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9 UNITED STATES DISTRICT COURT  
10 CENTRAL DISTRICT OF CALIFORNIA  
11 WESTERN DIVISION  
12

13  
14 **KATIE A., et al.,**

15 Plaintiffs,

16 v.

17 **TOBY DOUGLAS**, Director of the  
18 California Department of Health Care  
Services; et al.,

19 Defendants.  
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Case No. 2:02-cv-05662 JAK (SHx)

**STATE DEFENDANTS'  
RESPONSE TO THE SPECIAL  
MASTER'S JUNE 16, 2014  
REPORT**

Date: July 18, 2014

Time: 2:00 p.m.

Crtrm: 750

Judge: Honorable John A. Kronstadt

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1 State Defendants, Toby Douglas, Director of the California Department of  
2 Health Care Services (DHCS), and Will Lightbourne, Director of the California  
3 Department of Social Services (DSS) (State Defendants), hereby respectfully  
4 submit the following response to the Special Master's June 16, 2014 Report. ECF  
5 No. 899.

6 Through the efforts of State Defendants, in collaboration with county child  
7 welfare and mental health agencies, Plaintiffs' counsel, and the Special Master,  
8 implementation of the *Katie A.* settlement agreement is off to a strong start. With 50  
9 counties now providing and submitting claims for services in addition to the  
10 foundational work that has been accomplished, there can be no question that, while  
11 there still remains much work to be done to fully accomplish statewide system  
12 change, there can also be no doubt that implementation of the service component of  
13 the settlement has been successfully launched -- just as the settlement intended.  
14 State Defendants fully expect, and the data also supports, that this implementation  
15 momentum will continue and accelerate as the necessary infrastructure solidifies.

16 Nevertheless, the Special Master's report, while acknowledging that  
17 implementation of the Implementation Plan has progressed since the November 18,  
18 2013 Status Conference, also suggests that a "low" number of subclass members  
19 are currently receiving Intensive Care Coordination (ICC) and Intensive Home  
20 Based Services (IHBS) and, in turn, expresses dissatisfaction with the progress of  
21 implementation of this Settlement Agreement (settlement) that the State voluntarily  
22 entered into in 2011.

23 State Defendants strongly disagree with the Special Master's characterizations  
24 that suggest that the parties have not progressed far enough in settlement  
25 implementation at this point in time.<sup>1</sup> The Special Master's characterizations are

26 <sup>1</sup> State Defendants want to make clear that, contrary to statements made in  
27 the Special Master's Report, State Defendants were not provided a copy of the  
28 Special Master's Report before it was provided to the Attorney's General's Office  
for filing with the Court on June 16, 2014. While generally aware of the Special

(continued...)

1 incomplete, in some instances rely on lagging data (as the State has long and often  
2 indicated) that has since been updated, and in large part (and in this report in  
3 particular, in contrast to earlier reports) omit full recognition of the enormous  
4 foundational work that, per the settlement, needed to be completed before service  
5 delivery and implementation could properly take place. Indeed, given the  
6 significant and multi-tiered complexity of the services being provided, the cultural  
7 and systemic change that the settlement requires, and the practical and logistical  
8 hurdles that needed to be addressed (procuring contracts of providers being only  
9 one of them), it becomes clear that implementation has advanced dramatically and  
10 significantly in a relatively short timeframe. State Defendants have implemented  
11 the *Katie A.* settlement effectively, in good faith, and submit this response in an  
12 effort to put the current status of implementation in a proper context for the Court.  
13 As an aside, State Defendants have elected not to respond to assertions by the  
14 Special Master as to the capabilities of any one Department or its representative  
15 preferring instead to emphasize what has actually been accomplished since  
16 implementation began.

17 From the outset, the State Defendants wish to stress the relatively short  
18 timeframe in which so much effective system change has been accomplished.  
19 While the *Katie A.* settlement was approved on December 2, 2011 by the Honorable  
20 Judge Howard Matz, two key “deliverables” -- the Core Practice Model Guide  
21 (CPM Guide) (Exhibit A) and the Medi-Cal Manual (Exhibit B), which instruct the  
22 counties on how to provide and claim for IHBS and ICC services – were developed  
23 amongst the parties over a period of several months and posted on the Departments’  
24 respective websites on March 1, 2013. Trainings and orientations for the manuals  
25 were provided to the counties by the State between March 2013 and June 2013.

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(...continued)

27 Master’s concerns, State Defendants were not apprised as to the specific  
28 recommendations made by the Special Master nor the characterization that  
implementation is not sustainable.

1 Impressively, barely a year later, 50 counties are now providing and claiming ICC  
2 and IHBS services. This includes virtually all of the 12 largest counties who serve  
3 75% of California's foster care population. Just as importantly, the fact that 50  
4 counties are claiming for ICC and IHBS indicates that the foundations necessary to  
5 support the provision of these services are in place and being rapidly expanded.

6 Not only is implementation progressing well, there is every indication that  
7 *Katie A.* has taken hold in California and will become standard practice. In addition  
8 to providing continuing support to the 50 counties currently providing ICC and  
9 IHBS, the State is actively engaged with the remaining 8 counties to ensure that  
10 they move implementation forward as soon as possible. Two of those 8 counties  
11 have no subclass members to serve. Nevertheless, State Defendants are reaching  
12 out to those counties to determine whether a plan is in place to provide such  
13 services if there is ever a need. And even in counties already providing and  
14 claiming services, State Defendants fully anticipate that the number of children  
15 receiving services as well as the minutes billed will continue to grow as counties  
16 build capacity and establish their infrastructures. Indeed, collaboration between  
17 child welfare and mental health agencies has increased significantly in the past  
18 year. Almost half of the counties report having a shared management structure in  
19 place. Similarly, almost half of the counties report that hiring of additional staff is  
20 either underway or complete, or that their contracts with service providers are being  
21 established or increased all to support implementation of *Katie A.* *Katie A.* is now  
22 a consistent and dynamic topic of conversation among the counties, State, the  
23 Legislature, and vital stakeholders. Specifically, the California Mental Health  
24 Directors' Association (CMHDA) and the Child Welfare Directors' Association  
25 (CWDA) have both memorialized their commitment to providing ICC and IHBS to  
26 children and families, despite the dynamism of this unfolding *Katie A.* statewide  
27 superstructure. (Ex. C, December 6, 2013 Letter from California State Association  
28 of Counties (CSAC) and CMHDA; March 18, 2014 letter from CMHDA; April 2,

1 2014 letter from CSAC, CWDA and CMHDA; June 19, 2014 letter from  
2 CMHDA.)

### 3 **IMPLEMENTATION EFFORTS TO DATE**

4 To put the cumulative *Katie A.* settlement activities in a chronological context,  
5 State Defendants provide the following year-by-year summary.

