

SYSTEM OF CARE

FOR CHILDREN AND YOUTH

Memorandum of Understanding Implementation Guidance

DECEMBER 2019

State of California
Trauma Informed System of Care
for Children and Youth

PRESENTED BY



Department of
SOCIAL SERVICES



TABLE OF CONTENTS

INTRODUCTION	3
PURPOSE	5
Part One: Interagency Leadership Team	7
Part Two: Integrated Core Practice Model	10
Part Three: Information and Data Sharing	13
Part Four: Screening, Assessment, & Entry to Care	16
Part Five: Child and Family Teaming.....	19
Part Six: Interagency Placement Committee	22
Part Seven: Alignment and Coordination of Services.....	26
Part Eight: Staff Recruitment, Training, and Coaching	29
Part Nine: Financial Resource Management	31
Part Ten: Dispute Resolution Process.....	34
Part Eleven: Resource Families and Therapeutic Foster Care Services.....	36
Resource Library.....	39
Glossary	42

INTRODUCTION

State, county, local partners, and other stakeholders have convened to better serve children and youth who are receiving services from multiple public programs. **Our goal is simple: our programs must meet the needs of the children and youth we serve.** These are our collective children, and they all deserve the very best.

This effort builds upon the current Continuum of Care Reform (CCR) implementation effort by, among other things, developing a coordinated, timely, and trauma-informed system-of-care approach for foster children and youth. California’s investment in CCR established a new statewide vision for the role of residential care within the full continuum of available placement options, in which residential care is no longer viewed solely as a “placement” for children. Rather, residential care is a Short-Term Residential Therapeutic Program (STRTP) utilized to address the mental health needs of youth and to assess and support a well-planned transition to home-based settings.

Children in out-of-home placement are served by multiple systems and programs including, at a minimum, the placing agency (child welfare or probation), public education, Medi-Cal, county mental and/or behavioral health, and the local regional center. Navigating these various systems often leads to service gaps and placement instability, and ultimately compounded trauma for the child and family.

SYSTEM OF CARE

Collaborative work with our state, county, and local partners, which aims to ensure that the services we provide to our children and youth are coordinated, timely, and trauma-informed.

Our System of Care work has been accelerated by the implementation of [Assembly Bill 2083](#) (Chapter 815, Statutes of 2018), which requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. Additionally, the law tasks the State to establish a joint interagency resolution team to develop guidance to local agencies with regard to developing the MOU, supporting the implementation of those MOUs, and providing technical assistance to identify and secure the appropriate level of services to meet the needs of children and youth in foster care who have experienced severe trauma. This guide is intended to assist local partners in establishing an MOU, in accordance with the requirements of AB 2083. Additional topics may be included by local partners.

A local MOU should be designed to ensure that all public programs for children, youth and families will provide services in an integrated, comprehensive, culturally responsive, evidence-based/best practice manner, regardless of how they enter our system. This mission includes an awareness of and a commitment to incorporate foster youth experience and voice into county level collaborations and partnerships that manage or oversee the delivery of services affecting youth in foster care.

Memorandum of Understanding Checklist

AB 2083 Required Components

- Interagency Leadership Team
- Integrated Core Practice Model
- Information and Data Sharing
- Screening and/or Assessment, & Entry to Care
- Child and Family Teaming
- Interagency Placement Committee
- Alignment and Coordination of Services
- Staff Recruitment, Training, and Coaching
- Financial Resource Management
- Dispute Resolution Process
- Resource Families and Therapeutic Foster Care Services
- Signature Page

Additional Recommended Components

- Vision, Mission, Purpose, and Principles Statements
- Policies for Cross-County Placement
- Policies for Out-of-State Placement
- Consent and Confidentiality Procedures and Policies

PURPOSE

The goal of a Memorandum of Understanding (MOU), pursuant to Assembly Bill 2083, is to address systemic barriers to the traditional provision of interagency services.

It is the intent of the system partners to create a service plan that defines how they work together as an administrative team, as defined in the MOU, with collaborative authority over the interrelated child welfare, juvenile justice, education, developmental, and mental health children's services.

The MOU should support the structure and processes of each partner agency and provide a framework that will guide the operations and the activities, decisions, and direction of each of the partner agency employees regarding children, youth and family programming.

Assembly Bill 2083 Purpose

Develop and implement a MOU setting forth the roles and responsibilities of agencies and other entities that serve children and youth in foster care who have experienced severe trauma. To the extent possible, the implementation of the MOU must use existing processes and structures within and across the respective organizations that are parties to it.

The MOU is required to include, at a minimum, provisions addressing all of the following:

- ✓ Establishment and operation of an Interagency Leadership Team (ILT)
- ✓ Commitment to implementation of the Integrated Core Practice Model (ICPM)
- ✓ Information and data sharing agreements
- ✓ Processes for screening, assessment, and entry to care
- ✓ Processes for child and family teaming and universal service planning
- ✓ Establishment and operation of an Interagency Placement Committee (IPC)
- ✓ Alignment and coordination of transportation and other foster youth services
- ✓ Staff recruitment, training, and coaching
- ✓ Financial resource management
- ✓ Development of dispute resolution process
- ✓ Recruitment and management of resource families and delivery of therapeutic foster care services (TFC)

MOU Structure

Each section tackles a separate requirement of the MOU and has an identifying header, along with some context-setting. For example:

Part One: Interagency Leadership Team

The Interagency Leadership Team (ILT) serves as the governing and coordinating body of this collaborative. The ILT should consist of leaders from programs and departments that interact with children such as the Chief Probation Officer, the Director of Mental Health, the Director of Social Services or the Human Services Agency, the Superintendent of the County Office of Education, and Regional Center leadership, or designee.

Guiding Questions:

Identifies the critical questions that you should consider when developing the MOU.

MOU Framework:

These are the minimally required elements to be addressed in your MOU. Additionally, a *suggested* lead is included to be the point person on the development of each section.

Practices for Success:

These are the additional items for inclusion in your county MOU that will increase the county and system partners' likelihood of achieving the best outcomes.

Part One: Interagency Leadership Team

The Interagency Leadership Team (ILT) serves as the governing and coordinating body of this collaborative. The ILT should consist of leaders from programs and departments that interact with children such as the Chief Probation Officer, the Director of Mental Health, the Director of Social Services or the Human Services Agency, the Superintendent of the County Office of Education, and Regional Center leadership, or designee. The overarching goal of the is to work together as a governing body to ensure that coordinated, timely, and trauma-informed services are provided to children and youth in foster care who have experienced severe trauma. The ILT both establishes the MOU and oversees the execution of the MOU to meet the overarching goals of a coordinated, system of care for foster children, youth and families. The MOU should reflect the importance ILT members have in sharing information, guiding staff, identifying and resolving conflicts, and leveraging resources to ensure foster children, youth and their families receive the services they need to achieve federal and state child welfare goals: safety, permanency, well-being, and to allow children/youth to live in the least-restrictive environment that meets their needs.

Guiding Questions

- Is there already an Interagency Leadership Team or executive advisory council in place and do they represent all county systems? How can these be leveraged to meet the ILT requirement?
- Is there clear, consistent, alignment of values for the departments/divisions who form this System of Care?
- Are all county partners aware of the guiding principles and practice behaviors embedded in the Integrated Core Practice Model (ICPM) and in person-centered planning? To what extent are the leaders of the partner agencies supporting ICPM implementation and how does that impact the formation of the ILT?
- Do county partners implement the guiding principles of the ICPM?
- Is there shared understanding and agreement about the need and value of creating a System MOU?
- Does the County Executive team have awareness of and hold support for our efforts? If not, how do we build support for this work?
- Are the right individuals, including family and youth voices at the table?

- Do local partners have plans for how meetings and conversations will be hosted and facilitated?
- Are local partners coming to the team to participate in creative and strategic ways?
- Is there a system in place to periodically reaffirm and update the MOU, to ensure it remains current and takes into account leadership changes at local partner agencies?
- Are the responsibilities for conducting the ILT's efforts assigned?

MOU Framework

Recommended partner lead: the County Executive Team.

Your MOU must include, at minimum, the following:

- An identifying list of ILT Members that includes, at minimum:
 - The county child welfare agency
 - The county probation department
 - The county behavioral health agency
 - The county office of education
 - The regional center(s) that serves children and youth with developmental disabilities in the county
- ILT Governance procedures, which describes:
 - Frequency of meetings
 - Forum of the meetings
 - Methods of making decisions as a group
 - Methods of recording decisions and identifying responsible parties for following through on those decisions
 - Process (if any) for designees to be appointed
 - Structure of the ILT, including whether there will be an Executive Level body, etc.
 - Roles and responsibilities, including leads for sharing information, meeting notices, recording minutes, securing meeting venue, etc.
 - A process to revisit procedures as necessary to ensure that the MOU remains current
 - A process to communicate and check-in with the Interagency Placement Committee on a regular basis (e.g., semi-annually)

- Outlined roles for key systems partners.
- Plan for communicating to ILT Members.
- A policy for confirming consent when appropriate.

