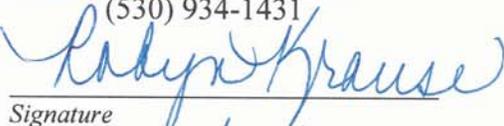


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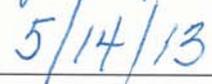


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Glenn County Behavioral Health Services
Katie A. Service Delivery Plan:
Intensive Care Coordination (ICC) and Intensive Home-Based Services

I. Needs Assessment

A. Subclass Analysis: Identification of Subclass Members

1) Determine and enumerate subclass members:

Staff from both Child Welfare and Mental Health will collaborate to identify children and youth (referred to as youth throughout this document) who meet the criteria for the Katie A. Subclass Criteria. Most youth will initially be identified through the Child Welfare System (CWS). The eligibility worker that initially opens a Medi-Cal case will determine if the youth is Full Scope Medi-Cal eligible. At this time, all open cases are court ordered, but for clarification purposes, any open case that is voluntary or court ordered and is Full Scope Medi-Cal eligible will be referred to Mental Health to determine if the youth meets medical necessity.

Youth who are currently receiving mental health services may also be referred to Child Welfare Services if they are being abused or neglected. If the youth and family become an open CWS case, and the youth is Full Scope Medi-Cal eligible, the youth will be assessed to determine if the youth meets Katie A. Subclass Criteria.

In order to determine if the youth meets the Katie A. Subclass Criteria, we have developed an Eligibility Assessment form that collects information on all key indicators identified in the Katie A. Subclass Definition. The Eligibility Assessment Form shows that the youth:

- Has an Open Child Welfare Case (voluntary or court)
- Full Scope Medi-Cal eligible
- Meets mental health medical necessity criteria

AND the youth is:

- Receiving, or considered to receive, intensive services

OR the youth is:

- Placed in an RCL 10 or above or Psychiatric Hospital or 24-hour MH Treatment facility

OR the youth has had:

- Three or more placements in the past two years

The CWS social worker will determine if the youth has an open child welfare case and if the youth is eligible for Full-Scope Medi-Cal. The Mental Health Clinician will conduct a brief mental health assessment and complete a Medi-Cal Mental Health Medical Necessity form to determine if the youth meets the medical necessity. Together, the CWS and Mental Health Katie

A. Assessment Team will assess the youth's need for intensive services, current placement, and placement history; and will complete and sign the Eligibility Assessment Form.

The completed Eligibility Assessment Form will be reviewed by the Mental Health Children's Program Coordinator for review. Upon review, the completed Eligibility Assessment will be submitted to the CWS/CHAT meeting for approval for Katie A services. The CWS/CHAT meeting includes supervisors and staff from both Child Welfare and Mental Health services. If the youth is not currently receiving mental health services, the Mental Health Children's Program Coordinator will also assign the youth to children's mental health clinician and/or Case Manager for ongoing services. The assigned mental health staff will work closely with the CWS social worker to create the Katie A team that will work closely with the family and child/youth and participate in the youth and family's plan development, as well as deliver coordinated services.

Information on Katie A activities will be discussed at the monthly MAP Team meeting. This discussion will highlight the number of youth approved for Katie A. Services; the level of placement; the need for ICC and IHBS; and ongoing data on service utilization, key outcomes, and the cost-effectiveness of Katie A services.

- 2) Identify categories of subclass members (kids at home; kids in group care; kids in foster care):

In this small, rural county, there is no plan to have specific categories of subclass members. The staff from both CWS and Mental Health Services will work closely with all identified Katie A subclass members.

B. Existing Services to Subclass: Identify Mental Health Services

Currently, our Glenn County Mental Health program delivers a range of EPSDT services including: Clinical Assessments, Individual and Group Therapy, Individual and Group Rehabilitation Services, and Medication Assessment and Management. We contract with an organizational provider to deliver Therapeutic Behavioral Service (TBS). We identify children and youth who are high-need and enroll them in the Mental Health Full Service Partnership (FSP) program, as appropriate. We have designed our mental health service delivery system to follow the Children's System of Care model, and have worked closely with our agency partners to provide intensive services to youth who are receiving services from multiple agencies, including Child Welfare, Probation, Education, Public Health, and Substance Treatment Services. Glenn County is in the process of implementing a Wraparound program and has very limited foster care options in the county. Many of our youth are placed in foster care settings in surrounding counties.

