UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

KATIE A., et al., Plaintiffs, **v.** **DIANA BONTA, et al.,** Defendants.	Case No. CV-02-05662 AHM (SHx) **EXHIBITS 1 TO 3 TO SPECIAL MASTER'S REPORT ON PROGRESS TOWARD COMPLETION OF THE KATIE A. IMPLEMENTATION PLAN** Judge: Honorable A. Howard Matz Crtrm: 14

Exhibit 1

STATE PROGRESS REPORT ON KATIE A PHASE ONE IMPLEMENTATION PLAN

November 29, 2012

The purpose of this progress report is to provide an update on the items specified in the August 28, 2012 Special Master's Report on Progress Toward Completion of the Katie A Implementation Plan. Specifically, it addresses the Special Master's Findings for Phase One, on pages 26-27 of the above referenced document. This progress report is organized to follow the format of the Phase Two Katie A Implementation Plan and provides information on each of the six Implementation Plan sections. Under each section, details are provided regarding anticipated results in Phase Two along with progress and challenges anticipated by DHCS and CDSS.

PHASE TWO

The Phase Two Implementation Plan has been modified to exclude completed Phase One Objectives and Anticipated Results. A matrix describing these completed Objectives, entitled, Tasks Accomplished, is included as Appendix A. The Phase Two document has been revised to present information in a more readable and logical manner. Following the Introduction, former Objectives are now referenced as Sections. Objectives to achieve the anticipated results are listed below relevant Sections followed by activities that will occur during January 2013 and Beyond, Anticipated Results and Responsible Parties. The document has been reordered as well to make the Objectives chronological and to better incorporate the Family and Youth voice throughout the document.

SECTION I - SHARED MANAGEMENT STRUCTURE

Continuing in Phase Two, the Departments of Health Care Services (DHCS) and Social Services (CDSS) Shared Management Structure (SMS) continues to consider and develop a shared vision and mission statement, policy and program direction, clear and consistent guidance, and outcomes and accountability measures consistent with the CPM.

<u>Anticipated Results in Phase Two</u>

Family and youth participation will be an integral component to shared DHCS and CDSS decision-

making, resources and activities, consistent with the CPM values and goals.

Coordinated policy and program direction will provide clear and consistent guidance to program managers, service providers, families and youth, and other stakeholders. Outcomes and accountability measures will be aligned with the mental health and child welfare needs of the Katie A. class members.

The SMS will exist at the state and local levels with better integration of counties' decision-making, resources, activities, and family and youth participation. The SMS will have improved coordination, broadened perspectives, improved accountability, strengthened existing relationships among child-serving agencies, increased community engagement, and includes family and youth participation and increased satisfaction.

Each Department will collect data elements from their respective data systems specific to the subclass and evaluate utilization (patterns, types, frequency and intensity of services) and timely access to care. Data, reports and timelines will be posted on the CDSS and DHCS websites.

Progress and Challenges anticipated by DHCS and CDSS

DHCS and CDSS have implemented a basic shared management structure to facilitate the development of the Implementation Plan. The structure includes regular meetings with the leadership of both departments and partial co-location of staff. This structure will be augmented based on recommendations from the Joint Management Taskforce, internal quality assurance processes and practice wisdom, to support service delivery and the adoption of the Core Practice Model. The departments are committed to continuously refining structure to ensure sustainability.

The Joint Management Taskforce (JMT) charter was approved on March 15, 2012. The Co-Chairs, Dina Kokkos-Gonzales (DHCS) and Greg Rose (CDSS), worked collaboratively to invite and assemble a diverse workgroup to consult with the departments on the development of practice tools, training curriculum, practice improvement protocols and quality control systems. The Taskforce held its initial orientation meeting on October 31, 2012, and will meet again in December 2012. A work plan for the JMT is currently being developed and will be completed by January 15, 2013. Meetings of the JMT will continue into 2013 for approximately six months.

The Core Practice Model Fiscal Taskforce (CPMFTF) charter was approved on March 1, 2012. The Co-Chairs, Gary Renslo (DHCS) and Pete Cervinka (CDSS), have worked collaboratively to invite and assemble a diverse workgroup to address fiscal issues regarding the Katie A. settlement. The Taskforce had its first meeting on October 26, 2012. The Taskforce has agreed to meet approximately every three weeks until their report is submitted to the Katie A. Negotiation Workgroup. Meetings are scheduled through mid-April 2013. A work plan for the taskforce is currently in progress and will be completed by January 15, 2013.

A challenge related to these Taskforces is to support and maintain meaningful youth participation.

SECTION II - CORE COMPONENTS

Continuing in Phase II, the purpose of the Core Practice Model is to develop a shared model of practice to better integrate services and supports for children, youth, families and communities. In addition, the purpose is to provide responsive, efficient and high quality services that promote safety, permanence, well-being and self-sufficiency.

Part A: Core Component Elements

Anticipated Results in Phase Two

Continuing in Phase Two, the CPM Guide will result in improved coordination of resources and services, greater family and youth engagement and participation, as well as greater uniformity in statewide practices by child welfare and mental health agencies and providers serving children and youth with an open child welfare case.

The TFC Addendum will result in statewide implementation of TFC services and will provide essential information regarding coverage, claiming and documentation.

The Documentation Manual developed in Phase One, the TFC Addendum and the CPM Guide will be used together in order to promote integration and alignment between practice and services. Additionally, training and technical support will be provided by the State in a manner that is intended to underscore the importance of using the Documentation Manual and the CPM Guide in unison.

Progress and Challenges Anticipated by DHCS and CDSS

The joint leadership process designed and implemented by CDSS and DHCS, ensures staff from each Department participates in the Documentation Manual and CPM Guide subgroups. The communication and interaction between the departments facilitates the connectivity of the two products.

The Documentation Manual describes ICC and IHBS as Medi-Cal Specialty Mental Health Services. The departments have drafted an All County Letter (ACL) to provide counties and providers with new procedure codes to facilitate claiming and reimbursements for ICC and IHBS. The Documentation Manual was posted for a 30-day public comment period between October 17 and November 18, 2012. State staff met weekly to evaluate any public comments received on a flow basis. However, 90% of the comments were submitted on the final two days of the public comment period and included the most critical, complex and specific analyses from counties, providers and advocacy organizations.

The departments are proceeding, in consultation with the Special Master and Plaintiffs, to evaluate the public comments and revise the Documentation Manual as appropriate. Two overarching themes were apparent from the public comment: recommendations that the Documentation Manual requires significant revision to add further clarity and supplemental examples, and that the CPM Guide and Documentation Manual be released simultaneously to provide holistic guidance to the field.

Part B: Core Practice Model Adoption

Continuing in Phase Two, the purpose of statewide adoption of the CPM is to develop a single model of delivery of intensive home and community based services to subclass and class members within the CPM framework, and to reduce the use of group homes and institutional placements. Additionally, the CPM Guide will enable and promote the adoption of a single model of service delivery that children and families receive when served by both Child Welfare and Mental Health agencies. The Core Practice Model Fiscal Taskforce will develop a strategic plan or proposal using fiscally sound incentives and reduced administrative barriers.

Anticipated Results in Phase Two

The adoption and use of the CPM will transform practice associated with the shared governance and delivery of services by child welfare and mental health services staff and the engagement and participation of families and youth. The practice will be adopted by state and county departments and individuals who serve the Katie A. class members and their families.

Progress and Challenges Anticipated by DHCS and CDSS

The parties have agreed to modify the public comment process for the CPM Guide from what as stated in Phase I of the Implementation Plan. The Guide will be released for stakeholder input on December 14, 2012, with an abbreviated time frame for public comments. CDSS will review the input provided by stakeholders and revise the CPM Guide as appropriate. The release date of January 31, 2013, remains the same.

The provision of services, consistent with the CPM, will reflect a shared, statewide practice model for mental health and child welfare which will increase the likelihood of positive outcomes for children, youth and families.

SECTION III - FAMILY AND YOUTH INVOLVEMENT

Continuing in Phase Two, the purpose of family and youth involvement means that state departments, counties and providers engage and involve youth, parents, and family group members in decision-making at the practice, program, and policy levels. Furthermore, it signifies that youth and families have meaningful influence in the design, delivery, and evaluation of services consistent with the values and principles of the CPM.

Family and youth involvement will not happen spontaneously in a historically prescriptive and agency based mental health and child welfare culture. State departments, counties and providers will proactively create environments or processes that welcome youth, parents, family, community and partnership.