Practices for Success

1. Consider adding the following partners as regular and contributing participants in the ILT:
 - Representatives of Local Education Agencies (LEAs), and Special Education Local Plan Areas (SELPA) located in the county
 - Managed Care Organizations
 - Youth, parents, and families
 - County office of education administered Foster Youth Executive Advisory Council
 - Tribal affairs partners or representatives
 - Department of Social Services (if separate from Child Welfare Services)
 - Superior Court Judge or Commissioner (i.e. Juvenile Court representative)
2. Consider the role of LEAs, their corresponding School Attendance Review Boards, county offices of education, and SELPAs in the ILT and if these roles may facilitate connections to county and community services that would augment an LEAs' instructional and support services systems.

For example, can the ILT collaborate with the Multi-Tiered System of Support (MTSS) framework and the county LEAs' ability to teach to the whole child?

Part Two: Integrated Core Practice Model

The California Integrated Core Practice Model (ICPM) for Children, Youth, and Families can be found here . This resource, created in collaboration between the Department of Health Care Services and the Department of Social Services, is intended to provide practical guidance and direction to support county child welfare, juvenile probation, behavioral health agencies, regional centers, and community partners to improve delivery of timely, effective, and integrated services to children, youth, and families.

The ICPM articulates the shared values, core components, and standards of practice reflecting current research that demonstrates how collaborative and integrated family services work best in meeting the complex needs of children, youth, non-minor dependent's and families involved with state and county agencies. The ICPM is based on 5 key components and 10 guiding principles.

The **5 key components** within the ICPM model include:

- Engagement
- Assessment
- Service planning/implementation
- Monitoring/adapting
- Transitions

The **10 principles** include:

- Team-based
- Family voice and choice
- Natural supports
- Collaboration and integration
- Community-based
- Culturally respectful
- Individualized
- Strengths-based
- Persistence
- Outcomes-based

The current ICPM is in iterative development with key stakeholders, and a revision is expected in late 2020.

Guiding Questions

- Are all agencies aware of the components and principles of the ICPM? How can the ILT share this information with these partners?

- Is the ICPM consistently referenced in trainings, meetings, and other settings as the source for best practice delivery?
- Are supervisors and managers allowed time to read, understand and practice ICPM related guidance with one another and with their subordinate staff?
- Do agencies ensure that principles of trauma-informed care are integrated into their work?
- How are required local partners currently implementing the ICPM and what are barriers to implementation or participation? How does the ICPM inform the relationship between partner agencies not involved in the ICPM?
- Does the LEA or county office of education use a Multi-Tiered System of Supports to connect county services to students receiving services?

MOU Framework

Recommended partner lead: county social services or human services agency.

Your MOU should include, at minimum, the following:

- A process for ensuring that participating and appropriate agencies are aware of the purpose and role of the ICPM.
- A process for ensuring that participating systems partners know the role of their team members in supporting the implementation of the ICPM principles.
- A statement that articulates how the system partners will cross train to the ICPM.

Practices for Success

1. Establish common values and principles in planning and providing services to individuals who are receiving services.

The shared ICPM and person-centered planning **values** include:

- Family/child-driven
- Community-based
- Culturally competent

The shared **principles** include:

- Family/youth choice
- Team-based

- Natural supports
 - Strength-based
 - Individualized
 - Outcome-based
2. Ensure all necessary partners participate in the planning and development of services and supports for children and their families utilizing the ICPM and person-centered planning.
 3. Integrate, as appropriate, education plans with services and supports that help to promote and support the desired outcomes for the child and family resulting from the ICPM and Child and Family Team (CFT).
 4. Work with local partner agencies to inform service professionals on the ICPM and person-centered planning frameworks.
 5. Collaborate from within the CFT, and partner agencies in family engagement, assessment, service planning, delivery, coordination, and care management, monitoring and adapting services, and transitioning.
 6. Consider including the following partners when determining outreach to other system partners and stakeholders to ensure their practices align with the ICPM, and provide support as necessary:
 - Youth and families
 - The regional center or centers that serve children and youth with developmental disabilities in the county.
 - Foster care or other child welfare advocacy groups
 - County office of education, LEAs, and SELPAs
 - Department of Rehabilitation Regional Office
 - Managed care organization
 - Judges and Court Appointed Special Advocates and attorneys
 - Tribal affairs partners or representatives
 - County or LEA School Attendance Review Board
 - Foster Care providers

Part Three: Information and Data Sharing

System partners agree, to the fullest extent allowed by law, to share necessary and relevant client specific information in order to conduct treatment, coordinate care and ensure the highest quality care is available to youth and caregivers.

To the extent permitted under federal law, members of the ILT may share confidential information if the member of the team having that information or writing reasonably believes it is generally relevant to the child or youth.

AB 2083 specifically provides that:

- Members of the Interagency Leadership Team may disclose and exchange with information or a writing with one another that may be designated as confidential under state law if the member of the team having that information or writing reasonably believes it is generally relevant to the identification, reduction, or elimination of barriers to services for, or to placement of, children and youth in foster care or to improve provision of those services or those placements.
- Members of the Interagency Leadership Team who receive disclosed or exchanged information or a writing shall destroy or return that information or writing once the purposes for which it was disclosed or exchanged are satisfied. Any information or writing disclosed or exchanged shall be confidential and shall not be open to public inspection, unless the information or writing is aggregated and de-identified in a manner that prevents the identification of an individual who is a subject of that information or writing. Any discussion concerning the disclosed or exchanged information or writing during a team meeting shall be confidential and shall not be open to public inspection.
- Members of an Interagency Placement Committee, child abuse multidisciplinary personnel team, or CFT that is convened for the purpose of implementing the provisions of the memorandum of understanding developed pursuant to this subdivision shall comply with applicable statutory confidentiality provisions for that committee or team. Members of teams convened for purposes of implementing the memorandum of understanding shall comply with applicable records retention policies for their respective agencies or programs.

Guiding Questions

- Do you have an operating MOU or interagency agreement to allow for the sharing of information, both child-specific and in aggregate, across partner agencies to support timely access to services for children and families?

- Are any of your ILT members considered a “covered entity” or a “business associate” under the Health Insurance Portability and Accountability Act (HIPAA)? If so, does your MOU enclose a “business associate agreement” that complies with HIPAA?
- Is assessment information shared across systems to avoid the over assessment of youth and families?
- Have you engaged your county counsel and privacy officer as you develop information sharing policies?
- Is there a process established for ILT members to confidentially share information that is generally relevant to the identification, reduction, elimination of barriers to services for, or to placement of, children and youth in foster care or to improve provision of those services or those placements?
- Is there a process established to ensure that confidential information or writings are destroyed or returned once the purposes for which it was disclosed or exchanged are satisfied?
- Do members of an IPC, child abuse multidisciplinary personnel team, or CFT know the policies regarding confidentiality laws and records retention for their respective agencies or programs?

MOU Framework

Recommended partner lead: county welfare services director.

Your MOU should include, at minimum, the following:

- While the details of your system’s confidentiality and privacy agreement will likely be best captured in separate policy, the MOU must articulate an agreement, to the fullest extent allowed by state and federal law, to share necessary and relevant client specific information in order to conduct treatment, coordinate care and assure the highest quality care is available to youth and caregivers.

Practices for Success

1. Consider using a single Release of Information (ROI) form across all agency partners and consolidating other releases or documentations required of

children, youth and families. To the extent barriers exist, these can be shared with the state resolution team.

2. Consider including the following partners when determining the protocols and implementation of data sharing agreements:
 - County Health and Human Services and/or Behavioral Health Agency
 - County office of education
 - SELPAs, LEAs, and community colleges
 - Other supporting socio-emotional and educational service providers that interact directly with foster children and youth
 - Child welfare
 - County probation department
 - Participating legal service providers
 - Regional centers

3. Information and Data Sharing Agreements should contemplate the role of the following:
 - Educational rights holder and district appointed surrogate parents
 - School placement choice
 - Change in schools
 - Residential placement
 - School Attendance Review Boards
 - Records, lists, notifications and monitoring information related to services provided
 - Transportation needs
 - CWS health passport

Part Four: Screening, Assessment, & Entry to Care

Each partner agency uses its own distinct processes and tools to determine eligibility and need for services, often as a result of federal, state or local mandates. This guide encourages counties, to the extent permitted by laws and regulations, to develop a process and tools to screen and assess the service needs of children, youth, and families that reduces redundancy and is youth and family-focused. Counties may choose to use a single shared assessment process, share information from different assessment tools or processes, or partner on specific assessment tools. Per part five of this MOU guide, system partners should agree to share those assessment outcomes and processes to facilitate care coordination through the CFT process and reduce youth and family impact wherever it is permissible and legally appropriate.