#### 6 **A. Year 1: December 2011 – December 2012: Drafting the** 7 **Implementation Plan**

8 By design, the *Katie A.* settlement was drafted in very broad terms, with the  
9 initial emphasis on establishing the framework by which far reaching,  
10 comprehensive systemic change would occur and which would allow the parties  
11 substantial latitude to fashion approaches and methods as conditions on the ground  
12 warranted and in response to the inevitable and often unpredictable changes that  
13 can occur years into the future. But as a specific feature of this settlement, it also  
14 expressly requires development of a more specific implementation plan in order to  
15 effectuate the settlement objectives. Thus, once the class action settlement was  
16 tentatively approved by the Court in September 2011, the very first task that needed  
17 to be completed was to fill in the details of the broad settlement with a more refined  
18 Implementation Plan.

#### 19 **1. The Year-Long Interactive Process to Draft and Complete the** 20 **Implementation Plan by November 2012**

21 State Defendants, along with the plaintiffs' counsel, and with the assistance of  
22 the Special Master, have expended a staggering amount of effort to implement the  
23 *Katie A.* settlement over the past two and half years. On September 30, 2011 Judge  
24 Matz gave preliminary approval of the parties' settlement thereby triggering the  
25 parties' obligation to begin drafting the implementation plan under the terms of the  
26 settlement. The Special Master began meetings of the negotiation workgroup  
27 tasked with drafting the *Katie A.* Implementation Plan in October 2011. The  
28 negotiation workgroup began its work in earnest on October 13, 2011 and consisted

1 of over 20 members including State Defendants, county representatives, plaintiffs'  
2 counsel, providers, parents, and the Special Master's staff. This "planning" phase  
3 of implementation took months to complete and involved extensive in-person  
4 meetings (all of which took place in Sacramento), discussions, and exchange of  
5 innumerable drafts. While this work was clearly the condition precedent to  
6 implementation, it was a slow and deliberate process that consumed fully the entire  
7 first year of implementation. The Special Master used the Interest-Based-Decision-  
8 Making (IBDM) process to develop the Implementation Plan which is inherently  
9 time consuming in that it affords participants sufficient opportunity to express their  
10 interests and agree to mutually acceptable terms. Ultimately, all of the stakeholders  
11 involved--, State, plaintiffs' and Special Master included--, agreed that the  
12 additional effort to achieve full consensus, despite its time consumption, would  
13 better serve effective system change in the future. This extra time in building a  
14 strong foundation did not delay implementation. Rather it laid the groundwork  
15 necessary for the implementation that is now proceeding. Moreover, counties could  
16 not begin to provide services or perform other implementation activities until this  
17 foundational planning work was complete.

18 The Implementation Plan was developed in two phases. Phase I of the  
19 Implementation Plan was filed with the Court on August 28, 2012 and covered  
20 activities that were slated for completion in 2012. (Ex. D, Katie A Implementation  
21 Plan.) The primary concern lodged at that time was to address service delivery and  
22 rollout in order to ensure the provision of services to children and families as soon  
23 as possible. Consequently, Phase I of the Implementation Plan focused on the steps  
24 the State Defendants would take to ensure service delivery began in 2013 such as  
25 drafting of the Medi-Cal Documentation Manual describing Medi-Cal claiming and  
26 documentation requirements, and developing the CPM Guide. In addition the State  
27 developed billing codes and other systemic changes needed so that claims for  
28 reimbursement of the services could be processed and paid.

1 It was agreed that Phase II of the Implementation Plan (Exhibit E) would be  
2 submitted at a later date and would contain more specificity regarding  
3 implementation activities that would occur in 2013 and beyond such as training to  
4 the CPM Guide, development of the readiness assessment, county service delivery  
5 plans, and statewide quality review systems, and more detail as to the steps to be  
6 taken to make therapeutic foster care available to subclass members.

## 7 **2. Sub-Group and Task Force Work in 2012-2013**

8 Concurrently with drafting the Implementation Plan, State Defendants  
9 participated in several sub-groups tasked with doing other work necessary to  
10 implement the settlement. This included drafting the charters for the Core Practice  
11 Model Fiscal Taskforce (Exhibit F), the Joint Management Structure Taskforce  
12 (JMT) (Exhibit G), and the Accountability, Communication and Oversight  
13 Taskforce (ACO) (Exhibit H). Each of these taskforces was required by the  
14 settlement agreement and their work deemed critical to implementation by the  
15 Negotiation Workgroup who drafted the settlement agreement. Still another  
16 workgroup was initiated to begin the work of developing the model for Therapeutic  
17 Foster Care Services. (Ex. I, TFC Implementation Deliverables Chart, Tab of State  
18 Defendants' Exhibit Binder.) State Defendants advised this workgroup as well.  
19 Additional staff from both departments were assigned to support this multi-faceted  
20 planning process.

## 21 **3. The CPM Guide and Medi-Cal Manual Are Developed and Released** 22 **in March 2013**

23 A key deliverable of Phase I was the release of the CPM Guide and the Medi-  
24 Cal Manual (Exhibits A and B) that instruct the counties on precisely how to claim  
25 for and provide ICC and IHBS in the context of the Core Practice Model. State  
26 Defendants drafted these manuals in close collaboration with stakeholders. While  
27 initially scheduled for release in November 30, 2012, feedback from the stakeholder  
28 community that would be using these manuals indicated that the manuals needed to

1 be edited and clarified further to ensure optimal guidance to the counties and  
2 providers. Given the critical nature of these manuals, all parties, Special Master  
3 included, agreed to postpone the release until March 2013 in order to make the edits  
4 requested by stakeholders. ECF No. 828. The Court approved this schedule on  
5 December 20, 2012, contingent on the Special Master's determination that  
6 significant progress was being made on finalizing the manuals, a determination that  
7 the Special Master made in his March 1, 2013, report with respect to  
8 Recommendation 2 and the modified timelines of the Implementation Plan. ECF  
9 No. 835.

10 In addition to developing the Implementation Plan, participating in the  
11 subgroups, and drafting the CPM Guide and the Medi-Cal Manual, State  
12 Defendants also began meeting with key county-level stakeholders such as  
13 CMHDA and CWDA to discuss *Katie A.* implementation. Additionally, both  
14 CDSS and DHCS developed websites devoted specifically to *Katie A.*  
15 implementation which have been regularly updated with necessary information.

16 The links to the websites are as follows:

17 <http://www.childsworld.ca.gov/PG3346.htm>

18 <http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx>.

19 The full Implementation Plan, including Phase II, was filed at the end of the  
20 first year of Court jurisdiction on November 29, 2012 thus concluding an  
21 indisputably successful first year of implementation.