Anticipated Results in Phase Two

Services will be delivered by counties and their providers in a manner that promotes engagement and youth and family participation in an approach that embraces the values and goals of the CPM. Quality assurance indicators will be consistent with consumers' needs and the service delivery system will place youth and families at the center. Enhancements to the system will be made to directly benefit youth and families that are provided services. By incorporating family/youth involvement in both implementation and outcomes throughout the processes, there will be an increase in service utilization, collaboration among team members, stable family structures and sustainable recovery.

Progress and Challenges Anticipated DHCS and CDSS

CDSS has had several ongoing conversations with individual youth and representatives from the California Youth Connection (comprised of former foster youth) to determine the feasibility of using focus groups as one method to engage their input for implementation. In addition, youth will be invited to partner on various activities such as training, curriculum development and workgroups.

A significant effort was made by the Negotiation Workgroup to increase and enhance this section of the Implementation Plan to emphasize the state's commitment to the inclusion of family and youth voice on the implementation of the CPM, ICC, IHBS and TFC. Family and youth voice and involvement have been woven into all six parts of the Implementation Plan. During Phase Two, the state departments will be making additional efforts to recruit and retain additional youth involvement.

SECTION IV - SERVICE DELIVERY AND ROLLOUT

Continuing in Phase Two, the service delivery and rollout component of the settlement is focused on supporting the development and implementation of a service structure and fiscal system for counties to support a core practice and service model in a coordinated, comprehensive, community-based approach. The strategy for this component will combine service access, planning, delivery and transition into a coherent and all-inclusive approach.

Anticipated Results in Phase Two

ICC and IHBS (and once determined to be a Medi-Cal covered service, TFC) will be provided statewide to eligible youth pursuant to the guidelines and procedures provided in the Documentation Manual and CPM Guide and the progressive adoption of the CPM will result in a joint practice model of care that children, youth and families receive when served by their local mental health and child welfare agencies and providers. Services delivered will respond explicitly to the culture and beliefs of youth and families.

Changes, Progress and Challenges Anticipated by DHCS and CDSS

There are two specific changes noted in the Phase Two Implementation Plan.
Change 1- In Phase Two, the state departments and Negotiation Workgroup identified that Counties and the state would benefit from having the counties submit to the state a completed Readiness Assessment Tool and Service Delivery Plan to develop and guide the implementation of ICC, IHBS and TFC. Part D of Section IV "Service Delivery and Rollout" includes this addition. Counties would also be required to provide the state with semi-annual progress reports. A possible challenge exists regarding the submission of the Readiness Assessment Tool, Service Delivery Plan and semi-annual progress reports as the counties may interpret that these are new requirements.

Change 2- The Negotiation Workgroup has changed the term "Early Implementer Counties" to "Learning Collaborative Counties." This change is consistent with an approach called Implementation Science that CDSS is using for implementing change initiatives. This strategy will allow identified counties to transfer lessons learned in a meaningful way on how to build and model strong collaboration between mental health and child welfare for other counties. Additional technical assistance and training activities have also been added to Section V of the Phase Two Implementation Plan to promote these activities.

TFC update: The Departments, Plaintiffs and Special Master continue to work with the national TFC consultants to evaluate TFC models from other states and to determine TFC coverage for California. The consultants have developed a model and a draft proposal for designing California's TFC services.

Future steps include continuing to work with the consultants and sharing their work with the larger TFC subgroup that will review the final proposal, model, and coverage options, and evaluate options for billing and claiming. The TFC Subgroup will forward their recommendations to the Negotiation Workgroup. Once the TFC model and coverage have been determined, the information will be integrated into the Documentation Manual.

SECTION V - TRAINING AND TECHNICAL ASSISTANCE

Continuing in Phase Two, the purpose of the training and technical assistance activities is to support adherence to a sustainable Core Practice Model which will facilitate the transformation of child welfare and mental health systems. Training activities alone are not enough to sustain the adherence to the core practice model. Solutions need to be hands on and practical to meet technical and adaptive challenges in order to achieve meaningful changes in values, beliefs, attitudes, family and youth inclusion and paradigms in real time.

Anticipated Results in Phase Two

County leadership from mental health and child welfare will be informed and advised based on experience from the learning collaborative counties. Families and youth will be included throughout the training process of development of materials. Training for the Documentation Manual will be coordinated with the training on the Core Practice Model Guide.

Progress and Challenges anticipated by DHCS and CDSS

CDSS did initiate a request to STEC on September 12, 2012, to convene a multi-disciplinary workgroup for the joint curriculum development.

On November 27, 2012, STEC convened a multidisciplinary workgroup who will begin the planning and development to produce joint curricula, educational materials, training and coaching guidance on the Core Practice Model.

Section V, titled "Training and Technical Assistance," has been revised to include specific training dates and activities for both the Documentation Manual and the CPM Guide.

SECTION VI - DATA AND QUALITY ASSURANCE

Continuing in Phase Two, several activities related to data, accountability, quality assurance, and the establishment of a data quality taskforce, are necessary to ensure clear and consistent guidance, outcomes, and satisfaction and accountability measures are consistent with the Core Practice Model, and quality control systems to support the shared Core Practice Model.

Anticipated Results in Phase Two

Adoption and statewide use of a data-informed system of performance oversight, accountability and communication that efficiently monitors, measures and evaluates access, quality, satisfaction, effectiveness, costs and outcomes at the individual, program and system levels.

The production of relevant, timely, and understandable measures that report who needs and who is receiving services, including the type, intensity and duration, at the individual, program, and system levels. Use a continuous quality improvement process to monitor and support service delivery, utilization and adherence to the Core Practice Model.

The State will have and share publicly the necessary information to determine whether implementation of ICC and IHBS and the CPM is successful, and if not, what measures need to be taken to achieve success. Data and oversight systems are used to improve performance and quality over time.

Families and youth will be active participants in state system planning. Family and youth satisfaction is a critical component of system evaluation. A formal mechanism exists for family and youth concerns to be addressed.

Progress and Challenges Anticipated by DHCS and CDSS

In the Phase Two Implementation Plan, the ACO Charter and ACO Mapping Charter were both approved on August 16, 2012. The ACO Mapping Group will be convened by January 31, 2013, and the ACO Taskforce will start meeting by February 28, 2013.

EXHIBIT 2

KATIE A. IMPLEMENTATION PLAN, PHASE TWO - NOVEMBER 21, 2012

INTRODUCTION

The *Katie A. v. Diana Bontá, et al.* (Former Director of the California Department of Health Care Services) federal class action lawsuit was filed July 18, 2002, seeking to make Wraparound services and Therapeutic Foster Care available to all class members. Without any admission of liability, the State defendants entered into a Settlement Agreement with the plaintiffs which was approved by the court in December 2011. The Settlement Agreement required, among other things, the parties to develop an Implementation Plan to fulfill the obligations of the Katie A. Settlement Agreement. Specifically, the Katie A. Implementation Plan will be used by the State to achieve the intended objectives of the Settlement Agreement. Pursuant to the Katie A. Settlement, the federal court will retain jurisdiction over the Katie A. Lawsuit until 36 months after the court's approval of the Settlement Agreement, which is December 1, 2014, at which time the Court's jurisdiction will expire. The implementation timeline, however, will include activities or deliverables that may be completed, or ongoing, after the end of court jurisdiction.

Since January 2012, the parties have continued to engage the Negotiation Workgroup in a process that supports the development of the Implementation Plan, including meeting as an entire group, often on a weekly basis, and participating in various workgroups, completing specific tasks and facilitating the development of the subgroup charters to help guide further development of the implementation plan. The parties have organized the requirements of the Katie A. Settlement into sections, objectives, dates, anticipated results and responsible parties, each of which are set forth in more detail below.

The Implementation Plan is intended to provide a road map to delivering Intensive Home Based Services (IHBS), Intensive Care Coordination (ICC) and Therapeutic Foster Care (TFC), that is consistent with the Core Practice Model (CPM) and that is coordinated, comprehensive, individualized and community-based. The plan was developed with parent and youth involvement and incorporates the strength-based, family focused practice principles which are to be supported by the child welfare and mental health systems.

The plan is organized by six sections that outline short-and long-term activities in two phases. Phase One activites that have been accomplished are noted in Appendix A. The current iteration of the Implementation Plan describes Phase Two that begins January 1, 2013 and continues forward. Phase Two focuses on adopting and promoting the CPM throughout the state and satisfying the remaining Settlement Agreement requirements. The purpose and anticipated results are included to provide context from the Settlement Agreement. Important accomplishments to date are summarized in an addendum. Taken together, these objectives, implementation activities, timelines and accountability roles constitute the parties' best effort to date to develop a comprehensive plan intended to produce meaningful and sustainable results for children and youth with an open child welfare case with mental health needs and achieve the requirements of the Settlement Agreement.