Guiding Questions

- Are the screening and/or assessment processes used by each of the partner agencies coordinated in such a way to reduce redundancy and support unified assessments of child, youth and family service needs?
- If not unified, are the screening and/or assessment processes of each of the partner agencies aligned in such a way that agencies can provide timely referrals between agencies?
- How can system partners strengthen the engagement, assessment, and care planning structure(s) at the county?
- Are each of the partner agencies using structures and processes that are culturally competent?
- What are the strengths and shortcomings of our current service, transition, care coordination, or discharge planning processes at the county level as well as for each county partner agency?
- Is there a written clear policy and procedure for the Child and Adolescent Needs and Strengths (CANS) tool use that is effective for applicable partners?
- Is assessment-derived information shared in a fluid and dynamic manner in support of timely care delivery and transition?

- Are families and youth accessing the screening benefits provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and are agencies referring to County mental health and managed care plans?
- Are referrals or requests for care in the county system processed in a timely manner in accordance with the various legal requirements of each system?
- Do youth and family understand how assessments are conducted and shared in multiple agencies and services?
- Is there a process for identifying and addressing the urgent service needs for a child when they are experiencing, or at risk of, placement instability, out-of-state residential placement, or hospitalization?
- How do child welfare case plans reflect assessment information for the child and family and how do these address the educational needs for the child/youth?
- Do LEAs have a process to refer students and families to county agencies and community providers, as part of an MTSS framework?

MOU Framework

Recommended partner lead: county welfare director.

Your MOU should include, at a minimum, content that outlines the following:

- Ensure each agency partner is aware of and understands the existing screening, assessment, and entry to care procedures of other partners serving youth.
- Ensure, to the extent possible, that these screening, assessment, and entry to care systems are collaborating and informing the youth and their guardians.
- Ensure necessary and legal timelines for services are being met.
- Identify a process for sharing assessment information to support coordinated service planning, consistent with applicable laws.

Practices for Success

1. Evaluate current assessment and intake processes for adherence to timeliness and complete all screenings and/or assessments within an appropriate timeframe.

2. Consider the development of a single, coordinated intake and assessment process across all systems.
3. Collaborate between agencies to determine all needs of the child is being met.
4. Solicit specialized expertise and experience in identifying children's needs.
5. Placement agencies and appropriate educational agencies may:
 - a. Participate in CFT meetings for children in the process of intake.
 - b. Participate with the IPC in reviewing cases for children who are:
 - i. reasonably believed to receive a determination of regional center eligibility;
 - ii. in the intake process; or
 - iii. currently being served by the regional center
6. Evaluate current assessment and intake processes for adherence to timeliness and how these impact/affect our partner agencies timelines.
7. Describe the process by which assessments will be shared across systems and the timeframe by which these assessments will be shared in order to reduce duplicative assessments.
8. Establish a process for expedited service approvals in order to reduce placement instability and hospitalization. Whenever a child is placed in an out-of-state residential program, ensure there is a process to identify and develop the services and supports needed for the child to return to an in-state placement, consistent with the child's case plan goals.

Part Five: Child and Family Teaming

System partners provide a single, unified teaming process for all youth in care. In order to maximize planning and family engagement, a single Child and Family Team (CFT) process is used. Typically, the agency with legal jurisdiction will convene CFT meetings and document CFT outcomes. The CFT meetings will be coordinated via appropriate placing agency or in conjunction with any other intensive mental health services provider. All parties should participate as required, on time, and in accordance with state mandate.

Guiding Questions

- Of the already existing processes within the local level, which are operating well? Could these processes provide support or be leveraged to better coordinate care or reduce the demand on youth and family for meetings?
- What are current local barriers to implementing or participating in CFTs?
- Do CFT participants understand the services and supports provided by or available through each of the partner agencies?
- Where can local partners change current practices to implement and utilize CFTs?
- How do system partners coordinate team structures from our local county partner agencies to decrease confusion and feelings of being overwhelmed for our youth and families?
- What supports or services are needed? What service gaps need to be addressed?
- Does the county have Wraparound and Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Behavioral Services (TBS) services available at the level needed to avoid unnecessary residential placements? How will child and family teaming incorporate wraparound, ICC, and IHBS services?
- How is the provider network, including natural supports, structured in our System of Care?

MOU Framework

Recommended partner lead: county welfare director.

Your MOU must, at minimum:

- Include a process for when a CFT meeting should be convened, by who, and how partner agencies can support the work of the CFT.
- Establish policies for cross-system planning and coordination to ensure that there is only one team process for any single family in care.

Practices for Success

1. Successful CFTs include persons with natural supportive relationships with the family, so that the family's support system will continue to exist after formal services are completed.
2. All team members will be present during the CFT meeting and help create the family case plan.
3. All team members will have a working knowledge of the CFT meeting process.
4. Invite regional center staff as appropriate, to participate in the CFT.
5. Participate in the planning and development of services and supports for children and their families utilizing the ICPM and person-centered planning.
6. Integrate services and supports into educational plans, as appropriate, that help promote and support the desired outcomes for the child and family resulting from the ICPM and CFT.
7. Consider working with local partner agencies to cross-train service professionals on the CFT process and framework and including them as members of a child's CFT.
8. Collaborate from within the CFT, and partner agencies in family engagement, assessment, service planning, delivery, coordination, and care management, monitoring and adapting services, and transitioning.
9. Contribute specialized expertise and experience in identifying child and family needs that may, potentially and unintentionally, not be identified or addressed by other service delivery systems.
10. Consider including the following partners in your processes for child and family teaming and universal service planning:
 - SELPA or SELPAs depending on county

- LEA and LEA staff such as pupil personnel services staff, attendance review staff, foster children and youth programs staff, and special education staff as appropriate
- Child welfare agency
- County probation department
- Mental health plan – if child/youth is likely to receive a specialty mental health service
- Managed care organization – if child/youth is or likely to receive a EPSDT covered service provided by the managed care organization
- Regional center – if child/youth is likely to receive services through the regional center
- Department of Rehabilitation Local Office – if student is likely to receive services for employment and daily living
- Child/youth
- Family
- Court Appointed Special Advocates
- County offices of education
- Other required members of a CFT
- Other required and suggested members of an Individualized Education Program (IEP) team
- Community services providers

Part Six: Interagency Placement Committee

The Interagency Placement Committee (IPC) is a multi-agency, multi-disciplinary team that supports children and youth, including Non-Minor Dependents (NMD), with significant behavioral, emotional, medical and/or developmental needs through a collaborative review process whereby a child/youth's treatment and placement needs are determined. The IPC review process includes consideration of available assessments/evaluations, treatment information, and other relevant information regarding the child/youth/ non-minor dependent's history and current services and needs.

The primary purpose of the IPC is to review and approve the initial or continued treatment of youth in a STRTP consistent with state law. The IPC assessment shall determine or confirm whether the child meets one of the following areas:

- Youth meets the medical necessity criteria for Medi-Cal specialty mental health services.
- Youth's individual behavior or treatment needs can only be met by the level of care provided in a STRTP, and not a lower level of care.

Guiding Questions

- What are current local barriers to participating in the IPC?
- Which partners should be included when determining the protocols for IPCs?
- What are the ways local partners are currently participating in IPCs?
- Where can local partners change current practices to participate in IPCs?
- Does the IPC have a process to ensure that when the placing agency is considering placing a child/youth out of state, that all appropriate options in the county and in the state been exhausted?
- For a regional-center eligible child, does the IPC have a process for engaging with the regional center to support outreach to other regional centers and/or the Department of Developmental Services for options outside of the regional center catchment area?

- Does the IPC have a process to ensure consultation with the LEA concerning educational services requested?
- Does the IPC have a process to notify impacted systems in other counties when the child/youth may be placed out-of-county?
- Does the IPC have a process to identify and ensure supports to the youth and families when they are between placements?
- Does the IPC include adult residential facilities or other living arrangements (i.e. transitional housing), when appropriate, to meet the long-term care needs of older youth?
- Does the IPC consider other services such as applied behavioral analysis or wraparound supports to address trauma in less-restrictive settings?
- Does the IPC consider the availability and appropriateness of educational programming needed by the youth?
- Does the IPC have a process to identify and approve after-care services to support the child's timely transition to a home-based placement?