The assigned CWS social worker will document mental health screenings, referrals, intervention plans, and treatment in the case notebook in the Child Welfare Services/Case Management System (CWS/CMS) for the youth's Health & Education Passport. These fields can be queried for monitoring and evaluation of the youth and family's progress in the program. These will also be designated as outcome measures for CWS statewide.

C. Adapting Existing Services

We will adapt existing mental health services to provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) services in our county. It is our value to train staff, caregivers, youth, and families to fully implement Katie A services as outlined in the Core Practice Model Guide and the Medi-Cal Guide.

We will follow the recommended stages outlined in the Core Practice Model Guide to implement the changes needed to fully implement services that value the family and youth voice, identify needs, integrate trauma-informed practices throughout the services, and monitor the success of the implementation through data, outcomes, and continuous quality improvement.

The four stages identified in the CPM guide include:

Exploration Stage: This includes these initial needs assessment activities, collecting information, analyzing data and information to identify needs, obtaining input on available resources, potential solutions, and identify strategies for moving the system forward. This will include holding meetings and focus groups to obtain input and utilize this feedback to identify strengths and areas for improvement throughout our local system.

Installation Stage: County staff will utilize the needs assessment, review of existing policies, and input from youth, families, and allied agencies to develop an implementation plan. This will create a strength-based plan for identifying strengths and areas for improvement, enhance collaboration and coordination of services across agencies, and develop a trusting partnership to help improve services and outcomes for youth and families. Staff and families will be encouraged to attend local, regional, and statewide trainings to develop skills and promote changes to existing practices and cultural norms.

Initial Implementation Stage: We will identify a First Implementer Child and Family Team (CFT) to initially implement the new, innovative model. The Team will be selected for their interest and vision to create a strong, family-focused model, which integrates Trauma-Informed Care, youth and family voice, and creative problem-solving to create positive outcomes. The team will continuously review data and outcomes, to quickly identify both successes and areas needing to be modified to ensure success. The CFT will begin utilizing the ICC code to document the staff time needed to plan and implement these collaborative services. Mental Health staff will utilize the ICC code when coordinating services, holding CFT meetings, and engaging agency partners to work together to support the youth and family to achieve their goals.

Similarly, mental health staff will utilize the IHBS services to support youth and families to develop the skills and strategies needed to be successful. This may include supporting youth to manage behaviors, work with families to recognize improved behavior in the youth, develop reinforcement strategies to celebrate successes, as well as offer other support services in the home.

Full Implementation Stage: As we fully implement the CPM model with fidelity, we will identify additional staff and create new CFTs to engage and support families using this model.

In addition, Glenn County CWS has implemented Safety Organized Practice (SOP) family meetings which are facilitated to ensure *client voice* in planning for safety, services, support, and outcomes. SOP family meetings are often conducted in the home and focus on family engagement, voice, and autonomy to reach an agreed upon clear sense of what steps will lead to increased safety. It is a process that involves families, support persons, and service providers working together to help a group think creatively together and plan for positive outcomes for the family.

Team Decision Making (TDM) meetings are conducted for all referrals in Emergency Placement or at risk of placement. This model of family meeting was implemented in 2005 and supports family-centered, family-focused decision making. The family engagement practices of TDM meetings have been identified as central to reducing risk of harm to youth in their own homes. It is also important in out-of-home care as active family participation provides information that is critical to assessment and follow-through on service referrals.

All CWS social workers are trained in this form of family engagement. Parents, support persons, service providers, and youth help make decisions about placement. Although placement decisions are the focus of TDM meetings, service needs are identified by the families, CWS, community partners, and family supporters during the process. Often, the TDM meeting will then lead to another family meeting (SOP) to further discuss the case plan, including the family strengths as identified by the family. Family Strengths and Needs Assessments are completed for all cases and used to identify the highest level of service needs.