Family and youth voice contributes a unique and valuable perspective and is most effective when used to balance decisions as they are made on a system and practice level. Therefore, as an integral part of implementation of this plan at all levels, the family and youth voice has been incorporated into each section of the Implementation Plan. Consequently, each section reflects the objective of including family and youth voice and experience, which models the teaming of systems, practice and family.

This plan is intended to be a living document that guides the parties forward towards successful implementation of the Settlement Agreement. There are elements of the plan and Settlement Agreement that require additional work product by certain taskforces and advisory groups. The parties will continue to work together, with the assistance of the Special Master, to integrate additional recommendations and contributions by these groups consistent with the Settlement Agreement to guide and inform implementation.

The parties appreciate the assistance and guidance of the Negotiation Workgroup in the development of the Katie A. Implementation Plan. Following the submission of the complete Implementation Plan to the Court in December of 2012, the Negotiation Workgroup will convene no less frequently than once every quarter for the remainder of the jurisdictional period to provide further direction and guidance, as necessary, to the Implementation Plan activities.

The California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) recognize the importance of maintaining transparency and open communication throughout the process of implementation and beyond. The dissemination of information to County Mental Health Plans (MHPs) and County Social Services (CSS) Directors will continue to be a priority for both departments and will include, but is not limited to: program instructions, the release of data and website postings, All County Letters (ACLs) and All County Information Notices (ACINs).

THE PATHWAYS TO MENTAL HEALTH SERVICES OBJECTIVES

SECTION I. SHARED MANAGEMENT STRUCTURE (SMS)

A shared management structure, at both the state and county levels, is important for the integration of essential elements of the settlement into current practice and to the long term sustainability and evolution of these practice changes. DHCS and CDSS will establish a shared management structure consistent with the CPM and develop a shared vision and mission statement, policy and program direction, clear and consistent guidance, and outcomes and accountability measures.

The SMS shall support and sustain active and meaningful participation from families and youth who have experienced an array of services from child welfare and/or mental health. The SMS may support ongoing strategies to gain information regarding quality of care from families and youth actively receiving services from child welfare and mental health systems. The SMS will coordinate

the work of the Joint Management Taskforce (JMT), Accountability, Communications and Oversight (ACO) and CPM Fiscal taskforces to ensure that service delivery is supported and improved over time by governance, quality/accountability, and fiscal systems and structures that are consistent with the CPM values, goals and services.

OBJECTIVES

1. To create cross-system processes and procedures to support and manage the shared responsibility between DHCS and CDSS for engaging and delivering services to children with an open child welfare case that is consistent with the CPM at the county/local level.

2. To develop and provide models for local agencies to consider in order working more effectively together consistent with the CPM and that involves families and youth in decision-making.

3. To align policies and procedures and revise them jointly as needed to ensure a shared practice that is consistent, avoids duplication and provides a process for quickly resolving conflicts.

4. Develop and provide models for local departments to consider in order to work more effectively together.

5. To reduce barriers to services that arise due to a lack of understanding of federal and state rules and regulations and to eliminate local rules that impede access to care and the adoption of the CPM.

6. To ensure that the shared management approach purposefully builds productive collaboration with youth and their families and involves them in decision-making and in implementing solutions.

Action Items for JANUARY 2013 AND BEYOND

In March 2012, DHCS and CDSS filed a Joint Leadership Plan with the Court, which identified a representative from each department to have direct authority for policy decision-making and to communicate with their respective Directors regarding the Katie A. Settlement. Since the plan was filed, the two departments have continued to meet weekly to collaborate and coordinate efforts, as well as provide policy leadership and direction to the Negotiation Workgroup and the Special Master (please see **Appendix A** for specific steps accomplished to date).

1. Continue convening the JMT and CPM Fiscal Taskforces with representatives from each department and representatives from youth, parent partner, county, provider and advocacy groups.

2. By January 15, 2013, the JMT and the CPM Fiscal Taskforces will develop work plans consistent with the approved charters that will organize and sequence the work of the taskforces and result in the required reports to DHCS and CDSS.

3. The taskforces will meet for approximately six to eight months to accomplish the tasks articulated in the charters.

4. The JMT will develop recommendations for an SMS to support the establishment of formalized, county-level shared management structures between county child welfare and mental health agencies that also involves youth and their families in decision-making. The JMT will consider the recommendations set forth in the CPM Fiscal Taskforce's strategic plan:

   a) to refine and/or augment the Implementation Plan activities;
   b) in developing its recommendations for the SMS; and
   c) in carrying out its obligations under the JMT Charter.

   The JMT will develop and provide a recommended mechanism to identify and measure local collaborative structures. This mechanism will also serve to identify any barriers that may prevent improved collaboration, the establishment of local collaborative structures, or access to services.

5. The JMT shall consider using the county readiness assessment tool as a mechanism for achieving the forgoing. The JMT shall ensure family and youth voice in this process, and utilize the findings to provide additional guidance or technical assistance relating to local agencies.

6. The JMT and/or SMS will consider the findings of the ACO Taskforce's study on utilization and timely access to care in developing its recommendations.

7. 90 days after DHCS and CDSS receive the recommendations from each taskforce, the departments will evaluate the recommendations for possible adoption by the State and for inclusion in an ACL/ACIN to the counties describing options for the counties to consider.

8. DHCS and CDSS will issue communication statements and guidance regarding the state and county shared management structure recommendations and will make administrative changes necessary to successfully implement and support the SMS. The two departments will also promote the SMS and ACO Taskforce and CPM Fiscal strategies statewide.

9. DHCS and CDSS shall take the necessary steps to implement the strategic plan or proposal for financing of the CPM and direct services consistent with the efforts of the Continuum of Care Reform recommendations.

ANTICIPATED RESULTS

Family and youth participation will be an integral component to shared DHCS and CDSS decision-making, resources and activities and consistent with the CPM values and goals.

Coordinated policy and program direction will provide clear and consistent guidance to program managers, service providers, families and youth and other stakeholders. Outcomes and accountability measures will be aligned with the mental health and child welfare needs of the Katie A. class members.

The SMS will exist at the state and local levels providing better integration of counties' decision-making, resources, activities, and family and youth participation. The SMS will improve coordination, broaden perspectives, improve accountability, strengthen existing relationships among child-serving agencies, increase community engagement, and include family and youth participation and increased satisfaction.

Each department will collect data elements from their respective data systems specific to the subclass and evaluate utilization (patterns, types, frequency and intensity of services) and timely access to care. Data, reports and timelines will be posted on both the DHCS and CDSS websites.

RESPONSIBLE PARTIES

DHCS, CDSS, Negotiation Workgroup, ACO Taskforce and CPM Fiscal Taskforce, Joint Management Taskforce

SECTION II. CORE COMPONENTS

The purpose of the CPM is to develop a shared model of practice to better integrate services and supports for children, youth, families and communities. In addition, the purpose is to provide responsive, efficient and high quality services that promote safety, permanence, well-being and self-sufficiency.

This section consists of two parts:

- Part A outlines the CPM approach and the tools to support the provision of services and describes the plan to promote adoption of the CPM through services that are

needs-driven, strength-based, family-focused, culturally competent, individualized and delivered in a multi-agency collaborative approach.

- Part B describes the departments' commitment to work with plaintiffs' counsel and consultants to determine which components of TFC are covered by Medi-Cal or Title IV-E and to design a plan to implement TFC statewide.

OBJECTIVES

1. To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines family and youth engagement, service access, planning, delivery and transition into a coherent and all-inclusive approach referred to as CPM.

2. To address the need for subclass members with more intensive needs to receive medically necessary mental health services that include IHBS, ICC and TFC. (Please refer to Appendices B and C for service definitions for IHBS and ICC as described in the Settlement Agreement).

3. To support the development and delivery of a service structure and a fiscal system that supports the core practices and services model described in Part A of this section.

4. To establish a CPM Fiscal Taskforce to guide and inform implementation to the fullest extent practicable consistent with the time available, that focuses on do-able, achievable and fiscally sound incentives to deliver IHBS, ICC and TFC within the Core Practice Model framework and reduce the use of group homes and other institutional placements.