MOU Framework

Recommended partner lead: county social services or human services agency.

Your MOU must, at minimum:

- An identifying list of IPC Members that must include the county placement agency and a licensed mental health professional from the county department of mental health.
- IPC Governance procedures.
- Plan for communication between IPC Members.
- A clear IPC screening process that includes a review of current services and needs and determination of how to meet those needs in the least-restrictive setting.
- A clear determination of appropriate therapeutic treatment for youth in the least restrictive setting.

- A process for monitoring and supporting transition planning for youth upon completion of treatment in STRTPs.
- Process for communicating to the Interagency Leadership Team any issues, concerns, practice, technical assistant or other support needs to the Interagency Leadership Team that will enable the IPC to meet its mandates and ensure trauma-informed services to children, youth and families.

Practices for Success

1. Identify IPC required and optional membership, or consider formation of an advisory group to the IPC and/or ILT. While the statute requires that at least the county placement agency and a licensed mental health professional from the county department of mental health participate in the IPC, it is strongly recommended that the following groups not named in statute are considered for participation in your placement committee as applicable:
 - Youth and families
 - The county child welfare agency
 - The county probation department
 - The county behavioral health agency
 - The regional center or centers that serve children and youth with developmental disabilities in the county
 - Foster care or other child welfare advocacy groups
 - County office of education, LEAs and SELPAs
 - Department of Rehabilitation Regional Office
 - Managed Care Organization
 - Court Appointed Special Advocates
 - Tribal affairs partners or representatives
 - County School Attendance Review Board
 - Public health or other health-related practitioner
 - Representatives of contracted providers
2. Conduct the following activities in pursuit of the shared goals of the MOU:
 - Review Intensive Services Foster Care placement recommendations;
 - Review wraparound placement recommendations;
 - Review Challenging Youth and Family Service Plans, when placement disruption is at risk;
 - Make decisions/recommendations that will become the recommendations of the responsible department, division or unit of the agency partner which referred the youth; and,

- Provide any follow up to ensure the child/youth receives adequate and timely services as assessed by the mental health clinician and IPC, including supporting any necessary linkages to services pending the “placement” into an STRTP or other higher-level therapeutic setting.
 - Approve aftercare services in support of a child’s timely return to a home-based placement setting.
3. Establish a dispute resolution and an appeal process for IPC decisions that allow for review of a decision to be made either immediately following the IPC meeting or, if not possible, within two working days.

Part Seven: Alignment and Coordination of Services

Children and youth with complex challenges and needs typically receive (or are eligible to receive) many services from multiple agencies. Coordination of services is required to minimize confusion for families and achieve desired outcomes. Care coordination permits an integration of services among service agencies to avoid working at odds with each other and unintentionally undermining the efforts of other agencies to support the child and family. Integration and coordination of services also makes it possible for each agency to maximize its resources to serve children, youth, and families through greater efficiencies.

Service alignment and coordination begins when agency partners agree to work together to engage and surround the child and family with needed services, resources, and supports. Community partners also must work collaboratively to align timelines for all aspects of care, from screening and assessment to service delivery. The CFT and IPC play critical roles in this process, assuming these entities are fully inclusive of multiple system partners.

Alignment and coordination of services is the objective of a care planning process that is implemented and supported with fidelity to the ICPM and other team-based system planning processes carried out by the ILT, IPC, and the CFT. Under each of these teams, collaborating agencies are seen as equal partners and remain well-informed of individual roles and responsibilities. Care planning is not meant to be prescriptive, but rather an investigative process that is responsive to the unique circumstances and needs of each child and family. Alignment and coordination of services includes the following:

1. Identifying the specific needs and strengths of the child and their family;
2. Identifying services and community supports that the youth and their family require to address the challenges they face as a result of their needs;
3. Identifying which partner agency, or agencies, can provide these services and community supports to address the needs of the youth and their family;
4. Developing a care plan that considers the youth and family's voice and choice, and provides them with realistic supports to address their needs in a timely and appropriate manner.

The county MOU should facilitate this investigative care planning process based on the principles of the ICPM. The MOU, through the previous six sections, should identify the roles and responsibilities of partner agencies, as well as provide the means for an infrastructure analysis of the continuum of local programs and supports available to the CFT. If the end result of case planning does not lead to a well-coordinated and aligned care plan, the ILP should revisit the previous six parts of the MOU and rewrite

their policies and procedures to facilitate effective CFTs that incorporate the ICPM principles and effective use of screenings and assessments.

Guiding Questions

- Does the county delivery system support coordination of care across settings and professionals and emphasize the importance of community partnerships?
- Does care planning and coordination take into account the full continuum of program options that each partner agency has at its disposal to improve the quality of care for foster children and youth and their families?
- Does care planning and coordination recognize the importance of child and family preferences, language, and culture in achieving desired outcomes?
- Has the county conducted an infrastructure analysis to identify potential gaps in the continuum of services available? How will the county plan to meet any potential gap(s) in the continuum of program options?
- Are the IPC and ILT aware of the county's continuum of program and service options, including the local MOUs between education and CWS for school-based transportation for foster children and youth?
- Does your county have a foster children and youth school stability transportation plan that outlines a single, jointly created and practiced policies and procedures to guide how foster care coordination and transportation will occur so that transportation needs are not a barrier to health, education, and other entitlements for foster children and youth? Does it fulfill statutory obligations for transporting foster children and youth and special education?
- When foster children and youth are placed out of county, is the referral packet complete with the education documentation and all other pertinent information to ensure timely review and education placement by the receiving county?

MOU Framework

Recommended partner lead: county social services or human services agency.

Your MOU should include, at minimum, the following:

- A mechanism for identifying the individual needs of children and their families.
- A compilation of educational, health, child welfare and placement continuum of program options for service delivery available to serve youth and any appropriate and legal timelines associated with those services.

- Procedures to identify, develop, and monitor coordinated policies, procedures, resources and implementation practices for the benefit of at-risk children, youth and families; and to hold member agencies and their staffs accountable in these efforts.

Practices for Success

1. All county partners should assist in locating resources for foster children and youth services that will provide additional support to the well-being and permanency of the child, youth, and families.
2. Consider including the following partners when planning for the alignment and coordination of care for youth services:
 - The county child welfare agency
 - The county probation department
 - The county behavioral health agency
 - The regional center or centers that serve children and youth with developmental disabilities in the county
 - County office of education, SELPAs, and LEAs, inclusive of the School Attendance Review Board Function
 - Department of Rehabilitation Regional Office
 - Managed Care Organization

Part Eight: Staff Recruitment, Training, and Coaching

System partners should acknowledge the value of having highly trained and competent staff teams. In order to ensure that social workers, probation officers, therapists, doctors, clinicians, rehabilitation specialists, support and administrative personnel are fully prepared to deliver the seamless and integrated trauma informed services as outlined in this agreement, partners agree to coordinate the training of staff.

Guiding Questions

- Is there a plan to cross train staff from various county systems (i.e. child welfare, behavioral health, juvenile probation, regional centers, education)?
- Is there a shared, single training plan that captures the collaborative content and processes for training to System of Care practice?
- Will the staff in direct service roles consistently be trained in trauma informed care?
- Will the staff in direct service roles consistently be cross-trained, especially in key elements of ICPM such as engagement, teaming, care and service planning and transitioning?
- Will county offices of education be involved in the cross-training?

MOU Framework

Recommended partner lead: a designee of the County Executive Team.

Your MOU should include, at minimum, the following:

- Articulate a commitment to trauma-informed care and collaborative work across county agencies to improve outcomes for children, youth, and families.
- Identify the strategies to ensure all staff are trained in the principles and practices of trauma-informed care, cross-system collaborative to deliver seamless, integrated services, including a commitment to recruitment and support of staff to align with collaborative work. Efforts should include both traditional “classroom”-based learning as well as coaching and mentorship opportunities to embed system of care practices.

- Provide ongoing coaching to help with the following: transfer of learning to practice, continue with skill building, being able to problem solve, and staying on track.

Practices for Success

1. Teams should demonstrate collaboration and transparency when developing action plans to meet the goals of the children, youth, and families.
2. Have all members complete a crosswalk training of each agencies systems.
3. Have all members complete a crosswalk training of other interagency initiative agreements including but not limited to Competitive Integrated Employment (CIE) Blueprint Local Partnership Agreements (LPAs).