22 **B. Year 2: December 2012 – December 2013: Provision of Services**  
23 **Begins**

24 State Defendants' efforts continued in full force during the second year of  
25 implementation. Even before the release of the CPM Guide and Medi-Cal Manual,  
26 starting in January 2013, counties were able to provide and submit claims for ICC  
27 and IHBS to members of the *Katie A.* subclass as DHCS had made the necessary  
28 system changes in order to allow counties to submit and process claims and receive

1 reimbursement for providing these services. (Ex. J, MHSD Information Notice 13-  
2 11.) Two months later, in March 2013, the CPM Guide and the Medi-Cal Manual  
3 were completed and released. (Ex. K, MHSD Information Notice 13-10.)  
4 Orientations to the manual and guide began immediately and were completed in  
5 June 2013. In total, 8 orientations (four more than what was required in the  
6 implementation plan) were held statewide in San Jose, Davis, Fresno, Redding,  
7 Pasadena, Anaheim, Sacramento, and Riverside. (Ex. L, CPM Guide and Medi-Cal  
8 Manual Regional Workshops Announcement.) Also in March 2013, State  
9 Defendants began hosting weekly *Katie A.* technical assistance calls to support and  
10 guide the counties' efforts. At this time DHCS and CDSS established their Shared  
11 Management Structure which entailed regular meetings between the Directorate of  
12 each Department as well as key staff regarding all aspects of *Katie A.*  
13 implementation.

14 Simultaneous with these efforts, the initial meetings of the JMT task force  
15 were held on December 19, 2012, January 16, 2013, and February 20, 2013. The  
16 focus then shifted to the work of the ACO Mapping Group which was tasked with  
17 developing an inventory of current methods of collecting data. As set forth in the  
18 charter of the ACO task force, the purpose of the Mapping Group was to determine  
19 what data, accountability, and quality assurance resources currently exist at the state  
20 and county levels in order to support *Katie A.* implementation. As reflected in the  
21 charter and acknowledged by the Special Master in his March 2013 report (ECF  
22 No. 839, p. 5, I. 1-5), this work was a prerequisite to the work of the full ACO and  
23 JMT task forces. The mapping group held meetings in May, June and July 2013 and  
24 ultimately produced a draft report which was provided to the Special Master and  
25 plaintiffs in September 2013. ECF No. 865. (Ex. M, Draft Mapping Report.)

26 **1. First Assessment of County Readiness to Provide Services**

27 During 2012-2013, State Defendants collected information about counties'  
28 capacity to deliver ICC and IHBS via the Service Delivery Plan and the Readiness

1 Assessment as required by the settlement. (Ex. N, MHSD Information Notice 13-03  
2 & Enclosures.) Importantly, all 58 counties submitted both the Service Delivery  
3 Plan and the Readiness Assessment. State Defendants' analysis of this information  
4 from across the State identified examples of implementation successes and  
5 challenges. (Ex. O, Analysis of Readiness Assessments and Service Delivery  
6 Plans.) The State was encouraged by the early examples of shared governance and  
7 interagency collaboration within counties, including co-location of staff,  
8 interagency Memoranda of Understandings (MOU), established processes for  
9 information sharing, and coordination of services. Certainly, identification of the  
10 subclass emerged as an issue at this early stage. While some counties provided a  
11 specific number of identified subclass members in their Service Delivery Plans, not  
12 all counties had a process in place to identify and track subclass members. As such,  
13 the majority of counties were collaborating and establishing such a process. Based  
14 on its analysis of the Service Delivery Plans and the Readiness Assessments, State  
15 Defendants engaged in ongoing communication with counties to assist them in  
16 various areas such as establishing a sustainable shared management structure,  
17 identifying service capacity needs, obtaining stakeholder involvement, and  
18 identifying and addressing training needs. (Ex. P, MHSD Information notice 13-  
19 13.)

20 **2. Collaboration with and Technical Assistance for Counties in 2013**

21 State Defendants reached out to counties in May 2013 giving them the  
22 opportunity to join one of four regional Learning Collaboratives. (Ex. Q, ACIN I-  
23 26-13.) This implementation strategy gave early implementing counties the  
24 opportunity to share knowledge, tools, and other resources through a structured  
25 learning process aimed at improving communication between child welfare and  
26 mental health agencies. Seventeen counties were ultimately selected to comprise  
27 the Learning Collaborative and have met several times as regions to share  
28 promising practices. Each of the Regional Learning Collaboratives have invited

1 and included other counties within their regions in the regional meetings in order to  
2 increase the number of staff participating to hear lessons learned, promising  
3 practices, and how to overcome implementation barriers.

4 The benefits of this deliberate planning process became apparent soon after  
5 this foundational work was completed. By August 2013 -- just 5 months after  
6 release of the CPM Guide and the Medi-Cal manual -- 24 counties reported they  
7 were providing ICC and IHBS, (Exhibit R, County Status of Providing/Claiming  
8 ICC and IHBS August 2013 through June 2014) although not all of these counties  
9 were submitting claims. State Defendants note that an unavoidable data lag  
10 inherent to the Medi-Cal claiming process continues to underrepresent the current  
11 level of service delivery. As State Defendants have repeatedly emphasized, by law,  
12 counties have up to one year following the provision of services to submit a claim  
13 for reimbursement. The *Katie A.* settlement and its time-frame did not seek to alter  
14 this claiming process; instead, the parties have worked within these well-established  
15 systems.

16 State Defendants continued their implementation efforts by developing and  
17 posting on their respective websites a list of Frequently Asked Questions that  
18 emerged from weekly technical assistance calls. (Ex. S, FAQs updated July 2014.)  
19 Other implementation efforts moved forward at this time as well. For example, the  
20 State Defendants developed and submitted an initial concept paper in August 2013  
21 on Therapeutic Foster Care (TFC) based on the model proposed by consultants to  
22 the Centers for Medicare and Medicaid Services (CMS). (Ex. T, TFC Concept  
23 Paper.)

24 Also during this period, the CPM Fiscal Task Force, which was chaired by  
25 executives from CDSS and DHCS, was continuing its meetings which had begun in  
26 October 2012. This taskforce had a broad membership that included both program  
27 and fiscal areas of the two departments, county child welfare and mental health  
28 agencies, provider organizations, parent partners, and others, including the special

1 master and plaintiffs' attorneys. The Task Force initially met every three weeks.  
2 Recognizing the complexity of child welfare and mental health funding demanded a  
3 more intense strategy, the Task Force decided to divide into three workgroups, each  
4 of which focused on a particular goal articulated in the charter. These groups met  
5 weekly to develop recommendations for their specific focus area. The groups'  
6 recommendations were then combined into a single set of recommendations. The  
7 full Task Force then reconvened as a single body, and over the course of several  
8 meetings, refined and finalized the complete set of recommendations for  
9 submission to the JMT on October 29, 2013. (Ex. U, CPM Fiscal Taskforce  
10 Recommendations.)

11 Meanwhile the ACO mapping group continued with their meetings and  
12 produced the draft report discussed above. As recommended by the Special Master  
13 in his court report of March 2013 (ECF No. 839) and concurred with by all the  
14 parties, the JMT task force assumed the responsibilities of the ACO task force that  
15 remained following completion of the mapping report. The JMT/ACO task force  
16 considered the mapping report in its November 20, 2013 meeting and subsequently  
17 formed a steering committee in December 2013 to streamline its efforts.