5. To develop a CPM Guide that is easily understood by multi-agency teams and stakeholders.

6. To identify components of TFC services/model program that are Medi-Cal reimbursable and components that are covered by Title IV-E, and to determine all steps necessary to implement the services/model.

7. To foster a statewide practice model where representatives of family and youth organizations are included in opportunities to advise administrators, contribute to policy development, provide systematic feedback on agency performance, and participate in staff development and program evaluation.

Part A: Core Practice Model Guide and Adoption

The CPM Guide will describe the core practice model adopted in the Settlement Agreement that is based on family-centered values and principles and describe how they should be utilized by the child welfare and mental health systems for the class. The core practice components are identified as: engaging, assessing, service planning and implementation (including child and family teaming), monitoring and adapting and transition. These five components continuously interact and rely on one another to support the CPM. All counties, agencies and individuals who serve children and families that are the clients of both child welfare and mental health agencies will be expected to utilize the CPM Guide to assist with the adoption of the CPM. The CPM Guide components will be reflected in the Documentation Manual and referenced where appropriate to promote the application of the CPM in delivering mental health services to class and subclass members.

Statewide adoption of the CPM is intended to develop a single model of delivery of intensive home and community based services to subclass and class members within the CPM framework, and to reduce the use of group homes and institutional placements. Additionally, the CPM Guide will enable and promote the adoption of a single model of service delivery that children and families receive when served by both Child Welfare and Mental Health agencies. The CPM Fiscal Taskforce will develop a strategic plan or proposal using fiscally sound incentives and reduced administrative barriers. The CPM Fiscal Taskforce's plan or proposal will guide and inform implementation to the fullest extent practicable consistent with the time available.

<u>Action Items for JANUARY 2013 AND BEYOND</u>

1. By January 31, 2013, DHCS and CDSS will issue an ACL/ACIN to all County MHPs and CSS Directors which will include background information regarding the Katie A. Settlement, purpose and goals for the CPM Guide and timeline for statewide implementation and initial and ongoing expectations for its use. The ACL/ACIN will emphasize the importance of engaging families and youth in decision-making at the practice, program, and policy levels.

2. By January 31, 2013, DHCS and CDSS will release the final CPM Guide for implementation.

3. By January 31, 2013, DHCS and CDSS will have released a schedule for basic orientation and training for the CPM Guide. CDSS will contract to provide the initial training and will also be prepared to provide technical assistance to answer questions by counties, providers and other stakeholders regarding the CPM Guide.

4. DHCS and CDSS will consult with the JMT on their obligation to develop and endorse practice tools, training curriculum, practice improvement protocols and quality review systems to support the shared CPM in order to support family and youth engagement and

decision-making, service integration and coordination for child welfare and mental health services for subclass/class members.

5. By January 31, 2013, develop basic orientation and adoption strategies for the CPM guide in order to promote understanding by stakeholders (State partners, Administrative Office of the Courts (AOC), counties and providers, beneficiaries and family members) about the practice model for serving children in the Katie A. class and adoption of the CPM by counties and child welfare and mental health provider agencies.

6. By January 31, 2013, issue an ACL/ACIN to describe IHBS and ICC services within a CPM approach.

7. By September 30, 2013, the CPM Fiscal Taskforce will submit a strategic plan or proposal to finance the implementation of the CPM. The recommendations shall include fiscally sound incentives to county agencies and shall be aligned with the Continuum of Care Reform efforts and recommendations to the extent possible. The recommendations must support the following desired outcomes:

   a) Reduction in administrative barriers;
   b) Statewide delivery of the CPM;
   c) Support training and coaching activities necessary to rollout the CPM and to support parent and youth participation in all aspects of implementation (e.g., child care, transportation and meeting attendance, etc.);
   d) Delivery of ICC and IHBS to subclass members within the CPM framework; and
   e) Reduction in the use of group homes and institutional placements.

8. By December 31, 2013, TFC (once determined to be a Medi-Cal covered service, but no later than December 31, 2013) will be addressed in the CPM Guide through an update or addendum.

PART B: Therapeutic Foster Care Model and Coverage

DHCS and CDSS, in concert with the plaintiffs' counsel and consultants, will determine which components of TFC are covered under Medi-Cal or Title IV-E, the preferred service model, and how the service should be claimed to Medi-Cal or Title IV-E. The TFC Model will seek to reflect ongoing partnership with the child/youth, birth parents, extended maternal and paternal family, and support communities in solution and outcome focused planning and decision-making. Once the TFC model and coverage have been determined, TFC will be added as an update or addendum to the Documentation Manual and the CPM Guide. While TFC implementation may commence after the rollout of IHBS and ICC, these services will not be hindered as a result of the TFC evaluation and implementation process.

Action Items for JANUARY 2013 AND BEYOND

1. Continuing through January 2013, the TFC Consultants will meet with DHCS, CDSS, the Special Master and plaintiffs' counsel, to provide research and information on other state models and provide a recommended model for California.

2. By January 31, 2013, DHCS and CDSS shall determine if any state law changes are necessary to implement TFC in California, and, if so, propose spot legislation in the regular legislative session by February 22, 2013 to enact such necessary changes.

3. By February 28, 2013, DHCS, CDSS and plaintiffs' counsel shall provide the model to the TFC subgroup for review.

4. By February 28, 2013, DHCS and CDSS shall reconvene the TFC Subgroup and the consultants to discuss the model. Continuing through May 2013, CDSS, and DHCS and plaintiffs' counsel will meet and continue to work with the consultants and the TFC Subgroup to modify and adopt a proposed TFC model to implement in California.

5. By June 30, 2013, the following activities will be completed:
   a) Identify components of TFC services/model program that are Medi-Cal reimbursable and any components that are covered by Title IV-E.
   b) Identify costs of the TFC program for which Title IV-E funds may be claimed.
   c) Determine all steps necessary to implement the services/model, including any necessary federal approvals (e.g. Medicaid State Plan Amendment (SPA) and Title IV-E SPA).

6. By July 31, 2013, submit any initial requests for federal approvals necessary, which may include submission of a SPA.

7. By September 30, 2013, provide first draft of the TFC Addendum to the Documentation Manual to the subgroup and Negotiation Workgroup and review and consider incorporating input and feedback.

8. Upon securing any necessary federal approvals, and with a target date by November 30, 2013, provide the final draft of the TFC update or addendum of the Documentation Manual and the CPM Guide to the TFC Subgroup and review and consider incorporating feedback received.

9. Upon securing any necessary federal approvals, and with a target date by December 31, 2013, provide final draft to the Negotiation Workgroup for review and consider incorporating feedback received.

10. Upon securing any necessary federal approvals, and with a target date by December 31, 2013, add final TFC services/model and billing rules to the Documentation Manual. Issue an ACL providing the TFC portion of the Documentation Manual and any other instructions necessary to counties to begin claiming TFC services under Medi-Cal and to begin claiming Title IV-E Federal Financial Participation to pay for allowable costs for foster youth in TFC facilities.

11. Contingent upon the outcome of activities 8, 9 and 10 above, TFC services will be made available statewide on January 1, 2014.

ANTICIPATED RESULTS

The CPM Guide will result in improved coordination of resources and services, greater family and youth engagement and participation, as well as greater uniformity in statewide practices by child welfare and mental health agencies and providers serving children and youth with an open child welfare case. Additionally, the CPM Guide will enable and promote the adoption of a single model of service delivery that children and families receive when served by both Child Welfare and Mental Health agencies.

The adoption and use of the CPM will transform practice associated with the shared governance and delivery of services by child welfare and mental health services staff and the engagement and participation of families and youth. The practice will be adopted by all state and county departments and individuals who serve the Katie A. class members and their families.

The TFC update or addendum will result in improved statewide implementation of TFC services and will provide essential information regarding coverage, claiming and documentation.

The Documentation Manual developed in Phase I, the TFC update or addendum and the CPM Guide will be used together in order to promote integration and alignment between practice and services. Additionally, training and technical support will be provided by the State in a manner that is intended to underscore the importance of using the Documentation Manual and the CPM Guide in unison.

RESPONSIBLE PARTIES
DHCS and CDSS

SECTION III. FAMILY AND YOUTH INVOLVEMENT

For the purposes of this plan, family and youth involvement means that state departments, counties and providers engage and involve youth, parents, and family members in decision-making at the practice, program, and policy levels, and that youth and families have meaningful influence in the design, delivery, and evaluation of services consistent with the values and principles of the CPM.

