Statewide Training and Education Committee (STEC)
Pathways to Well-Being Workgroup
November 18, 2015 | 11:00 am to 12:30 pm

S U M M A R Y

ATTENDANCE:

Lupe Grimaldi, Richard Knecht (CDSS); Troy Konarski (DHCS); Kim Mayer, Kelly Bitz (CIBHS); Brent Crandal, Andrea Hazen (Chadwick Center); Patricia Poulsen (CCTA); Amoreena Jaffe (PCWTA); Phyllis Jeroslow (CalSWEC)

1. **Updates**
    a. DHCS/CDSS:
        i. Concerns have surfaced regarding the restriction of ICC and IHBS services to the subclass. Expansion of these services beyond the subclass is being contemplated, and relevant documents are being reviewed. Service requirements include the program for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), which encompasses the provision of behavioral health services for children enrolled in Medicaid.
        ii. Therapeutic Foster Care (TFC) will be up and running in the next eight months, with its complement of integrated services. TFC will expand to include children that qualify for EPSDT.
        iii. The Executive Team is meeting regularly and the Community Team meets monthly.
    b. Central California Training Academy (CCTA):
        i. Merced County has requested additional training for Katie A.
    c. Public Child Welfare Training Academy (PCWTA):
        i. PCWTA recently held its final in-person regional convening for the learning collaborative. Counties support one another on an informal basis and continue to learn from each other. Support may include webinars or county newsletters where training opportunities are posted.
        ii. Community Care Reform (CCR) is a growing focus of the counties that is being integrated with Katie A. implementation.
    d. Chadwick Center:
        i. Screening efforts are winding down as sustainability concerns take center stage. Among these are ensuring that the screening tool is used consistently and addressing other aspects of 'drift' among workers. The tool is based on measurement and represents a shift for workers who formerly relied on data interpretation in order to make a decision. Chadwick continues to provide training for this tool so that it will be applied uniformly.
        ii. Tools are complicated and subtle. Chadwick is firmly in the 'evidence-based' camp, and researches tools that measure trauma in a manner useful for child welfare practice.
        iii. Chadwick currently assists Tulare County Mental Health with a mental health assessment process that enhances engagement and employs a trauma-informed approach.

iv. After staff has been trained, the mental health assessment will be rolled out by the start of 2016.
v. Chadwick is coordinating with the Northern Region to train trauma-informed care.

e. CIBHS
   i. CIBHS submitted its report on the August Statewide Convening to CDSS for review.
   ii. An emergent issue for CIBHS is how to sustain training in Therapeutic Foster Care if and when this program expands to serve a larger population of children.
   iii. CIBHS is assessing how best to use its resources.

2. The Transformation Manager and the Implementation Plan

a. Richard Knecht is the Transformation Manager and a liaison between CDSS and DHCS, as well as a liaison between the Executive Team, the Community Team, and our workgroup. Richard brings a local perspective to the state-level agencies.
b. Richard's work is strongly connected to the Settlement Agreement.
c. Richard provided an overview about the Community Team's role in training, drawing on the series of PowerPoint slides that had been distributed to the workgroup prior to the web conference. (Contact Phyllis if you need the slides to be re-sent.)
d. The Community Team meets monthly for 5 hours to address concerns from a consumer-based, youth-centered perspective that advances a shift in leadership culture from the exclusivity of state institutions towards inclusion of families. The team is exploring integrated, collaborative models and other "tools" that can be utilized.
e. At the state level, divisions of mental health, substance abuse, and child welfare are called upon to work as collaboratively as possible within legal limits and to listen to the lived experiences of families. The Joint Management Structure establishes shared accountability between state-level agencies, while the Community Team makes possible the involvement of parents and youth.
f. A graphic depicts 4 pillars of the functional and fiscal processes of the implementation plan which integrates Community Care Reform and Katie A. (See slides.)
g. The Community Team may extend an invitation to attend their meetings to members of our workgroup.

3. A Plan for Shared Training

a. Conversations regarding shared training across DHCS and CDSS are just beginning. Richard is working with Caroline Caton and Troy Konarski on this issue. Shared training should lessen redundancies and training costs in the two systems. Such redundancies create confusion for families and providers.
b. The Community Team is charged with discussing a plan for shared training. The Community Team intends to build on the work accomplished by our workgroup. The Community Team hopes to propose a framework for shared training after its December meeting.
c. Guidelines for an integrated training plan include the content areas of AB 403 and Community Care Reform.
d. The training plan needs to address: training content; how to deliver it; and who will be delivering it. In this regard, it is necessary to accommodate differences among training systems. For example, child welfare's training system is more complex than that of mental health.
e. The workgroup asked questions regarding the vision for shared training and how our workgroup could contribute to designing the shared training plan.

i. For example, what is the overarching concept? Would there be a singular, guiding document, including principles and recommended content? How will the plan be connected to existing training at the county level?
ii. Are we as a group responsible for the themes of training?
iii. How can we bring the training resources of DHCS and CDSS together? It would be helpful to identify effective methods of sharing information.
iv. What would be our workgroup's role? Will we add new partners to our workgroup?

f. One recommendation is to design an ongoing survey for the counties that would inquire about joint trainings that are already in place. This would include gathering information about the training content, how it is delivered, and who delivers it. For example, some counties might consider a designated staff person responsible for integrated training. The State would welcome information from counties about their training plans, especially since Progress Reports have been discontinued.
g. Another suggestion (submitted in writing prior to the web conference) is to identify and collect curricula for trainings that would be beneficial for child welfare and behavioral health staff to receive together. These could be posted in CalSWEC's toolkit for Katie A. implementation. Examples include: Solution Focused techniques; Safety Organized Practice (for joint identification of true safety threats and behavioral goals); and cultural humility.
h. An additional consideration was to include ongoing implementation support as a supplement to training. Such implementation support would rely on ongoing and intensive data collection.
i. Different training topics require different delivery methods. For example, T4Ts necessitate more intensive technical assistance than 'straight-up' trainings.
j. Based on prior accomplishments, our workgroup was acknowledged as the entity best suited to engage with the Community Team about developing a shared training plan.
k. The workgroup was asked to correspond with Richard about ideas for other entities that should be involved.
l. The Policy Working Group for Adverse Child Experiences at the Center for Wellness in the Bay Area, led by Dr. Nadine Burke, was suggested as a promising entity for future, cross-sector collaborations. The working group links the Departments of Justice, Education, Public Health (including mental health), and Social Services. Currently, child welfare does not have strong representation in this group. The Policy Working Group is beginning to approach the design of an action plan that includes a training component. The Working Group is considering sector-specific planning designs. Drawing from the knowledge base of the Adverse Childhood Experiences (ACE) Study, trauma-informed care will be a prominent focus of training.
m. It would be helpful for our workgroup to become more informed about the work of other people and groups, such as the Policy Working Group.

4. Future Web Conference

<u>December</u>
Wednesday, 12/9
2:00 pm – 3:30 pm
Dial-In: 1-866-740-1260; Access Code: 6435440#
A ReadyTalk web link and an agenda will be sent in advance of each web conference.