UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

KATIE A., et al., Plaintiffs, **v.** **DIANA BONTA, et al.,** Defendants.	Case No. CV-02-05662 AHM (SHx) **EXHIBITS 1 THROUGH 5 TO SPECIAL MASTER'S REPORT ON PROGRESS TOWARD COMPLETION OF THE KATIE A. IMPLEMENTATION PLAN** Judge: Honorable A. Howard Matz Crtrm: 14

EXHIBIT 1

EXHIBIT 1 **AUGUST 24, 2012**

KATIE A. IMPLEMENTATION PLAN

INTRODUCTION

The *Katie A. v. Diana Bontá, et al.* (Former Director of the California Department of Health Care Services) federal class action lawsuit was filed July 18, 2002, seeking to make wraparound services and Therapeutic Foster Care available to all class members. In December 2011, the Federal Court approved the Katie A. Settlement, which required, among other things, the parties to develop an Implementation Plan to fulfill the obligations of the Katie A. Settlement Agreement. Specifically, the Katie A. Implementation Plan will be used by the State to achieve the intended objectives of the Katie A. Settlement using the activities described in Paragraph 20 of the Settlement Agreement. Pursuant to the Katie A. Settlement, the federal court will retain jurisdiction over the Katie A. Lawsuit until 36 months after the court's approval of the Settlement Agreement, which is December 1, 2014, at which time the Court's jurisdiction will expire. The implementation timeline, however, will include activities or deliverables that may be completed, or ongoing, after the end of court jurisdiction.

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

The Implementation Plan is intended to provide a road map to delivering Intensive Home Based Services (IHBS), Intensive Care Coordination (ICC) and Therapeutic Foster Care (TFC), consistent with a Core Practice Model that is more coordinated, comprehensive, individualized and community-based. Various aspects of the plan were developed with parent and youth involvement via the subgroups and incorporate the strength-based, family focused practice principles which are to be supported by the child welfare and mental health systems. Various activities include State level supports that will guide the service delivery and facilitate the administrative supports needed for local implementation.

The plan is organized by six objectives that outline short- and long-term activities in two phases. Phase One covers a period for activities that are in development and slated for completion within the 2012 calendar year. Phase One focuses on taking all necessary steps to enable counties to deliver IHBS and ICC services beginning no later than January 1, 2013. Phase Two reflects activities that may or may not begin in 2012 but will extend into 2013 and beyond. Phase Two focuses on adopting and promoting the Core Practice Model throughout the state and satisfying the remaining Settlement Agreement requirements. The purpose and

anticipated results are included to provide context from the Settlement Agreement. Important accomplishments to date are summarized in an addendum. Taken together, these objectives, implementation activities, timelines and accountability roles constitute the parties' best effort to date to develop a comprehensive plan intended to produce meaningful and sustainable results for children and youth in the foster care system with mental health needs and achieve the requirements of the Settlement Agreement.

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

The parties appreciate the assistance and guidance of the Negotiation Workgroup in the development of the Katie A. Implementation Plan. It is anticipated that the Negotiation Workgroup will continue its participation for the remainder of 2012 through the subgroups and Implementation Planning Teams (IPTs). The parties will also look to the Negotiation Workgroup for assistance in developing Phase Two. Following the submission of the complete Implementation Plan to the Court in December of 2012, the Negotiation Workgroup will convene no less frequently than once every quarter for the remainder of the jurisdictional period to provide further direction and guidance.

CDSS and DHCS recognize the importance of maintaining transparency and open communication throughout the process of implementation and beyond. Therefore, the dissemination of information will continue to be a priority for both departments and will include, but is not limited to: Information Notices, All County Letters (ACLs), program instructions and the release of data and website postings.

THE PATHWAYS TO MENTAL HEALTH SERVICES OBJECTIVES

I. CORE COMPONENTS

The following objective consists of two parts: Part A outlines service arrays, a Core Practice Model (CPM) approach and the tools to support the provision of services using a core practice approach. Part B promotes the adoption of the CPM through services that are needs-driven, strength-based, family focused, culturally competent, individualized and delivered in a multi-agency collaborative approach.

PART A: CORE COMPONENT ELEMENTS

OBJECTIVES

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

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

- To clarify and provide guidance on state and federal laws as needed to implement the Settlement Agreement so that counties and providers can understand and consistently apply them.