Family and youth involvement will not happen spontaneously in a historically prescriptive and agency based mental health and child welfare culture. State departments, counties and providers must proactively create environments or processes that welcome youth, parents, family and community partnership.

OBJECTIVES

1. To ensure that family and youth involvement is prioritized and integrated at the practice, program and system levels and phases of implementation as envisioned by the CPM.

2. To ensure DHCS and CDSS utilize family and youth partnerships to assist with identifying the appropriate orientation, training, and other strategies needed to strengthen and/or change the State and local systems to meet the terms of the Settlement Agreement.

3. To improve service delivery practices by ensuring that family culture, strengths and vision are incorporated into services.

4. To improve service outcomes by including satisfaction and quality review measures that are meaningful, easily understandable and reflective of the family and youth perspective in measuring success.

Action Items for JANUARY 2013 AND BEYOND

1. By January 31, 2013, outreach, recruit and actively engage youth participation in all aspects of the implementation process.

2. By January 31, 2013, draft a joint ACL/ACIN to encourage and support specific strategies for involving family and youth, which may include, but are not limited to:

    a) Provide specific orientation and training, as well as ongoing assistance to parents regarding administrative, budgetary, and other elements of in planning social services. Support, encourage and value parents, youth and communities agencies at meetings.
    b) Provide contract and community grant opportunities with parent and youth advocacy groups or community-based organizations that employ parents or youth to develop and direct a process that ensures sustained and thoughtful participation in planning.
    c) Build collaborative working relationships by reaching out to parent and youth organizations, as well as agencies that work with parents and youth (e.g., schools, child care centers) to recommend parents and youth to participate in planning.

d) Build collaborative working relationships with agencies that work with parents (e.g., schools, child care centers) to recommend parents to participate in planning.
e) Establish a stipend program to parents and youth who participate in planning sessions and assist in paying for items that have historically not been reimbursed (i.e. transportation and childcare). Vary times and locations for planning meetings in communities across the state, and in community settings (i.e. schools, community centers, churches) Provide opportunities for parents to assist in many areas of the planning and implementation of ICC, IHBS and TFC (once determined to be a Medi-Cal covered service, but no later than December 31, 2013). Conduct surveys to elicit the views of a wide range of parents.
f) Conduct focus groups that address issues with specific groups in the treatment population (i.e., teenage parents, single parents, grandparents, foster parents, or adoptive parents).
g) Support family preservation and family reunification programs to identify and involve families who have benefited from these services.
h) Provide training to, administrators, and staff led by an experienced facilitator to explore attitudes and stereotypes.
i) Continually support and acknowledge the contributions of parents, family members, and community support for the CPM service delivery model.

3. The State and counties acknowledge the benefits of partnering with youth and families. The State and counties will continuously solicit input from and incorporate family and youth partners in the implementation and rollout of this section.

ANTICIPATED RESULTS

Services will be delivered by counties and their providers in a manner that promotes family and youth engagement in a system that embraces the values and goals of the CPM. Quality assurance indicators will be consistent with family and youth needs. The service delivery system will place youth and families at the center. Enhancements to the system will be made to directly benefit families and youth. Incorporating family and youth involvement in both implementation and outcomes throughout the processes will result in increased: service utilization, collaboration among team members, stable family structures and sustainable recovery.

RESPONSIBLE PARTIES

DHCS and CDSS

SECTION IV. SERVICE DELIVERY AND ROLLOUT

The purpose of the service delivery and rollout section is to support the development and implementation of a service structure and fiscal system for counties to support the implementation of a core practices and services model in a coordinated, comprehensive and community-based approach.

OBJECTIVES

1. To develop and guide implementation of a process or processes to identify/screen, refer and firmly link class members to services (refer to Section VI, Objective 8 for additional information).

2. To ensure statewide implementation of ICC and IHBS. County mental health and social services agencies will jointly develop and submit an ICC and IHBS service delivery plan to the State.

3. To ensure a forum is available to provide timely response to county and provider reports of challenges in implementing ICC and IHBS services.

4. To coordinate the work of the JMT, ACO and CPM Fiscal taskforces to ensure that service delivery is supported, and improved over time by governance, quality/accountability, and fiscal systems and structures that are consistent with the CPM values, goals and components.

Action Items for JANUARY 2013 AND BEYOND

DHCS and CDSS will consult with counties and providers, including parent and youth partners, to promote utilization of the CPM Guide in the delivery of all services, including IHBS and ICC (and TFC, once determined to be a Medi-Cal covered service, but no later than December 31, 2013) by:

1. DHCS and CDSS will provide a forum for problem resolution including, but not limited to:
   a) EPSDT billing or claiming barriers for MHPs and their contractors and make recommendations to DHCS and CDSS on steps to resolve.
   b) Addressing barriers related to sharing confidential juvenile court information with non-professionals.
   c) Clarifying the parameters and legal basis for counties to share child welfare and mental health data and qualitative information related to class and subclass members.

2. Provide consultation and guidance for counties to determine subclass members for whom IHBS and ICC (and TFC, once determined to be a Medi-Cal covered service, but no later

than December 31, 2013) services are medically necessary. A Katie A. Subclass Certification Form (in the Documentation Manual) will include criteria for identifying subclass members.

3. By January 31, 2013, DHCS and CDSS will issue an ACL/ACIN to inform counties of the criteria and selection process for designating Learning Collaborative Counties (previously referred to as Early Implementer Counties) with input from the Negotiation Workgroup, CMHDA, CWDA, and the family and youth partners.

4. By March 1, 2013, the MHPs and child welfare agencies will have lead responsibility for jointly completing a readiness assessment tool and developing a service delivery plan. Nothing in this requirement, or in the service delivery plan or planning process, is intended to impede timely access, or waive a child's entitlement to medically necessary Specialty Mental Health Services as required by law or the Settlement Agreement.

a) Readiness Assessment Tool
For the readiness assessment tool, MHPs and child welfare agencies will be encouraged to seek stakeholder input, and will be encouraged to incorporate input of youth, families and parent partners. The elements of the readiness assessment tool will include, but are not limited to:

i. Organizational leadership
ii. Systems and interagency collaboration
iii. Systems capacity
iv. Service array
v. Children, youth and families
vi. Fiscal funding resources

b) Service Delivery Plan
County mental health and child welfare agencies will jointly develop an ICC and IHBS (and TFC, once determined to be a Medi-Cal covered service, but no later than December 31, 2013) service delivery plan that includes specific methodology and timeframes to meet the need of class/subclass members consistent with the CPM and direction provided by DHCS and CDSS. The plan will include the minimum core components necessary for successful implementation of the CPM and will include the following information:

i. A needs assessment that will describe how the county will identify members of the subclass and screen, assess or otherwise determine their needs. The needs assessment will include a subclass analysis and identify existing services provided to the subclass.
ii. An analysis of how ICC and IHBS services will be delivered in a timely manner to eligible youth.

iii. Identification of the strength of the connectivity and collaboration between child welfare and mental health to administer an array of services to support IHBS, ICC and TFC.

iv. A description of stakeholder involvement in the implementation of ICC, IHBS and TFC, specifically how youth and families will be continuously involved in implementation, policy development, practice issues and continuous quality improvement.

v. An analysis to identify gaps between the needs of the subclass and services provided, and if such a gap is identified, a plan to address it.

vi. A services capacity assessment to determine the capacity of the MHP to provide ICC and IHBS to subclass members.

c) Semi-Annual Progress Reports

Beginning August 1, 2013, county mental health and child welfare agencies will jointly prepare and submit implementation progress reports on a semi-annual basis which will include:

i. Reporting on mental health service utilization

ii. Action plans to address areas identified for improvement

iii. Specified need for technical assistance or state support

5. DHCS and CDSS will consult with counties to ensure that each county has an ICC and IHBS service delivery plan that is capable of achieving the Objectives above. Establish and communicate guidance or standards for what is sufficient process or results for this action item.

6. By April 30, 2013, select Learning Collaborative Counties that will adopt the CPM and provide feedback, to identify barriers and determine potential areas for improvement to support continued rollout and promote statewide CPM adoption. The selection process for designating Learning Collaborative Counties will be based on a foundation of implementation science. The concept of implementation science allows for the appropriate grouping of peer counties based on their various levels of development/readiness, with special allowance for county size. This model allows counties to transfer "lessons learned" during the phases of implementation, how to build and deliver the services county wide and model the strong collaboration between mental health and child welfare for other counties.