II. Direct Delivery of Services

Currently, both Child Welfare and Mental Health programs assess the needs of youth and families, but do not routinely coordinate those assessments. We will train staff and expand our existing assessment model to help youth and families understand the assessment process, engage the youth and family in communicating their experiences and identifying their strengths and needs, and give youth and family choices so they can feel some control over the process. Staff will actively listen to the family, promote self-advocacy, and identify youth and family strengths functionally to help develop a realistic service plan. Trauma-informed services will be integrated throughout our assessment and service delivery system.

Mental Health staff currently hold Family Care Plan meetings to promote family and youth voice and choice in services. We will expand this practice to ensure that all Katie A families will experience service planning within the context of a Child and Family Team (CFT). Families will have a leadership role in designing and implementing their services, having both Child Welfare and Mental Health staff at these ICC meetings. Child Welfare and Mental Health staff will also engage the youth and family to identify their support team members.

The ICC planning and implementation of IHBS services will require additional training for staff, youth and families (including foster families/caregivers) to adapt our existing services to promote the vision of the CFT. Team members will learn how to create shared agreement on critical areas including safety, culturally sensitive services, and supports, and other needs identify by the team and the family. This will create a supportive environment that will help the team design, tailor, and implement a customized set of strategies, supports and services based on the youth and family's expressed needs, and will clearly outline each member's roles and responsibilities related to the services/supports plan.

The CFT model will also be utilized to monitor and adapt services as the youth and family develop skills and will help them transition toward identified goals and outcomes. The team will celebrate milestones achieved and identify needed supports as they meet goals and identify additional needs on their service plan and to ensure that transitions go smoothly and are understood by all team members.

Throughout the delivery of services, Intensive Home-Based Services (IHBS) will be delivered to support the youth and family to develop the skills needed to achieve their goals. These IHBS will create a learning environment to support the families and the youth to achieve their goals and develop behaviors that will help ensure positive outcomes.

We will also expand our Anasazi Information Technology (IT) program to be able to capture ICC and IHBS services and obtain Medi-Cal reimbursement for these Katie A services. This will expand our capacity to collect data and monitor outcomes over time. We have utilized data and information to inform staff on client outcomes, and will utilize this model to continuously integrate evaluation activities into the service delivery system.

III. Gap Analysis

- 1) Services to subclass members who are in congregate care or other group settings, including psychiatric hospitals, who have intensive mental health needs that should be addressed by ICC and IHBS:

Approximately 70% of our children in placement have been placed in the county. This includes 30 of the 35 children placed in relative homes are placed in the county. There are also 5 guardian homes. We have a few Foster Family Homes (FFH) and Foster Family Agencies Homes (FFAH) and/or Relative/Non-Relative Extended Family Members (NREFM) in this county. We have one group home, which takes mostly out-of-county probation youth. We do not have a psychiatric hospital in this county.

Currently, Child Welfare has 117 Open Cases. There are 70 youth in out-of-home placement (60%). Of the 70 in placement, 26 are placed out of Glenn County (37%). Of the children in Child Welfare cases, approximately one-third receive mental health services.

As the Katie A project is implemented, we will work closely with the state to determine how services will be coordinated across counties. This discussion will include which county will be

responsible for delivering ICC and IHBS services and how payment for these services will be reimbursed. As a result, we will continue to attend statewide training opportunities and update future written documents to ensure that we are meeting the needs of these subclass members who are in congregate care or other group settings.

- 2) Services to subclass members who are in the community and receiving less intensive mental health services & supports, but have been determined (identified by anyone) to need more intensive services (e.g., youth with placement disruptions due to behavioral health concerns/mental health needs.):

We will continue to assess and monitor all youth who are open to CWS, are Full-Scope Medi-Cal eligible, and need more intensive mental health services. As we implement the CPM and CFTs, we will assess all youth to determine their need for mental health services. If at any time the youth has been determined to need more intensive services, we will conduct a brief mental health re-assessment and identify any additional needed services, including the need for ICC and IHBS.