Part Nine: Financial Resource Management

Every individual agency within the local social service system is bound by statutes and regulations when funding services for children accessing their agency's resources. When service provision for these children and their families becomes more complex and involves multiple local social service agencies cost sharing and the management of financial responsibility can present barriers. These barriers typically create delays in services and breakdowns in timely, appropriate, and necessary supports and interventions for children and their families.

Ensuring that each local partner has an accurate interpretation and understanding of the regulations and statutes that determine financial responsibility, it is hoped that local partners will see a reduction in delays, and a unification of the current bifurcated systems that serve children and families. A child-family centered approach to planning and openness to creative and flexible financial solutions will help local partners avoid the exchange of misinformation and support a streamlined implementation process for services and supports for children and their families.

Guiding Questions

- Do county representatives and local agencies know and have an understanding of available resources and funding resources and the limitations of each resource for its use as part of braided funding?
- Do counties and local agencies understand entitlement responsibilities?
- What is a reasonable cost sharing responsibility given the services that are needed to fully serve children with significant needs? What is the process for exceptions to this cost-sharing?
- Which statutes and regulations guide each local agency's fiscal policies?
- What changes can local partners make to current practices to utilize creative fiscal strategies to provide effective and efficient child-family support?

MOU Framework

Recommended partner lead: county administrative officer or designee.

Your MOU should include, at minimum, the following:

- A process for identifying the federal, state, local, or private resources available across the system partners that can be utilized to serve children, youth and families, and a shared commitment to leverage those existing resource.
- A mechanism to ensure collaboration by partner agencies when paying for services provided to youth.

Practices for Success

1. Keep a child-family centered focus when discussing, planning, and determining solutions to local financial responsibility barriers.
2. Work with local partner agencies to cross-train service professionals and conduct joint interagency trainings on financial statutes and regulations to reduce antiquated processes and misinterpreted statutes and regulations.
3. Foster relationships with State agencies to support local understanding and interpretation of statutes and regulations.
4. Draw upon trainings, State guidance, and local partnerships to determine where regulations and statutes financially confine agencies and where space is available to be creative and flexible in financially providing efficient and timely supports and services to families and children.
5. Through a local partner workgroup, conduct an assessment of current financial barriers and local practices that represent ongoing conflicts and barriers to services and placement.
6. Utilize information about local practices to create uniform local practices that can be implemented when financial responsibility is in question.
7. Establish a local practice of inquiry by asking clarifying questions of local partner agencies. Use local partner responses and determinations as an invitation to openly discuss and explore the root of the financial barrier, and to elevate the barriers and inquiries to those in alternative decision-making positions.
8. Consider the following additional partners when determining the protocols for financial resource management and cost sharing:
 - Foster care or other child welfare advocacy groups
 - County office of education, LEAs, and SELPAs
 - Department of Rehabilitation Regional Office
 - Managed Care Organization
 - Youth voice
 - Court Appointed Special Advocates

- Community-based organizations and other partner organizations
- The regional center or centers that serve children and youth with developmental disabilities in the county.

Part Ten: Dispute Resolution Process

While ILT member agencies and leaders will utilize a shared decision making process for all programs and services identified by the system partners, challenges and disagreements may present. These disagreements sometimes are due to conflicting statute, regulations, policy, guidance, or in differing opinions as to what services are needed for a particular youth or family. System partners will attempt in good faith to resolve any dispute or disagreement arising out of this MOU.

Local Directors, Chiefs and Department heads will seek to settle relevant disputes by focusing on the shared vision, values and practices of this agreement. Consensus will be the preferable model; however, if consensus cannot be reached, decisions may be made by a simple majority vote of the ILT members.

Guiding Questions

- Is there a dispute resolution process in place? How are disputes triaged or categorized?
- What dispute resolution processes are in place at each partner agency? Are there alternative dispute resolution processes in place by each of the partner agencies? Can the agencies expand upon these processes to include disputes between agencies or disputes between families and multiple agencies?
- Who are the key individuals that can facilitate a resolution at the local level? Are they at the table?
- How does the locally established resolution team keep a person-centered focus when processing disputes?
- How can consensus be achieved to create results that best meet the needs of the child?
- What tools are already built into each individual system or agency that can be used to establish a dispute resolution process?
- What process is established to elevate an issue to the state resolution team when consensus cannot be reached and was every possible alternative method used?
- Do Department heads and senior staff have regular, informal opportunities to build a relationally-based shared approach to care and foster trust-building conversations?

- Do we know what county level entities are available and willing to assist when we cannot solve issues on our own?

MOU Framework

Recommended partner lead: county administrative officer or designee.

Your MOU should include, at minimum, the following:

- A description of the shared decision-making process for supporting children, youth and families that is aligned with the shared vision, mission and goals of the partner agencies.
- A process for demonstrating that all potential resources were exhausted prior to elevating the dispute to the state resolution team.

Practices for Success

1. Provide the ILT with appropriate administrative support, hold consistent meetings and build trust by doing the following:
 - Show up and be prepared to support the integration
 - Practice organizational empathy
 - Maintaining dialogue between all involved agencies
 - Incorporate alternative dispute resolution practices early to ensure alignment of norms, process agreements and getting to desired outcomes

Part Eleven: Resource Families and Therapeutic Foster Care Services

Resource families play a critical role in the life of children in out-of-home care. When out-of-home placement is needed to keep the child safe, Child Welfare Services (CWS) and Probation Departments make diligent efforts to identify, consider and evaluate relatives, family friends and those closely tied to the family as the primary placement option. When placement with a closely tied adult is not an option for the child, the placing agency makes efforts to actively recruit and support resource families that are able to keep the child or youth connected to their community and culture. Resource families work together with CWS or Probation staff and the child's family to successfully return the child to their parents, or when that is not possible, to support the child's transition to another permanent family. The purpose of a Resource Family is to provide a child with a feeling of safety, permanence, and well-being.

Therapeutic foster care (TFC) is available as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Specialty Mental Health Service (SMHS) to children and youth under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria. TFC is a short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a parent to a child or youth who has complex emotional and behavioral needs. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. TFC cannot be the only SMHS that a child or youth receives. Children and youth receiving TFC also must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the client plan.

TFC services offer an alternative to congregate care placement and are a critical resource in the foster care and behavioral health continuum of care. TFC services are highly dependent upon having high quality, trained, and supported caregivers to deliver trauma-informed care. Procuring TFC services requires joint partnership across system partners at the local level, working in partnership with provider agencies, to ensure this Medi-Cal service is available to children and youth in need.

While recruitment, retention and support of all resource families (including TFC families) has been viewed as the sole responsibility of the child welfare and probation systems, the reality is that resource families also interact with, and are dependent upon the services of, other partner agencies and systems to meet the health, mental health, developmental and education needs of the foster children and youth in their care. It is important that all system partners recognize their respective roles in identifying and supporting these resource family caregivers of foster children and youth and that all system partners work collaboratively to support these families.

Guiding Questions

- What efforts are underway by child welfare and probation departments to recruit, retain and support resource families? How can system partner agencies play a role?
- Has the county implemented TFC services? What are the barriers to TFC implementation and how are they being addressed?
- Is there a shared commitment across agencies (at a minimum, behavioral health and placing agencies) to recruit TFC providers? What are barriers to recruitment and retention of resource families to provide TFC?
- What are known characteristics or qualities of successful recruitment of resource families to care for children and youth with complex needs? What are the barriers to recruiting TFC parents? What are the known successful strategies to recruitment, retain and support TFC parents?
- Is the current delivery of TFC culturally appropriate and responsive?
- Are county partners (e.g., child welfare, probation, and county mental health plan) collaborating to implement TFC?
- Is there a shared commitment to recruit homes with contractual agreements with regional centers for children who are developmentally delayed? Is there a shared commitment of placement resources?
- How can LEAs assist in the recruitment of resource families?
- Are educational services and LEA resources considered when contemplating placement with a TFC parent?

MOU Framework

Recommended partner lead: county child welfare agency.

Your MOU should include, at minimum, the following:

- Identified ways partner agencies can support resource family recruitment and TFC implementation.
- A shared commitment to identifying, recruiting and supporting family-based caregivers and therapeutic care environments to deliver high quality, trauma-informed care to children, youth, and their families. This should include

identifying the roles and responsibilities of the respective partner agencies in this process.