### 18 **3. County Progress Reports Begin to Issue in the Fall of 2013**

19 In September 2013, State Defendants issued instructions to the counties on  
20 how to complete the first progress reports due in October 2013. (Ex. V, MHSUDS  
21 Information Notice 13-19/All County Letter 13-73 & enclosures.) The instructions  
22 sought detailed information from the counties, such as how many subclass members  
23 there were in each respective county, what type of services the subclass members  
24 were receiving, and the projected numbers of subclass members to receive ICC and  
25 IHBS. State Defendants assisted counties during the reporting process with their  
26 questions and with difficulties associated with identifying subclass members.

27 Challenges to identifying subclass members included confidentiality and  
28 information sharing issues, confusion regarding children and youth who would

1 need to be screened and assessed to determine subclass eligibility, and lack of  
2 clarity as to what methodology to use to identify subclass members. The State  
3 provided guidance on these and other issues on an ad hoc basis through its weekly  
4 technical assistance calls. Because counties used different approaches to  
5 identifying subclass members and had different interpretations of what constituted a  
6 subclass member, the results of the progress reports were difficult to compare  
7 across counties.

8 State Defendants also met with numerous stakeholders during this time,  
9 including CMHDA and CWDA, to provide updates on implementation as new  
10 developments occurred and to receive feedback from counties on their progress  
11 with *Katie A.* implementation.

12 Counties submitted their first progress reports in October 2013, giving the  
13 State an opportunity to assess early implementation efforts. Even in the span of a  
14 few months State Defendants saw meaningful progress since the counties filed their  
15 service delivery plans. Specifically, there was an increase in counties who had co-  
16 located child welfare and mental health staff. Some counties had developed joint  
17 *Katie A.* Leadership Teams that dedicate their efforts to implementation of ICC,  
18 IHBS, and the CPM. Collaborative practices had also increased including the  
19 development of MOUs, interagency placement teams, multiagency services teams,  
20 and coordination between agencies on service delivery. Also encouraging was the  
21 development of screening and assessment tools, both in English and Spanish, and  
22 referral processes designed to identify subclass members and ensure timely delivery  
23 of services. Counties also reported provision of cross-systems trainings for social  
24 workers, mental health staff, parent partners, and community providers to increase  
25 cross system communication, information sharing, and increased knowledge about  
26 the mental health and child welfare systems.

27 Along with State Defendants, counties also identified key system  
28 improvements and barriers to better implementation. For example, counties

1 continued to struggle with identification of the subclass for a variety of reasons  
2 such as confidentiality concerns, lack of information sharing, and lack of a  
3 consistent methodology to identify subclass members. With respect to  
4 confidentiality, concerns arose when counties attempted to identify and count  
5 subclass members. This requires sharing information maintained by each agency  
6 independently and there was a concern that sharing information between local  
7 agencies and the state would result in Health Insurance Portability and  
8 Accountability Act (HIPAA) violations. Currently, however, most counties have  
9 resolved their confidentiality issues with only six counties still reporting this as a  
10 concern.

11 In addition to the confidentiality concerns, some counties did not have  
12 information sharing procedures in place. Even if they did, due to the lack of a  
13 consistent methodology, local child welfare and mental health agencies often had  
14 different interpretations of what to include in the subclass member count and how  
15 to report the subclass. Examples of different methodologies include the use of  
16 estimates, hard counts that were not matched between agencies, and under inclusive  
17 counts given that identification of subclass members was implemented in stages.

18 Because counties were using different methods to identify subclass members,  
19 analysis and comparison of county progress difficult. State Defendants later  
20 addressed this issue by revising the instructions for subsequent progress reports.  
21 Counties also reported an inability to update their data systems with their  
22 Information Technology (IT) vendors to support claims for services within the  
23 reporting period. As of the date of this filing, however, this IT issue has largely  
24 been resolved since only two counties report they are not yet able to process claims  
25 for ICC and IHBS. In sum, by October 2013, 28 counties were providing ICC and  
26 IHBS, an increase of 4 new counties in just three months. (Ex. R, County Status of  
27 Providing/Claiming ICC and IHBS August 2013 through June 2014.) Additionally,

28

1 the Core Practice Model Fiscal Taskforce submitted its recommendations to the  
2 Joint Management Task Force at this time. (Ex. U.)

3 To recap, the second year saw further and continued demonstrable progress in  
4 implementing the *Katie A.* settlement. By this time, the CPM Guide and Medi-Cal  
5 Manuals had been issued and orientations provided throughout the State. The State  
6 had held numerous technical assistance calls to understand and address questions  
7 from the counties. Twice counties had gathered and shared information with State  
8 as to the number of subclass members to be served, their ability to do so, the  
9 barriers and promising practices counties were experiencing. By the end of Year  
10 Two, 36 counties were now providing ICC and IHBS. (Ex. R.) The work of the  
11 ACO, JMT and CPM Task forces began and moved forward. In addition to  
12 meeting all of the deliverables described herein, State Defendants had in place their  
13 Shared Management Structure. Regular meetings with Plaintiffs' Counsel and the  
14 Special Master continued throughout this period to discuss implementation  
15 challenges and continued progress. Thus, Year 2 of Implementation also drew to a  
16 close as a success in effectuating the settlement and Implementation Plan.

17 **C. Year 3: December 2013 – July 2014: Significant Upward**  
18 **Growth in Service Delivery and in the Creation of the Service**  
19 **Delivery Action Plan**

20 In this third year of settlement implementation, State Defendants developed  
21 the more refined Service Delivery Action Plan (Exhibit W) in collaboration with  
22 Plaintiffs' Counsel and the Special Master, based on recommendations adopted by  
23 the Court in December 2013. While State Defendants agreed to assume the burden  
24 of drafting the plan to advance implementation, the process consumed a  
25 monumental amount of resources that had to be redirected from other  
26 implementation activities.

26 **1. Training and Technical Assistance to Counties Continues**

27 Implementation continued to steadily move forward during this 2013-2014  
28 time-frame, particularly in the area of training and technical assistance. For

1 example, in January 2014, the State partnered with the UC Davis Resource Center  
2 for Family Focused Practice to provide statewide trainings on such topics as Child  
3 and Family Teams, the Core Practice Model, and Involving Youth and Families.  
4 These trainings continued through June 2014. There were six different trainings  
5 offered in four different regions, totaling 24 sessions all together. (Ex. X, Resource  
6 Center for Family Focused Practice Workshop Announcements.)

7 Also, in January 2014, the California Social Worker Education Center  
8 (CalSWEC) hosted a webinar to orient leadership to the Implementation Toolkit  
9 which serves as an information hub and provides and training resources for counties  
10 participating in the Learning Collaborative. (Ex. Y, CalSWEC Training Toolkit.)  
11 Further, DHCS and CDSS collaborated with the Chadwick Center, Rady Children's  
12 Hospital to provide a webinar in April 2014 on an overview of the screening and  
13 assessment process which is critical to *Katie A.* implementation. (Ex. Z, Behavioral  
14 Health Screening and Assessment Webinar.)