IV. Services Capacity Assessment

A. Existing Capacity

- 1) By services type (ICC; IHBS):

We have staff who are experienced in Trauma-Informed Services and will be available to offer ICC and IHBS services. Currently, we are fully staffed and will be able to work closely with CWS to coordinate services for these identified clients. There is a need for additional training for staff to deliver ICC and IHBS services and documentation training to ensure compliance with Medi-Cal regulations. We also plan to train staff in Trauma Informed Services as soon as possible, to develop and expand our expertise in this important area.

- 2) By provider types (county-operated; contracted agencies):

The majority of mental health services are county operated. CWS contracts with some private providers to conduct some mental health assessments, delivery and mental health services for children and youth who do not meet medical necessity and/or do not have Full-Scope Medi-Cal benefits.

- 3) Geographic coverage:

All services are offered throughout the county.

B. Short-Term Expansion Capacity

As noted above, we have staff that have excellent skills and will be available to offer ICC and IHBS to these newly identify youth and families. We will arrange for them to receive training in

all components of the CPM in order to ensure that they embrace and fully implement the vision and goals of the CPM. If there is funding available, we will hire additional staff to meet the added demands of holding frequent CFT meetings, working collaboratively as a member of the CFT, and delivering IHBS.

Initially, we will pilot one CFT to develop staff skills and successfully implement the core practice model. We will utilize this experience to revise and strengthen the original plans to ensure that youth and families are fully involved in service planning, implementation and evaluation of the CFT. In addition, we will utilize a continuous quality improvement process that will routinely examine what works and what needs to be modified to meet the needs of the youth, family, and the CFT.

C. Unmet Long-Term Capacity Needs

1) By service type:

Our most significant gap in service capacity is training both Child Welfare and Mental Health staff to fully embrace and implement the CPM and CFT. As we pilot one CFT, and share successes with all staff, we will be able merge our existing organizational cultures and fully implement an enhanced model of service delivery. In addition, we will continue to identify opportunities to increase our county Foster Family Homes and foster care training through the Quality Parenting Initiative (QPI). We are working with a Foster Family Agency to identify and train an ITFC foster parent. Glenn County is committed to keeping youth in their families, schools, and communities, whenever possible.

2) By provider type:

The majority of our services are delivered by county staff.

3) By geographic area:

All services are available throughout the county.

V. Stakeholder Involvement

A. Methods to Obtain Stakeholder Input

We continued to utilize the strategies that we developed when we obtained stakeholder input for the initial MHSA planning process, and annually for our Annual Updates. We will expand our stakeholder input to include youth and families during ongoing planning and implementation meetings, in the Quality Improvement Process, and as a component of our evaluation activities to manage positive outcomes over time.

B. Stakeholder Entities Involved in ICC and IHBS

We will expand involvement of stakeholders as we develop and implement our ICC and IHBS policies, services, and evaluation and quality improvement activities. We will include family and youth in our meetings and will routinely solicit input from youth and families receiving ICC and IHBS services to continuously improve our program.

C. Collaboration Strategies

We have had several meetings involving Child Welfare and Mental Health staff in the development of this Service Delivery Plan. We have also invited family members and youth to join our planning meetings. We conducted focus groups and administered surveys to obtain information about Child Welfare and Mental Health services in Glenn County. We will continue to identify stakeholders who are interested in providing ongoing input to the development, implementation, and evaluation of these services as we develop and implement our CFT, ICC, and IHBS services. There are a number of different groups that involve parents and community partners. We will utilize these groups to help inform our planning and implementation of Katie A activities. These groups include Parent Partners and the PIE Unit of the Community Action Division of HRA. We also have a local chapter of the California Youth Connection, which is led by a former foster youth. Their participation would greatly strengthen our planning and implementation process.

We are excited about the opportunities this collaboration will have on improving services to these high-need youth and families. While youth and family voice and involvement have been a core value of the Children's System of Care, this collaboration will enhance these values and provide the training, coaching, and mentoring needed to empower youth and families to be involved in all aspects of their services.