Practices for Success

1. Consider including the following partners when determining the protocols for recruitment and management of resource families and delivery of TFC services:
 - County behavioral health agency
 - Providers (FFAs, etc.)
 - Current resource families
 - Youth
 - Parents and families
 - Tribes
 - Department of Rehabilitation Regional Office
 - Regional center(s)
 - Early Start program representative
 - County office of education, Special Education Local Plan Areas, and LEAs
 - County office of education administered Foster Youth Services Coordinating Program Executive Advisory Council
 - Foster care or other child welfare advocacy groups
 - Managed care organizations

2. Ensure CFT processes are in place to guide and plan TFC service provision.

Resource Library

The Resource Library is a collection of valuable references and citations that may assist in the development of the MOU.

All County Letters

- Part 5: ACL 16-84 [Requirements and Guidelines for Creating and Providing a Child and Family Team](#)
- Part 5: ACL 18-09: [Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool](#)
- Part 7: ACL 11-09 [Independent Living Services](#)
- Part 7: ACL 11-77 [Extending Foster Care Beyond Age 18](#)
- Part 7: ACIN I 28-99: [Wraparound Services](#)
- Part 7: ACIN I 52-15: [Wraparound Services Training](#)
- Part 7: ACL 19-53: [Requirements And Guidelines For Participation In The Active Supportive Intervention Services For Transition \(ASIST\) Program For Children, Youth, And NMD To Transition From Residential Placements To Family-Based Settings.](#)
- Part 9: ACL 18-85 [Joint Clarification Sharing CANS Assessments](#)
- Part 9: ACL 16-91 [Use of Title IV-E funds to support county foster youth services coordinating programs.](#)
- Part 11: ACIN 05-17 [Therapeutic Foster Care \(TFC\) Service Model and Parent Qualifications](#)
- Part 11: ACIN 91-17 and MHSUDS IN NO.17-069: [Therapeutic Foster Care \(TFC\) Training Resource Toolkit](#)

State Resources and Statutes

- General: [Child Welfare and School Attendance](https://www.cde.ca.gov/ls/ai/cw/) (<https://www.cde.ca.gov/ls/ai/cw/>)
- Part 5: California Early Intervention Services Act (CEISA) Government Code [§ 95020.](#)
- Part 1: State Law: County Office of Education Foster Youth Services Coordinating Program Executive Advisory Council (FYSCP EAC) [Education Code § 42921.](#)
- Part 2: [California Department of Justice Office of the Attorney General Foster Youth Data Sharing Guidance](#)
- Part 3: Departments of Education and Social Services MOU Requirements [California Education Code § 49085.](#)

- Part 3: Written Interagency Agreements Requirements: [California Education Code § 56475](#).
- Part 4: Entry to Care for Foster Youth, with time limitations [California Education Code § 48853.5](#).
- Part 5: Individual Program Plans--Regional Center Responsibilities: [WIC § 4646](#).
- Part 6: Interagency Placement Committees (IPCs) [WIC § 4096](#).
- Part 6: Out of State Placements General Provisions [WIC § 4519](#).
- Part 7: Extended Foster Care General Provisions: [Extended Foster Care AB 12 \(2010\)](#).
- Part 7: Foster Youth Transportation [California Education Code § 48853.5 \(f\)](#).
- Part 7: Special Education Transportation: [California Education Code § 56342](#).
- Part 7: Special Education Transportation: [California Education Code § 56195.8\(b\)\(5\)](#).
- Part 9: Individual Program Plans--Regional Center Responsibilities: [WIC § 4648](#).
- Part 9: Rates of Payment for Community Living Facilities: [WIC § 4684](#)
- Part 9: Regional Center Funding: [WIC § 4659](#).
- Part 9: Computation and Payment of Aid Grants: [WIC § 11464](#).
- Part 10: Regional Center Disputer Resolution Provisions: [WIC § 4659.5](#).

State Regulations

- Part 5: Procedures for IFSP Development, Review and Evaluation [CCR, Title 17 § 52102](#).
- Part 5: Individualized Family Service Plan (IFSP) CCR [Title 17 § 52100](#).
- Part 5: Participants in Initial and Annual IFSP Meetings and Periodic Reviews [CCR, Title 17 § 52104](#).
- Part 5: Content of IFSP [CCR, Title 17 § 52106](#).
- Part 7: Early Intervention Services, [CCR, Title 17, § 52000](#).
- Part 10: Dispute Resolution: Education Uniform Complaint procedure: Title 5, California Code of Regulations sections 4660-[4665](#).

State Templates

- General: Model 2083 MOU: [Sample County MOU](#)
- General: [Kids Alliance Education Toolkit](#) (<http://kids-alliance.org/programs/education/educational-equity/edtoolkit/>)
- General: [Foster Youth Education Rights](#) (<https://www.cde.ca.gov/ls/pf/fy/documents/fosteryouthedrights.pdf>)
- General: Multi-Tiered Systems of Supports Framework

- [UCLA MTSS Overview](http://smhp.psych.ucla.edu/pdfdocs/newsletter/fall19.pdf)
(http://smhp.psych.ucla.edu/pdfdocs/newsletter/fall19.pdf)
- [California Department of Education Multi-Tiered System of Support \(MTSS\) Web Page](https://www.cde.ca.gov/ci/cr/ri/) found (https://www.cde.ca.gov/ci/cr/ri/)
- [Orange County Department of Education MTSS Web Page](https://ocde.us/mtss/Pages/MTSS-Overview.aspx)
(https://ocde.us/mtss/Pages/MTSS-Overview.aspx)
- Part 2: [California Integrated Core Practice Model](http://www.cdss.ca.gov/Portals/9/CFT/ICPM%20document%20with%20CDSS%20and%20DHCS%2012-17-2018%20FINAL.pdf?ver=2019-03-07-095448-867)
(http://www.cdss.ca.gov/Portals/9/CFT/ICPM%20document%20with%20CDSS%20and%20DHCS%2012-17-2018%20FINAL.pdf?ver=2019-03-07-095448-867)
- Part 3: [California Bureau of Children’s Justice Data Sharing Guidance](https://oag.ca.gov/sites/all/files/agweb/pdfs/bcj/fy-info.pdf)
(https://oag.ca.gov/sites/all/files/agweb/pdfs/bcj/fy-info.pdf)
- Part 3: [Focusing on Children Under Stress Data Network](https://www.focuscalifornia.org/)
(https://www.focuscalifornia.org/)
- Part 5: [Child and Family Team Model Curriculum](https://www.oercommons.org/groups/child-and-family-team-cft-model-curriculum/2392/)
(https://www.oercommons.org/groups/child-and-family-team-cft-model-curriculum/2392/)
- Part 5: [Child and Family Team Brochure](http://www.cdss.ca.gov/Portals/9/CFT/Professional%20Brochures/TEMP%203013.pdf?ver=2018-12-06-133539-970)
(http://www.cdss.ca.gov/Portals/9/CFT/Professional%20Brochures/TEMP%203013.pdf?ver=2018-12-06-133539-970)
- Part 7: [Los Angeles county motion for a transportation plan for foster youth](http://file.lacounty.gov/SDSInter/bos/supdocs/128162.pdf)
(http://file.lacounty.gov/SDSInter/bos/supdocs/128162.pdf)
- Part 7: [Los Angeles county MOU for transportation](http://file.lacounty.gov/SDSInter/bos/supdocs/111642.pdf)
(http://file.lacounty.gov/SDSInter/bos/supdocs/111642.pdf)
- Part 7: [San Diego County transportation agreement](http://files.constantcontact.com/24a86362301/4e96e92e-7dba-4931-ab1d-7941af847da3.pdf)
(http://files.constantcontact.com/24a86362301/4e96e92e-7dba-4931-ab1d-7941af847da3.pdf)
- Part 9: [Coordination of Services Toolkit \(COST\)](http://www.achealthyschools.org/schoolhealthworks/tools---resources.html)
(http://www.achealthyschools.org/schoolhealthworks/tools---resources.html)
- Part 10: [Dispute Resolution: ESSA Transportation Dispute Resolution Guidance](https://naehcy.org/wp-content/uploads/2018/04/Foster-Sample-Dispute-NAEHCY-Sep-2016.pdf)
(https://naehcy.org/wp-content/uploads/2018/04/Foster-Sample-Dispute-NAEHCY-Sep-2016.pdf)
- Part 10: [Medi-Cal Fair Hearing](https://www.dhcs.ca.gov/services/medical/Pages/Medi-CalFairHearing.aspx) (https://www.dhcs.ca.gov/services/medical/Pages/Medi-CalFairHearing.aspx)

Glossary

[Assembly Bill 2083](#)

AB 2083 (2018, Cooley) requires each county to develop a memorandum of understanding (MOU) to describe the roles and responsibilities certain entities that serve children and youth in foster care who have experienced severe trauma, and instructs the Secretary of California Health and Human Services, and the Superintendent of Public Instruction to establish a joint interagency resolution team.