15 Through several contracts with CalSWEC and four Regional Training  
16 Academies, revisions to the mandatory social worker CORE curriculum continues  
17 to focus on the Core Practice Model as developed through *Katie A.* The  
18 Assessment block of curriculum will be piloted in the fall of 2014, with an  
19 anticipated full roll out of the full CPM curriculum by 2017.

20 Additional training opportunities are in progress. For example, DHCS'  
21 current contract with the California Institute for Mental Health (CiMH) includes  
22 *Katie A.* related deliverables. Through this contract, CiMH will conduct various  
23 trainings devoted to *Katie A.* and will develop materials (including practice tools,  
24 training curricula, practice improvement protocols, quality control systems,  
25 educational materials) all supporting adherence to the CPM. CiMH has hosted  
26 three Webinars devoted to *Katie A.* since May 2014 with one additional Webinar  
27 scheduled for the near future. (Ex. AA, CiMH Webinars.) Additionally, CiMH  
28 will continue to provide technical assistance and training extending through Fiscal

1 Year 2014-15. DHCS and CDSS are currently developing specific trainings based  
2 on the needs and requests of the counties. At the same time, State Defendants have  
3 continued their weekly technical assistance calls with the counties and have  
4 participated in ongoing stakeholder meetings to guide county efforts or hear their  
5 concerns.

6 **2. Doubling of Counties Providing ICC and IHBS in Less Than One**  
7 **Year**

8 By March 2014, 43 counties had confirmed that they were providing ICC and  
9 IHBS and submitting claims. (Ex. R.) At this time, DHCS began posting the *Katie*  
10 *A. Specialty Mental Health Services (SMHS) Reports* which break down the  
11 subclass members' service utilization of specialty mental health services including  
12 ICC and IHBS. (Ex. BB, SMHS Claiming Reports.) Consistent with the claims  
13 data, these reports show a significant and dramatic upward trend in the number of  
14 minutes claimed by service for ICC and IHBS as well as the number of subclass  
15 members served. For example, as of June 2014, 6,644 subclass members have  
16 received services compared to 4,255 members in the March 2014 report. (*Id.*)  
17 Likewise, the number of ICC minutes reported in June is 44,715,040 compared to  
18 16,320,784 in March. The number of IHBS services for June is reported to be at  
19 3,248,894 minutes compared to 1,498,664 minutes in March. (*Id.*) These reports  
20 also document the number of counties submitting claims using the "KTA"  
21 Demonstration Project Identifier (DPI) which identifies and tracks *Katie A.* subclass  
22 members. Consistent with the number of counties providing services to subclass  
23 members and the number of minutes billed to ICC and IHBS, the number of  
24 counties using the DPI to track subclass members has continued to increase since  
25 March 2014, and now stands at 46 counties as of the date this report was filed. (*Id.*)

26 **3. Revised Instructions for the Second Progress Report Issue**

27 Also in March 2014, State Defendants drafted the instructions for the next  
28 progress reports with considerable input from Plaintiffs' Counsel and the Special

1 Master. The changes to the instructions and reporting tool were intended to address  
2 the issue identified in the first progress report, which was the lack of a consistent  
3 approach to identifying the subclass. State Defendants note that the identification  
4 methodology was always intended to be over-inclusive in that it directed counties  
5 begin with a large pool of potential subclass members and then refine that number  
6 by applying the eligibility criteria. For example, child welfare agencies were  
7 instructed to pull the files for children who had experienced three or more  
8 placements in a 24 month period from the Child Welfare Services/Case  
9 Management System (CWS/CMS). The CWS/CMS does not allow the query to  
10 identify that the three or more placement changes are due to behavioral needs as the  
11 eligibility criteria require. As a result, the county projections which were then used  
12 by the Special Master to assess the level of service delivery are artificially high for  
13 the specific purpose of capturing more subclass members than less. The  
14 instructions for the second progress reports were issued April 1, 2014. (Ex. CC,  
15 MHSUDS Information Notice 14-012/ACL 14-29.)

16 Additionally, in March 2014, to determine whether and to what extent a State  
17 Plan Amendment (SPA) may be necessary for the provision of TFC services to  
18 children and youth, as part of Medicaid's Early and Periodic, Screening, Diagnosis,  
19 and Treatment obligation, DHCS submitted a placeholder SPA to CMS regarding  
20 TFC services. (Ex. DD, Transmitted SPA 14-011 TFC.) Since then, DHCS has  
21 had ongoing conversations with CMS regarding the TFC model and has provided  
22 detailed information in order to facilitate CMS' review, specifically as to the core  
23 issue of whether a SPA is even necessary to implement the TFC model. (Ex. EE,  
24 TFC Cover Letter Dated June 18, 2014.) As part of the normal SPA process, CMS  
25 had 90 days from the date of SPA submission (March 28, 2014) to approve or deny  
26 the SPA or release a Request for Additional Information (RAI).

27 DHCS received an RAI on June 25, 2014, and is presently currently preparing  
28 responses to the RAI. (Ex. FF, Request for Additional Information for SPA 14-

1 011.) Following the response to these RAIs, CMS will then have at least an  
2 additional 90 days to review the responses and address whether or not a SPA is  
3 needed to implement TFC services. Accordingly, while State Defendants are  
4 unable to estimate how long CMS will need to determine whether a SPA is  
5 necessary, and if so, what changes to the State Plan would be necessary, DHCS will  
6 continue to work with CMS through the usual SPA process and timelines and apply  
7 its expertise working with CMS, its federal oversight agency. (Ex. GG, TFC Work  
8 Plan.)

9 At the same time, as the JMT develops formal recommendations related to the  
10 coordinated use of federally required quality improvement processes, the State  
11 Defendants are taking the necessary steps to embed *Katie A.* into their existing  
12 quality assurance systems. For example, DHCS has requested that APS Healthcare,  
13 the designated External Quality Review Organization (EQRO) for mental health  
14 services, collect information on each county's *Katie A.* implementation activities.  
15 APS Healthcare conducts external quality reviews of all county MHPs and analyzes  
16 and evaluates the information on access, quality, and timeliness of services that  
17 MHPs or their contractors provide to Medi-Cal beneficiaries, including ICC and  
18 IHBS services provided to *Katie A.* subclass members. Information obtained  
19 through the EQRO reviews will provide State Defendants qualitative information,  
20 via a structured process, about systemic factors and practices related to  
21 implementation.