7. By June 1, 2013 (and by April 30, 2014 for TFC, once determined to be a Medi-Cal covered service) DHCS and CDSS will complete a statewide analysis of the information provided by the counties as described in activity D above to (1) develop and model child welfare and mental health service delivery systems based on the CPM, (2) identify opportunities for and challenges to providing full access to services for subclass members and broad, statewide application of the CPM, and (3) provide an initial framework for an ongoing process of communication, engagement, collaboration, and problem-solving with county partners and other stakeholders.

8. By June 30, 2013, the county-selected Implementation Teams comprised of county child welfare, mental health, youth and family support partners and providers will be required to participate as part of the learning collaborative process for implementing the CPM. The Learning Collaborative Counties will be grouped based on their level of readiness, and will be oriented to the coaching materials and receive joint training and technical assistance in exchange for providing feedback about the implementation of the CPM training, coaching and other materials developed by the MDT training subgroup.

9. DHCS and CDSS are committed to continuously:
   a) Identifying state supportive activities, resources, incentives, sanctions and guidance that may be available to increase access to ICC, IHBS and TFC.
   b) Developing an ongoing state, county, provider and parent and youth problem-solving, opportunity-developing dialog/process focused on expanding service capacity at the county level.
   c) Establishing program priorities and developing population-specific strategies including geographic, resource, training, and workforce challenges for increasing access to services over time.
   d) Setting annual or bi-annual performance goals or targets based on appropriate localized conditions or circumstances.
   e) Regularly communicating with stakeholders and developing solutions to identify challenges.
   f) Borrowing/sharing resources from other successful efforts to adopt CPM or similar system of care/ wraparound methods.
   g) Seeking out federal and private resources to support this effort.
   h) Exploring ways to develop and/or support centers of excellence that can provide strategic, logistic, and technical support for developing and sustaining CPM systems and core elements. Such organizations could also address workforce challenges.

10. Additional training and technical assistance guidance is referenced in Section V.

ANTICIPATED RESULTS

IHBS and ICC (and once determined to be a Medi-Cal covered service, but no later than December 31 2013, TFC) will be provided statewide to eligible youth pursuant to the guidelines and procedures provided in the Documentation Manual and CPM Guide. Progressive adoption of the CPM will result in a joint practice model of care that children, youth and families receive when served by their local mental health and child welfare agencies and providers. Services that are delivered respond explicitly to the culture and beliefs of youth and families.

RESPONSIBLE PARTIES

CDSS, DHCS, Negotiation Workgroup, County MHPs and County Child Welfare Services.

SECTION V. TRAINING AND TECHNICAL ASSISTANCE

The purpose of the training and technical assistance activities is to support adherence to a sustainable core practice model which will facilitate the transformation of child welfare and mental health systems. Training activities alone are not enough to sustain the adherence to the CPM. Solutions also need to be hands on and practical to meet technical and adaptive challenges in order to achieve meaningful changes in values, beliefs, attitudes, family and youth inclusion and paradigms in real time.

OBJECTIVES

1. To develop cross-system training and coaching curriculum and educational materials for child welfare and mental health staff, youth, family support partners, providers and parents/caregivers and to include families/caregivers in the development of training.

2. To develop joint training and/or technical support for a child welfare and mental health leadership and workforce that is in line with the CPM to support the integration and coordination of child welfare and mental health leadership and workforces in order to deliver consistent and quality services that include families and youth in the training process.

3. To clarify and provide guidance on state and federal laws as needed to implement the Settlement Agreement so that counties, providers, families and youth, and other stakeholders can understand and consistently apply them.

4. To develop and endorse practice tools, training and coaching curriculum, practice improvement protocols and quality control systems to support the shared CPM in order to support service integration and/or coordination for mental health services for class members.

5. To ensure family and youth involvement is included in all aspects of training and support development and activities.

Action Items for JANUARY 2013 AND BEYOND

1. The statewide training plan for the adoption of the Documentation Manual includes the following:
   a) By January 16, 2013, Documentation Manual training materials will be drafted.
   b) Starting January 16, 2013 DHCS will host weekly technical assistance calls to address questions, needs regarding the use of the Documentation Manual and to set time aside for CDSS to answer questions related to the core practice model following the release of the CPM Guide.
   c) By February 1, 2013, DHCS will establish a webpage for Documentation Manual frequently asked questions and update the information on a monthly basis.
   d) By February 28, 2013, CDSS will contract to facilitate the identification of locations for four regional trainings (Los Angeles, Bay, Sacramento and Redding). The trainings will consist of three hours of CPM training and four hours of Documentation Manual training.
   e) By March 31, 2013, DHCS will schedule two train-the-trainers sessions (one in Sacramento and one in Los Angeles.)
   f) By December 31, 2013, DHCS will host two Promising Practices Webinars. County MHPs and County Child Welfare Services organizations that are identified as demonstrating strong implementation will be recruited to share their experiences.

2. The statewide training plan for the adoption of the CPM includes the following:
   a) Thirty days after the issuance of the CPM Guide, the Statewide Training and Education Committee's Multi-Disciplinary Training (MDT) subgroup comprised of counties, providers, parents and youth, training academies, caregivers and other stakeholders will assemble and begin the process of developing curricula, educational materials and peer support training.
   b) Thirty days after the issuance of the CPM Guide, review the CPM guide and determine if existing training curricula and coaching materials can be enhanced or if new curricula and coaching materials need to be developed for use by mental health, child welfare, family and youth partners and providers and other stakeholders, including assessing the need for educational materials and/or an implementation toolkit.
   c) By May 1, 2013, the MDT will finalize the training curricula, coaching and educational materials and the implementation toolkit and schedule the four Regional Trainings for Trainers.
   d) By June 30, 2013, the county Implementation team comprised of child welfare, mental health, family and youth partners and providers will be required to participate as part of learning collaborative for implementing the CPM. The Learning Collaborative Counties will be grouped based on their level of readiness, and will be oriented to the coaching materials and receive joint training and technical assistance in exchange for providing feedback about the implementation of the CPM training, coaching and other materials developed by the MDT training subgroup.

e) Curricula and coaching materials will be revised by the training subgroup based on the feedback and experience of the Learning Collaborative Counties.

f) All curricula and coaching materials will be finalized and made available for all counties, other training entities and stakeholders and accessible by posting to appropriate websites.

g) Additional training for trainers and webinars will be scheduled by DHCS and CDSS leveraging the Statewide Training and Education Committee's system of coordination in addition to identifying other training opportunities from mental health entities. The learning collaborative will provide a county peer to peer learning environment that will include joint planning, common technical assistance themes, modeling for other counties and address emerging barriers, with solutions for county sites.

h) DHCS and CDSS will coordinate and stage additional rollout efforts based on counties' identified area of need for technical support based on their readiness assessment and from information on the notice of the service delivery plan that will be submitted to the State.

i) A transfer of knowledge process will be targeted to County supervisors and managers from child welfare and mental health agencies in order to further their understanding and skills about what the CPM is supposed to accomplish with their support. Materials will be developed to enhance their knowledge and skills through a variety of methods that may include but are not limited to: the use of learning agreements, curricula, online materials, webinars, technical assistance from Federal, State, contracted consultants, and coaching or mentoring support.

j) To further encourage transfer of learning, social workers and mental health staff and their supervisors will be guided on how to develop a learning plan that includes pre and post training goal setting, follow-up and assessment.

k) Advanced Training modules will be developed and made available which will assist social worker and mental health staff in delivering the CPM approach.

3. Continuous and ongoing technical assistance will include but not be limited to:

a) Assessing and evaluating coaching and mentoring needs and developing a plan to assist the counties in meeting these needs.

b) Developing policy guidance on the interrelationship between ICC, IHBS, TFC and the CPM.

c) Continuing to issue communications to describe and provide guidance regarding the expectations for and benefits of delivering services in a child/youth-centered, family-focused, community-oriented manner (e.g., ACL/ACIN) and participate in calls/meetings/presentations with stakeholders and associations (e.g. California Mental Health Directors Association, California Welfare Directors Association, Chief Probation Officers of California and the California Alliance of Child and Family Services).

d) Targeting specific audiences, such as: county leadership, courts, and counties that have an identified area of need for technical support based on readiness assessment.

e) Leveraging additional resources and the State Regional Training Academies to support integrated training for child welfare and mental health.

ANTICIPATED RESULTS

County leadership from mental health and child welfare agencies will be informed and advised based on experience from the Learning Collaborative Counties. Families and youth will be included throughout the development of the training materials process.