[Assembly Bill 403](#)

AB 403 (2015, Stone) began the process of reforming the continuum of care (CCR) for foster children and youth. The reform effort aimed to make sure that children and youth in foster care have their day-to-day physical, mental, and emotional needs met; that they have the greatest chance to grow up in permanent and supportive homes; and that they have the opportunity to grow into self-sufficient, successful adults. AB 403 advanced California's long-standing goal to move away from the use of long-term group home care by increasing youth placement in family settings and by transforming existing group home care into places where youth who are not ready to live with families can receive short term, intensive treatment.

[Child and Adolescent Needs and Strengths \(CANS\) Tool](#)

CANS is a multi-purpose tool that supports decision-making, including level of care and service planning, which allows for the monitoring and outcome of services. When used as part of the Child and Family Team (CFT) process, as California is doing, the CANS tool can help guide conversations among CFT members about the well-being of children and youth, identify their strengths and needs, inform and support care coordination, aid in case planning activities, and inform decisions about placement. Click [here](#) to learn more about the CANS tool.

[Child and Family Team \(CFT\)](#)

The CFT process begins when a child or youth enters foster care, and a child welfare social worker or juvenile probation officer engages with a child or youth and his or her family and then uses a variety of strategies to identify other team members, the child or youth's strengths, the child, youth, and family's concerns, and a plan to help achieve positive outcomes for safety, permanency, and well-being. This strengths-based approach to practice recognizes that families are experts in their own lives, and they can achieve success when they have an active role in creating and implementing solutions. The CFT process aligns with recent implementation of the Child and Adolescent Needs and Strengths (CANS) Assessment tool by CDSS and the Department of Health Care Services (DHCS). Click [here](#) to learn more about how the CANS and the CFT process work together.

Continuum of Care Reform (CCR)

CCR draws together a series of existing and new reforms to our child welfare services program designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed nurturing family homes. Assembly Bill 403 provides the statutory and policy framework to ensure services and supports provided to the child or youth and his or her family are tailored toward the ultimate goal of maintaining a stable permanent family. CCR is designed to meet the individualized needs of children and youth in foster care who have experienced trauma, abuse and neglect, and meaningfully supports for the families that care for them. The reform is founded on child development research, including research related to adverse childhood experiences, and practice knowledge showing that resilience and recovery from trauma is best supported by loving, accepting and healthy parenting, while recognizing that state and local programs must support caregivers in meeting the educational, developmental, physical and behavioral health needs of children and youth involved in the child welfare and probation systems. For more information on CCR, click [here](#).

County Offices of Education

There are 58 county offices of education that provide services to the state's school districts. The county offices have elected governing boards and are administered by elected or appointed county superintendents. The county superintendent is responsible for examining and approving school district budgets and expenditures. County offices of education support school districts by performing tasks that can be done more efficiently and economically at the county level. County offices provide or help formulate new curricula, staff development and training programs, and instructional procedures; design business and personnel systems; and perform many other services to meet changing needs and requirements. When economic or technical conditions make county or regional services most appropriate for students, county offices provide a wide range of services, including special and vocational education, programs for youths at risk of failure, and instruction in juvenile detention facilities.

County Executive Team

The executive leadership team of any county including the Members of the Board of Supervisors, The County Executive, County Cabinet Members, and relevant department heads.

County Managed Care Plan

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems and contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Medi-Cal beneficiaries in all 58 California counties receive their

health care through six main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito. Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network. For more information on county managed care plans, click [here](#).

[Early and Periodic Screening, Diagnostic, and Treatment Services \(EPSDT\)](#)

The EPSDT benefit provides comprehensive health coverage for all children under age 21 who are enrolled in Medicaid, or Medi-Cal in California. Consistent with state and federal law and regulations for EPSDT, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illnesses or conditions. This includes, but is not limited to, physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; and treatment for vision, hearing, and dental diseases and disorders. All of these services are at no-cost to individuals under age 21 who have full-scope Medi-Cal. Click [here](#) for more information on the EPSDT services.

[Family Educational Rights and Privacy Act \(FERPA\)](#)

FERPA is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students." Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

Foster Youth Executive Advisory Council

Foster Youth Services Coordinating Programs (FYSCP) were established by the Legislature in 2015 so that the county office of education could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care. This is a key component to the successful implementation of the local control funding formula (LCFF). The FYSCPs support and facilitate collaboration and capacity building while preserving the ability to provide direct services such as tutoring, mentoring, counseling, transition, school-based social work, and emancipation assistance when there are identified gaps in service at the local level for foster youth. Each FYSCP established a local Executive Advisory Council (EAC) whose members include local or tribal welfare probation departments, the courts, and other stakeholders. The EAC establishes that these services are needed, coordinates services to avoid redundancy, and aligns its efforts with local control and accountability plan priorities.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPPA is federal legislation that provides data privacy and security provisions for safeguarding medical information. HIPPA required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA [Privacy Rule](#) and the HIPAA [Security Rule](#). The Privacy Rule, or *Standards for Privacy of Individually Identifiable Health Information*, establishes national standards for the protection of certain health information. The *Security Standards for the Protection of Electronic Protected Health Information* (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called “covered entities” must put in place to secure individuals’ “electronic protected health information” (e-PHI).

Individuals with Disabilities Education Act (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a law that makes available a free appropriate public education to eligible children with disabilities throughout the nation and ensures special education and related services to those children. The IDEA governs how states and public agencies provide early intervention, special education, and related services to more than 6.5 million eligible infants, toddlers, children, and youth with disabilities. Infants and toddlers, birth through age 2, with disabilities and their families receive early intervention services under IDEA Part C. Children and youth ages 3 through 21 receive special education and related services under IDEA Part B.

Individual Family Service Plan (IFSP)

Infants and toddlers ages zero to three, with or at risk of a developmental disability and/or delay may be found eligible for early intervention services through the Early Start program. Once an infant or toddler is determined to be eligible for services, an Individual Family Service Plan (IFSP) is developed with a multidisciplinary planning team, including the parents.

An IFSP is a written document or plan based on an assessment of the child's needs and the needs and concerns of the family. An IFSP will address the strengths, and needs of the infant or toddler, parental concerns, and early intervention services identified. Specifically the IFSP contains 1) information on the child's present level of development in five developmental domains; 2) outcomes for the child and family; 3) services the child and family will receive to help them achieve the outcomes; 4) timelines; and 5) steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services.

The federal Individuals with Disabilities Education Act (IDEA, 303.26) states that services are to be provided in the child's "natural environment." Therefore, services contained in the IFSP are often provided in the home and can include child care settings, Early Head Start, preschools, or other community settings in which young children without disabilities are typically found.

Individual Program Plans (IPP)

The Lanterman Developmental Disabilities Act (Lanterman Act) requires that a person who is found eligible for regional center services, have a person-centered Individual Program Plan (IPP). The IPP is a written plan and agreement between the consumer and the regional center, which assists persons with developmental disabilities and their families to build their capacities and capabilities. This planning effort is not a single event or meeting, but a series of discussions or interactions among a team of people including the person with a developmental disability, their family (when appropriate), regional center representative(s) and others.

The planning team decides what needs to be done, by whom, when, and how, if the individual is to begin (or continue) working toward the preferred future. The IPP is a record of the decisions made by the planning team. The IPP identifies 1) outcomes the consumer is working towards; 2) who will provide the services and/or supports; and 3) if there is a cost associated with the service or support, who will fund it.

Individualized Education Program (IEP)

Each public school child who receives special education and related services must have an Individualized Education Program (IEP). Each IEP must be designed for one student and must be a truly individualized document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a

disability. To create an effective IEP, parents, teachers, other school staff--and often the student--must come together to look closely at the student's unique needs. These individuals pool knowledge, experience and commitment to design an educational program that will help the student be involved in, and progress in, the general curriculum. The IEP guides the delivery of special education supports and services for the student with a disability.

Intensive Care Coordination (ICC)

ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the ICPM, including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems.