22 The EQRO, which works with County Mental Health Plans (MHPs) and their  
23 Child Welfare Service (CWS) partners, is collecting information regarding  
24 counties' implementation of the *Katie A.* settlement agreement. This includes  
25 describing the status of the shared management structures, stakeholder input to the  
26 development of the programming, the process for identifying current and future  
27 subclass members (screening, referral, assessment, linkage to services), the  
28 provision of ICC and IHBS and claiming for those services, convening Child and

1 Family Teams, and providing services to the class and subclass consistent with the  
2 Core Practice Model. The discussion with the MHP and CWS is informed by the  
3 EQRO's review of the county's initial readiness assessment, service delivery plan,  
4 and all progress reports to date.

5 As of April 2014, EQRO has issued 38 reports and has conducted 50 reviews  
6 concerning county mental health plans' implementation of the *Katie A.* settlement  
7 agreement. The EQRO is therefore able to identify areas where additional technical  
8 assistance may be needed and gain a broader perspective of the MHPs and Child  
9 Welfare Departments implementation efforts than is provided in the Counties'  
10 Service Delivery Plans, Readiness Assessments and Progress Reports. DHCS uses  
11 this information to better focus its technical assistance and outreach planning.

12 Additionally, development of the Performance Outcomes System (POS) is  
13 underway. Required by California Welfare and Institutions Code section 14707.5,  
14 the POS requires DHCS to develop a performance and outcomes system for Medi-  
15 Cal Specialty Mental Health Services (SMHS) for children and youth to improve  
16 outcomes and improve decision making. The POS will ultimately bring together  
17 information from different sources in order to better understand the outcomes of  
18 Medi-Cal SMHS provided to children and youth. The positions for DHCS staff  
19 who will be assigned to this implementation were funded in July 2014. Through  
20 this project, DHCS and CDSS are assessing how POS data can be utilized and  
21 shared between the two Departments to assess service delivery to the subclass.

22 As for child welfare, the federal Administration of Children and Families  
23 (ACF) is in the process of revising its guidelines and expectations for the Child and  
24 Family Services Review (CFSR) used by all states to assess key program outcomes  
25 and systemic supports for quality services. A central component of the updated  
26 CFSR process is a Continuous Quality Improvement (CQI) process; ACF must  
27 approve each state's CQI process and assure that it has specific procedures and  
28 capabilities, including a statistically valid case review process and the ability

1 regularly analyze data to aid in achieving federally required outcomes. One criteria  
2 for approval is a requirement to use the case review tool created by ACF. This  
3 compressive tool includes elements that will assist CDSS and counties to identify  
4 the fidelity of CPM implementation. The tool is being piloted in San Bernardino  
5 County and will be used routinely beginning January 2015. Additionally, CDSS is  
6 training its staff that facilitates county level self-assessments to work with counties  
7 to obtain the above mentioned relevant EQRO information and include it into the  
8 county-wide self-assessment, thereby ensuring that Katie A implementation is  
9 included in the counties' analysis of their practice and outcomes.

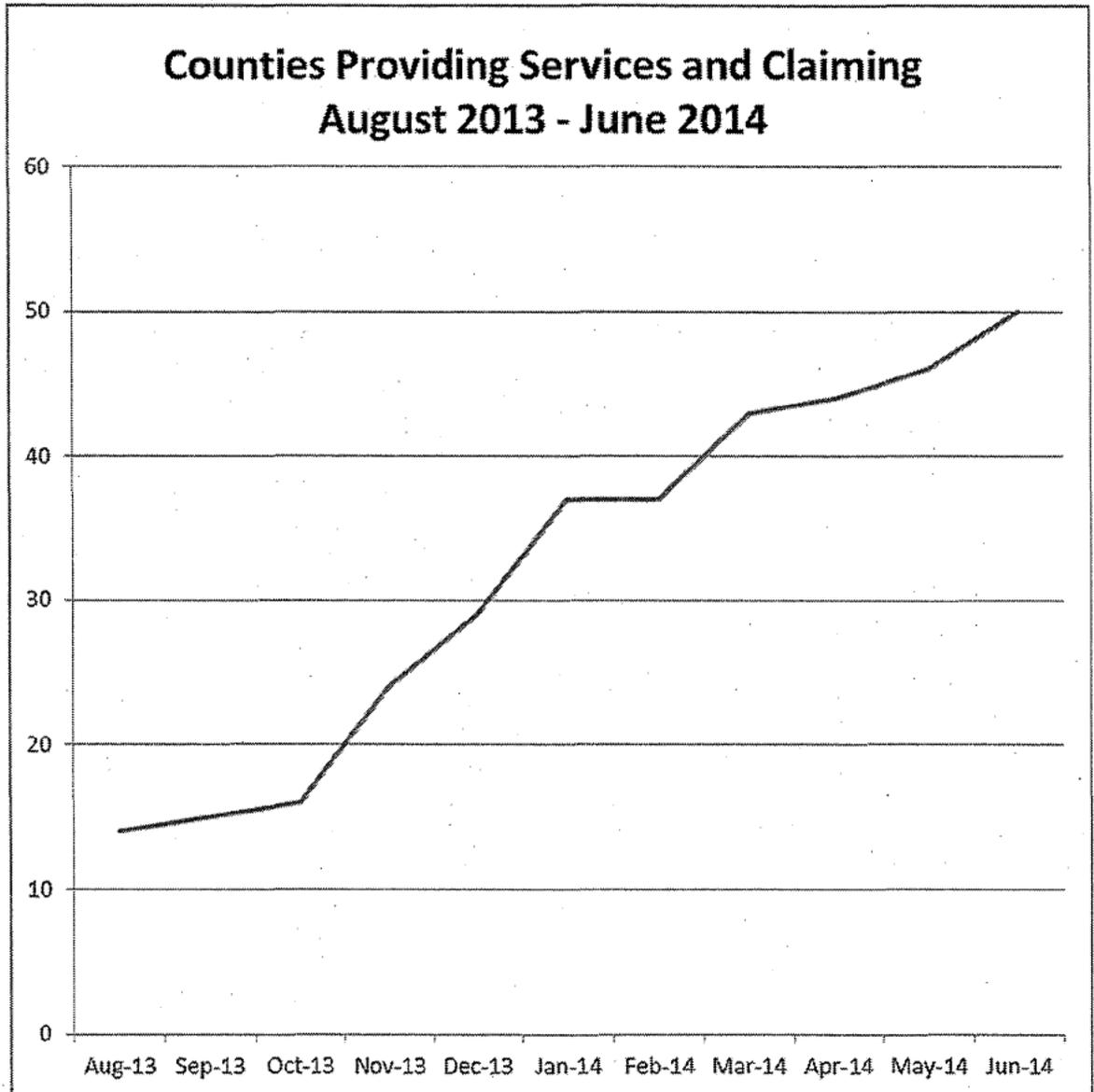
10 Further, CDSS and DHCS are developing an Interagency Agreement to  
11 develop data exchange processes that will support future monitoring and  
12 compliance efforts. This agreement will specify the data elements, data sources and  
13 necessary data analysis needed for on-going county support.