- To develop and disseminate a Medi-Cal IHBS and ICC Services Documentation Manual.

IMPLEMENTATION ACTIVITIES AND TIMELINES

The tools supporting the service arrays and the practice model are described in the following narrative and are also addressed in the Training and Technical Assistance section:

A. Medi-Cal IHBS and ICC Services Documentation Manual

The Medi-Cal IHBS and ICC Services Documentation Manual (hereinafter referred to as "the Documentation Manual") will inform and instruct counties and providers on IHBS and ICC. The manual will clarify Medi-Cal coverage of these services including billing rules and documentation requirements for Medi-Cal claiming. Additionally, the manual will address service function codes, scope of practice issues and staffing qualifications. The Documentation Manual will only address the specific Medi-Cal mental health services, not Title IV-E eligible services.

B. Core Practice Model Guide

The Core Practice Model (CPM) Guide will describe the core practice model adopted in the Settlement Agreement that is based on family-centered values and principles and describe how they should be utilized by the child welfare and mental health systems for the class. All counties, agencies and individuals who serve children and families that are the clients of both child welfare and mental health agencies will be expected to utilize the guide to assist with the adoption of the Core Practice Model. The CPM Guide will be linked to the Documentation Manual and referenced where appropriate to promote the application of the CPM in delivering mental health services to class and subclass members.

C. Therapeutic Foster Care Model and Coverage

CDSS and DHCS, in concert with the plaintiffs' counsel and consultants, will determine which components of TFC are covered under Medi-Cal, the preferred service model, and how the service should be claimed to Medi-Cal. Once the TFC model and coverage have been determined, TFC will be added as an addendum to the Documentation Manual. While TFC implementation may commence after the rollout of IHBS and ICC, these services will not be hindered as a result of the TFC evaluation and implementation process.

DHCS will complete the initial draft of the Documentation Manual and CDSS will complete the initial draft of the CPM Guide. The Core Components Implementation Planning Team (Core Components IPT) will consult with CDSS and DHCS on the development of the Documentation Manual and CPM Guide. The Core Component IPT consists of three separate workgroups: the Documentation Manual Subgroup; the CPM Guide Subgroup; and the TFC Model and Coverage Subgroup.

Although each subgroup has a specific purpose and identified deliverables, the three subgroups will continue to work in collaboration to ensure consistency with the manual, guide and communications and basic orientation regarding these tools.

Phase One Timeframe: July 2012 – December 2012

For specific steps accomplished to date, please refer to **Appendix A**.

A. Produce the Documentation Manual

1. By August 6, 2012, DHCS will complete an initial draft of the Documentation Manual and submit to the Documentation Manual Writing Team and subgroup for review.
2. By September 17, 2012 the subgroup, Documentation Manual Writing Team, CDSS and DHCS will have reviewed the initial draft and submitted it to the Core Components IPT and the Negotiation Workgroup for review.
3. By September 30, 2012, CDSS and DHCS will review and consider the input and feedback from the Negotiation Workgroup and will post the draft for 30-day public comment.
4. By November 15, 2012, the Core Components IPT will submit the final draft to the Negotiation Workgroup for final review.
5. By November 30, 2012 DHCS/CDSS will release the Documentation Manual and will issue an ACL/Notice to all County Mental Health Plans and County Social Services Directors that includes background information regarding the Katie A. Settlement, the Documentation Manual, the specific date for commencement of delivery and claiming of IHBS and ICC, initial training dates and information on how to access technical assistance and Web page updates. It will also be posted on the DHCS and CDSS websites.

6. By December 31, 2012, CDSS and DHCS will have provided a basic orientation and will have released a scheduled of future webinars and regional trainings. DHCS will also be prepared to provide technical assistance to answer questions by counties, providers and stakeholders regarding the Documentation Manual.

B. Develop a Core Practice Model Guide

1. By September 30, 2012, the CPM Guide Subgroup, CDSS and DHCS will submit the initial draft of the CPM Guide to the Negotiation Workgroup for review.
2. By October 30, 2012, CDSS and DHCS will release the draft CPM Guide for 30-day public comment.
3. By November 30, 2012, the CPM Guide Subgroup, CDSS and DHCS will have received public comment and feedback on the CPM Guide.
4. By December 31, 2012, the Core Component IPT will review and consider feedback received for incorporation and submit the final CPM Guide to the Negotiation Workgroup.