The CFT includes formal supports (such as the care coordinator, providers, and case managers from child-serving agencies), natural supports (such as family members, neighbors, friends, and clergy), and other individuals who work together to develop and implement the client plan and are responsible for supporting children and their families in attaining their goals. ICC also provides an ICC Coordinator who:

- Ensures that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, client-driven, and culturally and linguistically competent manner.
- Ensures that services and supports are guided by the needs of the child.
- Facilitates a collaborative relationship among the child, their family, and systems involved in providing services to them.
- Supports the parent or caregiver in meeting their child's needs.
- Helps establish the CFT and provides ongoing support.
- Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

Intensive Home Based Services (IHBS)

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child or youth's family's ability to help the child or youth successfully function in the home and community. HBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the CFT in coordination with the family's overall service plan, which may include, but are not limited to assessment, plan development, therapy,

rehabilitation, and collateral. IHBS is provided to beneficiaries under 21 who are eligible for full scope Medi-Cal services and who meet medical necessity criteria.

[Interagency Leadership Team \(ILT\)](#)

AB 2083 provides that the MOUs that are required to be established by counties include establishment and operation of a local interagency leadership team comprised of the county child welfare agency, county probation department, county behavioral health agencies, county office of education, regional center or centers and (in an advisory capacity) foster care or other child welfare advocacy groups, as deemed appropriate by the organizations that will be parties to the memorandum. AB 2083 provides guidance regarding the sharing of information and data between members of the interagency team.

[Integrated Core Practice Model \(ICPM\)](#)

The Integrated Core Practice Model (ICPM) articulates shared values, core components and standards of practice expected from those serving California's children, youth and families. The primary purpose of the document is to provide practical guidance and direction to support county child welfare, juvenile probation, behavioral health staff, and their community partners in using best practices for the delivery of timely, effective, and collaborative services to children, youth, non-minor dependents and families. Derived from a compilation of Pathways to Well-Being Services, the ICPM is the enhanced rendition of previous service models that moves from working in an individual system/agency to working in a cross-system teaming environment. Click [here](#) for more information about the ICPM.

[Lanterman Developmental Disabilities Services Act](#)

The Lanterman Developmental Disabilities Services Act and related laws are codified in the California Welfare and Institutions Code Divisions 4.1, 4.5, and 4.7 and Title 14 of the Government Code. The Lanterman Act outlines the rights of individuals with developmental disabilities and their families and the responsibilities of local regional centers and service providers. The Lanterman Act created an entitlement to services that enables Californians with intellectual and developmental disabilities and their families to the right for services and supports which will enable them to make decisions and choices about how, and with whom, they want to live their lives; achieve the highest self-sufficiency possible; and lead productive, independent and satisfying lives as part of the community in which they live. This entitlement ensures that Californians with intellectual and developmental disabilities receive the right to live independent and productive lives in the community with individualized planning and to live in appropriate, quality, community-integrated homes.

[Local Education Agencies](#)

As defined by Education Code section 56026.3 for special education a "local educational agency" means a school district, a county office of education, a

nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area. It can also be defined as, A public board of education or other public authority within a state that maintains administrative control of public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state. School districts and county offices of education are both LEAs. Under the Local Control Funding Formula, charter schools are increasingly treated as LEAs.

Managed Care Plan/Organization

Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. A managed care organization is an organization that practices managed care principles. Most managed care systems utilize an HMO, EPO, PPO, or POS network design, limiting to varying degrees the number of providers from which a patient can choose, whether the patient has to use a primary care physician, and whether out-of-network care is covered under the plan. It is a health plan or health company which works to provide quality medical care at a cost-effective price. Healthcare organizations include providers such as hospitals, doctors and other medical professionals and facilities who work together on behalf of patients.

Multi-Tiered System of Support (MTSS)

The California Department of Education defines MTSS as an integrated, comprehensive framework that focuses on core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success. MTSS offers the potential to create needed systematic change through intentional design and redesign of services and supports that quickly identify and match the needs of all students.

Non-Minor Dependents (NMD)

The Non-Minor Dependent (NMD) is a current dependent child or ward of the juvenile court, or a nonminor under the transition jurisdiction of the juvenile court, who satisfies all of the following criteria: 1) has attained 18 years of age while under an order of foster care placement by the juvenile court, and is not more than 21 years of age; 2) is in foster care under the placement and care responsibility of the county welfare department, Indian tribe, consortium of tribes, or tribal organization; and 3) has a transitional independent living case plan. The NMD meets the legal authority for placement and care by being under a foster care placement order by the juvenile court, or the voluntary reentry agreement, and is otherwise eligible for AFDC-FC payments. Payments shall continue if the NMD is completing secondary education or a program leading to an equivalent credential, enrolling in an institution which provides postsecondary or vocational education, participating in a program or activity designed to promote or remove barriers to employment, employed for at least

80 hours per month, or unable to engage in the activities listed above due to a medical condition.

Out-of-State Placement

Out-of-state placements are governed by the Interstate Compact on the Placement of Children (ICPC). The ICPC helps the County meet AFDC-FC service requirements for children placed out-of-state by creating a formalized process of reciprocal service provision outlined in the Inter-State Compact Act. The receiving state will provide services to California dependents in accordance with the terms of the ICPC.

Regional Center

Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate community-based services and supports for individuals with developmental disabilities. There are 21 regional centers, with offices throughout California which provide local resources to help plan, access, coordinate, and monitor the many services available to individuals and their families. Seven regional centers serve different regions of Los Angeles County. Each remaining county is served by one of the remaining centers.

Resource Families

A resource family is an individual or family that a County or Foster Family Agency has determined to have successfully met the application and assessment criteria necessary for providing care for a child or nonminor dependent who is under the jurisdiction of the juvenile court, or otherwise in the care of a county child welfare agency or probation department.

School Attendance Review Board

State law (*EC* Section 48321) provides for the establishment of School Attendance Review Boards (SARBs) at the local and county level that support enforcement of compulsory education laws and seek to divert students with school attendance or behavior problems from the juvenile justice system. Additionally, *EC* Section 48325 established a State SARB for statewide policy coordination and personnel training.

School Education Local Plan Areas (SELPA)

Special Education Local Plan Areas (SELPAs) are regional consortiums of school districts that provide for all special education service needs of children residing within the region boundaries. In each region SELPAs developed a local plan describing how it would provide special education services and ensure that all students who are eligible for special education must be provided with a free appropriate public education in the least restrictive environment. SELPAs are responsible to ensure that there is a regional in place for the identification, assessment and placement of disabled students, including broad community engagement, and that a required annual compliance monitoring system is implemented.

Specialty Mental Health Services (SMHS)

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal). The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services under Section 1915(b) of the Social Security Act. DHCS is responsible for administering and overseeing the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs). MHPs are required to provide or arrange for the provision of outpatient and inpatient SMHS to beneficiaries in their counties who meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals, as documented in their client plans. In accordance with Medicaid Early and Periodic Screening, Diagnostic, and Treatment provisions, the intervention criteria for beneficiaries under the age of 21 are less stringent than they are for adults. SMHS include Intensive Care Coordination (ICC), intensive home-based services (IHBS), therapeutic foster care (TFC), and Therapeutic Behavioral Services (TBS). There are other services included in SMHS.

Short-Term Residential Therapeutic Programs (STRTP)

A Short-Term Residential Therapeutic Program (STRTP) is a children's residential facility licensed by the California Department of Social Services and operated by a public agency or private organization. An STRTP provides specialized 24-hour care and supervision, treatment, and services and supports, to children and non-minor dependents.

System of Care

Assembly Bill 2083 requires counties to design and implement a Memorandum of Understanding, framing a unified System of Care which coordinates timely, and trauma-informed services for foster children and youth, other vulnerable youth and their caregivers in a way that is comprehensive, culturally competent, timely, integrated, community-based, individualized, with strength-based services based on plans tailored to their individual needs.

Children in out of home placement are inherently served by multiple systems and programs including the placing agency (child welfare or probation), education, county mental and/or behavioral health, and sometimes the local regional center. The challenges of navigating these various systems leads to service gaps and placement instability, and ultimately compounded trauma for the child and family. A single, uniform System of Care, when well delivered, closes these gaps and improves outcomes.

Therapeutic Foster Care Services (TFC)

Therapeutic foster care (TFC) is a short-term, intensive, highly coordinated, trauma informed and individualized rehabilitative service covered under Medi-Cal that is

provided to a child/youth up to age 21 with complex emotional and behavioral needs who is placed with trained and supported TFC parents.

Wrap Around Services

Collaborative and coordinated system of support for an individual through a team that includes family members, friends, service providers, peer specialists, advocates, and others. Addresses crisis with the goal of keeping an individual in their current living arrangement, through identification of strengths, goals, and needed supports.

Provides an array of services and supports, including: respite, case management, activities, support groups, advocacy, treatment, family training, home/school services, psychiatric services, and coordination with community services.