Training for the Documentation Manual will be coordinated with the training on the Core Practice Model Guide.

RESPONSIBLE PARTIES

DHCS and CDSS

SECTION VI. DATA AND QUALITY ASSURANCE

Several activities related to data, accountability, quality assurance, and the establishment of an ACO Taskforce are necessary to ensure clear and consistent guidance and that outcomes, satisfaction and accountability measures are consistent with the CPM. These include adoption and statewide use of a data-informed system of performance oversight, accountability and communication that efficiently monitors, measures and evaluates access, quality, satisfaction, effectiveness, costs and outcomes at the individual, program and system levels.

OBJECTIVES

1. To establish an ACO Taskforce and produce a report with recommended actions and timelines.

2. To engage youth and families in all aspects of data and quality assurance planning, design, decision-making and implementation.

3. To establish a method to track the use of IHBS, ICC and TFC services for subclass members.

4. To facilitate a stakeholder meeting to solicit ideas from youth and families, providers, advocates, counties, and other stakeholders about the data DHCS and CDSS should routinely produce and post on both departments' websites.

5. To establish a procedure and timeline to produce and post data that is useful to counties, stakeholders and State departments in addressing the needs of children in the class, including information and data regarding the use of less restrictive, informal services, and natural linkages used to address youth and families' strengths and needs.

6. To develop a plan for the collection of data and information about children in the class who receive mental health services.

7. To collect existing data specific to the class (and subclass) in order to evaluate utilization (patterns, type, frequency, intensity of services) and timely access to appropriate care, including informal services and natural linkages.

8. To measure the success of the processes to identify/screen, refer and firmly link class members to services and to adapt and modify Implementation Plan strategies to resolve problems or eliminate barriers that may arise and impede access to IHBS, ICC, TFC, or the application and use of the CPM.

9. Using the ACO and/or JMT taskforces, identify monitoring, measuring, evaluating, reporting and adapting mechanisms that will be used to assure that local efforts meet Section IV, Objective 1 and 2 as appropriate.

Action Items for JANUARY 2013 AND BEYOND

1. By January 1, 2013, DHCS will implement new procedure codes in the SD/MC II system.

2. By January 31, 2013, DHCS and CDSS will establish and convene an ACO Mapping Group to inventory and report on the current array of ongoing state and county data efforts by CDSS, DHCS and others.

3. By February 28, 2013, the ACO Taskforce will begin convening monthly meetings. The ACO Taskforce will support service integration and/or coordination for mental health services for class members by improving methods and adequacy of data collection, matching and sharing to support the CPM at the State, county and provider levels. The taskforce will provide recommendations to DHCS and CDSS to inform the design, development and support of the SMS.

4. By April 1, 2013, DHCS and CDSS will analyze and evaluate utilization (patterns, types, frequency and intensity of services) and timely access to care based on data elements in both departments' data systems specific to the class and subclass.

5. By April 30, 2013, the ACO Taskforce will convene and facilitate a stakeholder meeting to solicit ideas from youth and families, providers, advocates, counties, and other stakeholders about what data concerning the class DHCS and CDSS should routinely produce and post on both department's websites.

6. By June 30, 2013, data and subsequent analysis and evaluation of utilization (as described in item A above) will be shared publicly with counties, providers and all stakeholders through postings on both departments' websites, every six months through December 31, 2014.

7. By September 1, 2013, the ACO Taskforce will produce a report with recommended actions and timelines related to identifying, devising and collecting:
   a) A method to track the provision of mental health services to the class and the use of IHBS and ICC (and after December 31, 2013 for TFC) service arrays for subclass members. Consider utilizing or revising the External Quality Review Organization (EQRO) and California Child and Family Services Review (C-CFSR) requirements in developing a plan for the collection of data and qualitative information about children. Also consider utilization of a nationally recognized fidelity tool to measure the adoption of the CPM.
   b) A process to measure the engagement and participation of youth and families in the planning and implementation phases by counties and providers.
   c) Data elements in DHCS and CDSS data systems specific to the class and subclass in order to evaluate utilization (patterns, types, frequency, intensity of services) and timely access to care.

ANTICIPATED RESULTS

Adoption and statewide use of a data-informed system of performance oversight, accountability and communication that efficiently monitors, measures and evaluates access, quality, satisfaction, effectiveness, costs and outcomes at the individual, program and system levels.

The production of relevant, timely, and understandable measures that report who needs and who is receiving services, including the type, intensity and duration, at the individual, program, county, and system levels. Use a continuous quality improvement process to monitor and support service delivery, utilization and adherence to the Core Practice Model.

The State will have and share publicly the necessary information to determine whether implementation of IHBS, ICC and the CPM is successful, and if not, what measures need to be taken to achieve success. Data and oversight systems will continue to be used to improve performance and quality over time.

Family and youth satisfaction is a critical component of system evaluation. Families and youth will be active participants in state system planning. A formal mechanism will be used to address family and youth concerns.

1
2 RESPONSIBLE PARTIES
3
4 DHCS and CDSS
5

APPENDIX: A

SECTION I - SHARED MANAGEMENT STRUCTURE

Task	Responsible Party	Date Accomplished
Convened Joint Management Taskforce meetings	CDSS/DHCS	November 2012
Held regular joint leadership meetings with their respective Directorates for briefings, policy decision making and issue resolution	CDSS/DHCS	Ongoing since January 2012
Held ongoing, regularly scheduled meetings to discuss status and planning of the Implementation Plan	CDSS/DHCS	Ongoing since January 2012
Provided policy leadership and direction to the Negotiation Workgroup and Special Master	CDSS/DHCS	Ongoing since January 2012
Continued to meet weekly to collaborate and coordinate efforts	CDSS/DHCS	Ongoing since January 2012
Continued facilitating interagency commitment and collaboration between the state departments and at the county/and subcontractor levels to implement the core practice model, intensive services and training, and accountability efforts	CDSS/DHCS	Ongoing since January 2012

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SECTION II - CORE COMPONENTS

Task	Responsible Party	Date Accomplished
Completed a draft Documentation Manual and posted for 30-day public comment period on the DHCS and CDSS websites	Documentation Manual Subgroup	October 2012
Reviewed public comments and considered input/feedback and revised Documentation Manual as needed	DHCS	Ongoing
Finalized Documentation Manual and submitted to Negotiation Workgroup	DHCS	Ongoing
Distributed Documentation Manual statewide	DHCS	Pending
Provided basic Documentation Manual orientation and scheduled webinars/ trainings	DHCS/CDSS	Scheduled December 17, 2012
Developed and released an All County Letter/Notice regarding the Katie A Settlement, Documentation Manual, the date for delivery/claiming of ICC and IHBS, training dates and info on how to access technical assistance	DHCS/CDSS	Draft Pending
Completed a draft Core Practice Model Guide	Core Practice Model Guide Subgroup	Ongoing
Released draft Core Practice Model Guide for review to subgroup	CDSS	Ongoing
Continued to work with TFC Consultants regarding state models and recommendations on TFC coverage	DHCS, CDSS, Plaintiffs' Counsel and Special Master	December 2012
Convened the CPM Fiscal Taskforce meetings	DHCS/CDSS	October 2012

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SECTION III - FAMILY AND YOUTH INVOLVEMENT

Task	Responsible Party	Date Accomplished
Provided youth partners with orientation	CDSS	July 2012
Engaged family partners to provide input on implementing Implementation Plan	DHCS/CDSS	Continuous

SECTION IV - SERVICE DELIVERY AND ROLLOUT

Task	Responsible Party	Date Accomplished
Drafted and prepared for release the Readiness Assessment Tool	DHCS/CDSS	Ongoing
Developed and issued an ACL and/or Information Notice to counties regarding IHBS and ICC	DHCS/CDSS	Pending
Determined IHBS and ICC billing codes and ensured that State systems are able to process claims	DHCS/CDSS	Pending
Implemented IHBS and ICC for availability statewide	DHCS/CDSS	January 2013

SECTION V - TRAINING AND SUPPORT

Task	Responsible Party	Date Accomplished
Initiated a request to the Statewide Training and Education Committee to convene a multidisciplinary team to develop statewide integrated curriculum and training	CDSS	September 2012
Instructed appropriate State and County auditors to follow the billing and documentation guidelines	DHCS	December 2012
Worked collaboratively with the counties to provide ongoing technical assistance and support on Readiness Assessment tool	DHCS/CDSS	Pending
Developed educational materials for counties and providers and toolkit for Child and Family Teams	DHCS/CDSS	Pending

SECTION VI - DATA AND QUALITY ASSURANCE

Task	Responsible Party	Date Accomplished
Finalized ACO Taskforce charter and made recommendations for Taskforce membership	DHCS/CDSS	August 2012
Finalized membership of ACO Taskforce	DHCS/CDSS	October 2012
Conducted initial ACO Taskforce meeting	DHCS/CDSS	Moved to Phase 2
Identified existing data systems and resources which are capable of measuring who is receiving services &	DHCS/CDSS	Moved to Phase 2

identifying service needs		

APPENDIX: B

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning. Interventions are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the youth successfully function in the home and community.