14 As authorized by the court order issued on April 11, 2014, the Special Master  
15 hired two consultants to assist the JMT in completing its recommendations to  
16 CDSS and DHCS for a Shared Management Structure and an Accountability  
17 Communication and Oversight system. Ultimately, as specified in the Service  
18 Delivery Action Plan and concurred with by all parties and the special master, the  
19 JMT/ACO will finalize its recommendations to the Departments who will decide  
20 which ones to adopt.

21 **4. The May 2014 Progress Reports Show Implementation Continuing to**  
22 **Move Forward**

23 The May 2014 progress reports showed marked progress in *Katie A.*  
24 implementation with 50 counties now providing and claiming for ICC and IHBS  
25 services. For example, county progress reports show a sharp upward increase in  
26 the number of children receiving IHBS and ICC since the October 2013 report even  
27 beyond what is reflected in the claims data. The number of children receiving ICC  
28 increased 683 percent, and the number of children receiving IHBS increased 800

1 percent over the numbers reported in the October 2013 report. See  
2 <http://www.childsworld.ca.gov/PG3515.htm> State Defendants provide the graph  
3 below to illustrate the rapid increase in the number of counties providing services  
4 since August 2013.



25 In addition to this exponential growth, counties report increased levels of  
26 collaboration, completion of training, finalization of new and modified contracts,  
27 and completion of system modifications that allow counties to submit claims for  
28 ICC and IHBS. Simply put, since the October 2013 report, counties have had the

1 necessary time for their personnel and their infrastructure to develop in order to  
2 provide ICC and IHBS.

3 For example, several counties, including two of the 12 largest counties, have  
4 developed MOUs and/or data sharing agreements between local child welfare and  
5 mental health entities. These actions have led to streamlined communication,  
6 increased sharing of information and more timely access to services for children  
7 and families. One of these counties has also formally established a Joint  
8 Management Group. As one component of the Joint Management Group, an  
9 Administrative Steering Committee has been formed which includes both child  
10 welfare and behavioral health management, a presiding Judge of the Juvenile Court,  
11 parent and youth voice, representation from the Probation Department and several  
12 community partners. Still another county reported that, as a result of streamlined  
13 processes and weekly meetings between child welfare and mental health agencies,  
14 it has dramatically increased the provision of ICC and IHBS to subclass members  
15 since the October 2013 reporting period.

16 **5. State Defendants Engaging Counties to Move Implementation**  
17 **Forward**

18 State Defendants' are expending considerable effort to work with counties to  
19 continue to move implementation forward based on the May 2014 progress reports.  
20 These efforts began as soon as the State Defendants started to receive the reports  
21 and have been ongoing. Now with almost all of the reports submitted, State team  
22 members have prioritized their efforts and have contacted the 12 counties with the  
23 largest foster care caseloads to target implementation issues these counties are  
24 reporting. Issues of immediate concern identified by the counties include lack of  
25 fiscal and staffing resources, challenges with confidentiality and information  
26 sharing, training needs, and the lack of shared data systems across local agencies.  
27 In their conversations with counties, State Defendants are discussing concerns  
28 raised by information provided in the progress reports, clarifying any ambiguities or

1 irregularities in the data or the narratives, identifying barriers and challenges related  
2 to implementation, offering tangible support, identifying what specific steps the  
3 county believes it must take to eliminate such barriers and timeline for this work,  
4 monitor the counties' progress, and identify if or whether a site visit or other action  
5 would be helpful.

6 In addition to contacting the 12 counties with the largest foster care caseloads,  
7 State team members have contacted the child welfare and mental health agencies in  
8 the 8 counties not currently providing or claiming ICC and IHBS. The purpose of  
9 these calls is to determine whether these counties have a process in place to  
10 appropriately identify subclass members, provide services, and whether these  
11 counties are likely to meet the number of children projected to receive services as  
12 projected in the counties' progress reports. State Defendants will determine how to  
13 assist these counties with their implementation efforts based on the individualized  
14 needs of the counties (i.e. provide additional training, connect with peer counties,  
15 site visits etc.)

16 **6. Additional Funding Provided by the California Legislature for *Katie***  
17 **A. Implementation**

18 In June 2014 the California Legislature passed and the Governor signed the  
19 2014-2015 Budget. Included in the budget was an additional \$7.2 million in state  
20 general fund and federal matching funds to fund counties' use of the CFSR review  
21 tool to assess implementation and fidelity of CPM implementation. Still another  
22 \$1.8 million in state general fund and federal matching funds was added to revise  
23 core training for child welfare workers and supervisors to include detailed training  
24 on the CPM. The curriculum will be used for induction training for new workers  
25 and for refresher training for the existing workforce. Portions of the curriculum  
26 will be well suited for joint training with MHP staff and contracted providers.

27 Also included was \$2 million as a placeholder for potential county  
28 administrative costs associated with the semi-annual progress reports. The use of

1 this funding is subject to further discussions between the Administration and the  
2 counties. (Ex. HH, Proposition 30 Budget Language.) This acknowledgement of  
3 the State's responsibilities under Proposition 30 was noted by CMHDA Executive  
4 Director Robert E. Oaks in his June 19, 2014, letter to Toby Douglas, Director of  
5 DHCS. The letter goes on to reaffirm the commitment of the association's  
6 members to implementation of the *Katie A.* both now and post court jurisdiction.  
7 (See Ex. C.)

8 **7. Additional Implementation Activities Performed Above and Beyond**  
9 **the Settlement**

10 State Defendants have performed additional tasks that were not required by the  
11 settlement yet will move implementation forward. In June 2014, State Defendants  
12 repurposed what was previously scheduled to be the Eighth Wraparound Institute to  
13 the Partnerships for Well-Being Institute. In all, 82 workshops took place giving  
14 attendees the opportunity to learn community-based strategies critical to  
15 implementation of the settlement such as how to enhance services, shared  
16 management structures, and family engagement. The Institute was well attended by  
17 almost 1000 participants including county representatives, providers, parents,  
18 youth, and other stakeholders. Staff from CDSS and DHCS presented in multiple  
19 workshops and provided one on one TA with county staff and providers when  
20 requested. In addition, in November 2013, DHCS and CDSS staff presented a  
21 workshop at the second bi-annual Intensive Behavioral Health Services Conference  
22 (formerly, the Therapeutic Behavioral Services (TBS)) in Los Angeles, CA. (Ex.  
23 II, Partnership for Well Being Institute Documents.) An additional webinar was  
24 conducted on the Core Practice Model on January 23, 2014 which was posted on  
25 the RCFFP website on March 14, 2014, at the following URL:  
26 <http://humanservices.ucdavis.edu/Resource/Pathways/InThisSection/Courses.aspx>  
27 (Ex. JJ, CPM Webinar flyer entitled "Pathways to Services Webinar")  
28

1 Beginning in August 2013, DHCS collected monthly information from  
2 counties on identification of the subclass, access and usage of IT vendor systems,  
3 provision of services, and claiming capabilities to report to Special Master. (Ex.  
4 BB.) In response to county feedback, DHCS and CDSS created the ICC and IHBS  
5 Service Comparison Tables, which provides counties and stakeholders with the  
6 differences between ICC, Targeted Case Management, and Wraparound, as well as  
7 the differences between IHBS, Mental Health Services, Therapeutic Behavioral  
8 Services, and Wraparound. The tables include the service definitions, funding  
9 sources, eligibility criteria, service distinctions, and service settings. (Ex. KK,  
10 Service Comparison Chart.)

11 Finally, the CDSS is implementing the “Continuum of Care Reform” (CCR), a  
12 comprehensive overhaul of California’s out-of-home placement policies and  
13 practices. The CDSS is statutorily required to present the Legislature with a  
14 comprehensive plan to create a family-centered, community-based continuum of  
15 placements, services and supports to better serve children, youth and families  
16 involved with the child welfare system. (Cal. Welf. & Inst. Code § 11461.2, added  
17 by SB 1013, ch. 35, Stat. 2012.) State law further specifies that the plan must  
18 consider how provision of an integrated, comprehensive set of services in family-  
19 like settings supports the achievement of well-being, permanency, and safety  
20 outcomes. Given that the goals of the CCR reflect the values and principles  
21 outlined in the CPM, as well as the commitment of the Administration and the  
22 interest of the Legislature, CCR is yet another vehicle for ongoing and sustained  
23 quality implementation of the principles, services and accountability structures of  
24 *Katie A.*

#### 25 **FULFILLMENT OF *KATIE A.* SETTLEMENT OBLIGATIONS**

26 As the foregoing summary indicates, State Defendants have already complied  
27 with the vast majority of the settlement’s broad requirements and are well on track  
28 to complete the rest. State Defendants do not deny that some due dates for certain

1 deliverables have been extended – often with the agreement of the Parties, Special  
2 Master, and approval of the Court. Stakeholder requests, practical and logistical  
3 reasons also drove many of these changes. They are normal for the implementation  
4 of a complex project of this size and scope. They are not indicative of any  
5 resistance to the most expeditious implementation of the *Katie A.* settlement  
6 feasible. Further evidence of the State Defendants’ strong commitment to full  
7 implementation of the settlement is the additional money requested from and  
8 approved by the State Legislature and Governor. Service delivery is expanding  
9 and will continue to do so.

10 It cannot be credibly argued that State Defendants have failed to comply with  
11 both the terms and the spirit of the settlement agreement. Specific key deliverables  
12 such as the Implementation Plan, the Medi-Cal Manual, and the CPM Guide are  
13 complete. The Medi-Cal Manual was posted for public comment with the final  
14 version also being posted as required by the settlement. The readiness assessment  
15 was completed as required. The Learning Collaborative was established thereby  
16 satisfying the settlement requirement that counties of varying sizes receive  
17 intensive training. State Defendants have also complied with settlement’s  
18 requirements regarding training including curriculum development, technical  
19 assistance, and education.

20 As noted, DHCS is currently engaged in the SPA Review Process with CMS  
21 to determine whether a SPA is necessary to cover TFC as required by the  
22 settlement. State Defendants also have a shared management structure in place as  
23 required by the settlement that includes regular meetings at both the Directorate and  
24 staff level dedicated exclusively to *Katie A.* Staff from each Department jointly  
25 performs implementation activities such as review of progress reports, technical  
26 assistance to the counties, and drafting of county notices that are issued jointly by  
27 the Departments. Moreover the work of the JMT/ACO Taskforce is nearly  
28 complete as is the work of the CPM Fiscal task force.

1 State Defendants will consider and adopt appropriate JMT/ACO  
2 recommendations to further strengthen their respective quality assurance systems as  
3 the settlement requires and shared management structures. (Ex. M.) The bulk of  
4 this work will occur post jurisdiction yet its impact will be significant.<sup>2</sup> Once State  
5 Defendants have the MOU in place to permit the sharing and matching of  
6 administrative data, they will be able to assess implementation and refine and target  
7 technical assistance to specific counties as needed. The matched data will also  
8 provide essential information on utilization of mental health services vis-a-vis  
9 important child welfare service outcomes related to safety, permanence and well-  
10 being. State Defendants are equally committed to coordinating their formal quality  
11 improvement systems to more fully and accurately monitor service delivery.  
12 EQRO observations, for example, will be included in the C-CFSR process. Content  
13 from C-CFSR System Improvement Plans will be used to fine tune EQRO inquiries  
14 into service for children/youth in foster care. In addition to this qualitative and  
15 quantitative data, counties will gain additional insight as they adopt their shared  
16 management structures which will likely include consumers and service providers.

17 **BEYOND COURT JURISDICTION: BUILDING THE KATIE A. LEGACY**

18 State Defendants are fully resolved to leverage the strong foundations and  
19 implementation progress to date to bring CPM, ICC/IHBS, and TFC to scale  
20 statewide. It is the expectation of State Defendants that one day these services will  
21 become standard practice throughout California such that they will no longer be  
22 considered deliverables resulting from the settlement the Katie A. lawsuit. The  
23 State will continue to support, assist and guide county child welfare and mental  
24 health agencies as they continue to build their infrastructures and increase service  
25 delivery as they have committed to do. The substantial cultural and systemic

26 <sup>2</sup> Settlement Agreement, para. 21, pp.17: "It is understood by the parties that  
27 the implementation timeline will include activities or deliverables that may not be  
28 completed, or ongoing, after the end of jurisdiction."

1 change required and occurring by the settlement will continue to take place and  
2 solidify. The settlement agreement anticipated that such change would not happen  
3 quickly and that time and discretion were needed to fully implement its terms and  
4 objectives. The current status of implementation demonstrates that this discretion  
5 was well placed.

6 Dated: July 11, 2014

Respectfully submitted,

7 KAMALA D. HARRIS  
8 Attorney General of California  
9 JENNIFER M. KIM  
Supervising Deputy Attorney General

10  
11 /s/ CARMEN D. SNUGGS

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## CERTIFICATE OF SERVICE

Case Name: KATIE A., et al. v. BONTA, et al. No. 2:02-cv-05662 JAK (SHx)

I hereby certify that on July 11, 2014, I electronically filed the following document with the Clerk of the Court by using the CM/ECF system:

### **STATE DEFENDANTS' RESPONSE TO THE SPECIAL MASTER'S JUNE 16, 2014 REPORT**

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 July 11, 2014, 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:

John F. Toole, Esq.  
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405 14th Street, 15th Floor  
Oakland, CA 94612-2701

Kathleen R. Wolfe  
Travis W. England  
U.S. Department of Justice  
950 Pennsylvania Ave NWN  
Washington, DC 20530

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct.

This declaration was executed on July 11, 2014, at Los Angeles, California.

M. Chacon  
Declarant

/s/M. Chacon  
Signature