IHBS are delivered according to an individualized treatment plan developed by a care planning team (see ICC). The care planning team develops goals and objectives for all life domains in which the child's mental health condition produces impaired functioning, including family life, community life, education, vocation, and independent living, and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives should seek to maximize the child's ability to live and participate in the community and to function independently, including through building social, communication, behavioral, and basic living skills. Providers of intensive home-based services should engage the child in community activities where the child has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

IHBS includes, but is not limited to:

1. Educating the child's family about, and training the family in managing the child's disorder;
2. Medically necessary skill-based remediation of behaviors, including developing and implementing a behavioral plan with positive behavioral supports and modeling for the child's family and others how to implement behavioral strategies;
3. Improving self-care, including by addressing behaviors and social skills deficits that interfere with daily living tasks and with avoiding exploitation by others;
4. Improving self-management of symptoms, including assisting with self-administration of medications;
5. Improving social decorum, including by addressing social skills deficits and anger management;
6. Supporting the development and maintenance of social support networks and the use of community resources;
7. Supporting employment objectives, by identifying and addressing behaviors that interfere with seeking and maintaining a job;
8. Supporting educational objectives, through identifying and addressing behaviors that

interfere with succeeding in an academic program in the community; and

9. Supporting independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

IHBS are highly effective in preventing a child being removed from home (biological, foster, or adoptive) through admission to an inpatient hospital, residential treatment facility or other residential treatment setting.

Settings: IHBS may be provided in any setting where the child is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings.

Availability: IHBS are available wherever and whenever needed, including evenings and on weekends.

Providers: IHBS are typically provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS. More complex cases may require service delivery by a clinician rather than a paraprofessional.

APPENDIX: C

Intensive Care Coordination

Intensive Care Coordination (ICC) is a service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services for children and youth who meet the Katie A subclass criteria. ICC provides:

- A single point of accountability for ensuring that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth-driven, and culturally and linguistically relevant manner;
- Services and supports that are guided by the needs of the youth;
- Facilitation of a collaborative relationship among a youth, his/her family, and involved child-serving systems;
- Support the parent/caregiver in meeting the youth's needs;
- A care planning process which ensures that a care coordinator organizes and matches care across providers and child serving systems to allow the youth to be served in their home community; and
- Facilitated development of the Child and Family Planning Team (CFT). (The CFT includes as appropriate, both formal supports, such as care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy.)

ICC service components consist of:

Assessment: The CFT completes a strength-based, needs-driven, comprehensive assessment to be integrated into the development of an Individual Care Plan (ICP) and a risk management/safety plan. The assessment process determines the needs of the youth for any medical, educational, social, mental health or other services. ICC may also include the planning and coordination of urgent needs before the comprehensive assessment is completed. The initial assessment will be reviewed as necessary, but at least every 90 days.

Planning: Development of an Individual Care Plan (ICP): Using the information collected through the assessment process, the care coordinator convenes and facilitates the CFT meetings, and the CFT develops a child- and family-centered ICP which specifies the goals and actions to address the medical, educational, social, mental health, or other services needed by the youth and family. The care coordinator works directly with the youth, the family and others significant to the child to identify strengths and needs of the youth and family, as well as to develop a plan for meeting those needs and goals.

Referral, Monitoring and Related Activities: ICC also includes the following service activities:

- Working directly with the youth and family to implement elements of the ICP;
- Preparing, monitoring, and modifying the ICP in concert with the CFT;

- Determining whether services are being provided in accordance with the ICP;
- Determining whether the services in the ICP are adequate to meet the needs of the child and family;
- Determining whether there have been changes in the needs or status of the youth and, if so, adjusting the plan of care as necessary in concert with the CFT; and
- Will identify and actively assist the youth and family in obtaining and monitoring the delivery of available services, including medical, educational, mental health, social, therapeutic, or other services.

Transition: ICC also includes:

- Developing with the CFT a transition plan when the youth has achieved goals outlined in the ICP; and
- Collaborating with the other service providers and agencies on behalf of the youth and family.

Settings: ICC may be provided to children living and receiving services in the community as well as to children who are currently in a hospital, group home, or other congregate or institutional placement as part of discharge planning.

EXHIBIT 3: Katie A. Negotiation Workgroup Members

- DeAnna Avey-Motikeit, Deputy Director, Child Welfare Services Division, San Bernardino County Department of Social Services, Representing County Welfare Directors Association of California.
- Diana Boyer, Senior Policy Analyst, County Welfare Directors Association of California, Sacramento.
- Fran Bremer, Senior Staff Counsel, Legal Division, California Department of Social Services, Legal Services.
- Mary Ellen Collins, Executive Director, United Parents, Camarillo.
- Susan Diedrich, Assistant Chief Counsel, Legal Division, California Department of Social Services, Legal Services.
- Patrick Gardner, Director, Young Minds Advocacy.
- Don Kingdon, Deputy Director, California Mental Health Directors Association.
- Dina Kokkos-Gonzales, Chief, Program Policy and Quality Assurance Branch, Mental Health Division, California Department of Health Care Services.
- Steve Korosec, Special Master's Assistant, Facilitator.
- John Krause, Senior Staff Counsel, Legal Services, California Department of Health Care Services.
- Greg Lecklitner, Clinical District Chief, DMH, Child Welfare Division, Los Angeles County Department of Mental Health.
- Rita McCabe, Chief, California Department of Health Care Services
- Kim Lewis, Managing Attorney, California, National Health Law Program, Los Angeles.
- Debbie Manners, Senior Executive Vice President, Hathaway-Sycamores Child and Family Services, Los Angeles.
- Ernest Martinez, Deputy Attorney General, Department of Justice, Office of the Attorney General.
- Vickie Mendoza, Director of State Wide Community Network, United Advocates for Children and Families, Sacramento.
- Adrienne Olson, LCSW, Division Chief, Child Welfare Mental Health Services, Bureau of the

Medical Director, LA County Department of Children and Family Services.

- Greg Rose, Deputy Director, Children and Family Services Division, California Department of Social Services.
- Richard Saletta, Federal Court Special Master.
- Carmen Snuggs, Deputy Attorney General, Department of Justice, Office of the Attorney General.
- VACANT, Youth Representative (Vacancy will be filled December 1, 2012)
- Suzanne Tavano Ph.D., Director, Contra Costa County Mental Health, Representing California Mental Health Director's Association.
- Cheryl Treadwell, Bureau Chief, Resource Development and Training Support, California Department of Social Services.
- Barbara Zweig, Senior Staff Counsel, Legal and Forensic Services, California Department of State Hospitals.

Changes to the Negotiation Workgroup since the August 28, 2012, Special Master's Report to the Court: Departures: John Lessley, DHCS, new assignment at DHCS and David Gray, Special Master's Assistant and Facilitator, health reasons. Arrival: Rita McCabe, Chief, Mental Health Program Supervisor, Department of Health Care Services.

CERTIFICATE OF SERVICE

Case Name: **KATIE A., et al. v. BONTA, et al.** No. **CV-02-05662 AHM (SHx)**

I hereby certify that on November 29, 2012, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

EXHIBITS 1 TO 3 TO SPECIAL MASTER'S REPORT ON PROGRESS TOWARD COMPLETION OF THE KATIE A. IMPLEMENTATION PLAN

Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. On November 29, 2012, I have mailed the foregoing document by First-Class U.S. mail, postage prepaid, for delivery within three (3) calendar days to the following non-CM/ECF participants:

Catherine J. Pratt, Esq.
Gerald M. Custis, Esq.
Children Services Division
201 Centre Plaza Dr., Suite 1
Monterey Park, CA 91754-2143

John F. Toole, Esq.
National Center for Youth Law
405 14th Street, 15th Floor
Oakland, CA 94612-2701

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on November 29, 2012, at Los Angeles, California.

M. Chacon	/s/M. Chacon
Declarant	Signature

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