Phase Two Timeframe: January 2013 and Beyond

A. Produce a Core Practice Model Guide

1. By January 31, 2013, CDSS and DHCS will issue an ACL/Notice to all County Mental Health Plans and County Social Services Directors which will include background information regarding the Katie A. Settlement, purpose and goals for the CPM Guide and timeline for statewide implementation and initial and ongoing expectations of its use.
2. By January 31, 2013, CDSS and DHCS will release the final CPM Guide for implementation.
3. By January 31, 2013, CDSS and DHCS will have released a schedule for basic orientation and training of the CPM Guide. Under contract with CDSS, the UC Davis Resource Center for Family-Focused Practice will provide the initial training. CDSS will also be prepared to provide technical assistance to answer questions by counties, providers and stakeholders regarding the CPM Guide.

B. Therapeutic Foster Care

1. Continuing through (date to be determined), the TFC Consultants will meet with DHCS, CDSS, the Special Master and plaintiffs' counsel, to provide research and information on other state models and provide recommendations on alternative potential models for California.
2. Continuing through (date to be determined), it is anticipated that the TFC Subgroup, CDSS, and DHCS will continue to work with consultants, counties and providers to identify risks and benefits of a particular model for California and make a determination of the best model to implement in California.
3. By (date to be determined), the following activities will take place:

a) Identify components of TFC services/model program that are Medi-Cal reimbursable.
b) Determine steps necessary to implement the services/model, including any necessary federal approvals.
c) Draft TFC Documentation Manual addendum.
d) Provide first draft to the Core Components Workgroup and Negotiation Workgroup and review and consider incorporating input and feedback.
e) Post draft for 30-day public comment and review and consider incorporating feedback received.

4. By (date to be determined), provide final draft to the Negotiation Workgroup for review.
5. By (date to be determined), add the TFC services/model and billing rules to the Documentation Manual as an addendum or supplement.

ANTICIPATED RESULTS

The development and release of the Documentation Manual will provide essential information for Mental Health Plans (MHPs) and their contractors regarding coverage, claiming and documentation of IHBS and ICC services as part of the Medi-Cal Specialty Mental Health Services array.

The CPM Guide will lead to improved coordination of resources and services, as well as greater uniformity in statewide practices by child welfare and mental health agencies and providers serving children in the foster care system. Additionally, the CPM Guide will enable and promote the adoption of a single model of care that children and families receive when served by both Child Welfare and Mental Health agencies.

The Documentation Manual and the CPM Guide will be developed in collaboration with each other in order to promote integration and alignment between practice and services and are intended to be used in tandem. Additionally, training and technical support will be provided by the State in a manner that is intended to underscore the importance of utilizing the Documentation Manual and the CPM Guide together.

RESPONSIBLE PARTIES

DHCS, CDSS and Documentation Manual, CPM and TFC Subgroup Members

PART B: CORE PRACTICE MODEL ADOPTION

OBJECTIVES

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

- To establish a CPM Fiscal Taskforce that will draft a plan for inclusion into this Implementation Plan to the fullest extent practicable consistent with the time available, that focuses on do-able, achievable and fiscally sound incentives to deliver IHBS, ICC and TFC within the Core Practice Model framework and reduce the use of group homes and other institutional placements.

- To establish a Joint Management Taskforce (JMT) with representatives from each department and representatives from youth, parent partner, county and provider groups.

- To develop a CPM Guide.

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IMPLEMENTATION ACTIVITIES AND TIMELINES

Phase One: July 2012 – December 2012

A. The development and completion of the CPM Guide will describe an approach to services that is based on family-centered values and principles made available to county mental health and social work staff.

B. CDSS and DHCS, in consultation with the Negotiation Workgroup, shall establish and charter the CPM Fiscal Taskforce. The Taskforce will begin meeting no later than October 31, 2012.

C. CDSS and DHCS shall establish and charter the JMT. The JMT will begin meeting no later than October 31, 2012.

Phase Two: January 2013 and Beyond

A. The CPM Fiscal Taskforce will develop a strategic plan that focuses on doable, achievable and fiscally sound incentives to deliver the services within the core practice model framework and reduce the use of group homes and other institutional placements. The strategic plan recommendations will be incorporated into the Implementation Plan or directly implemented to the fullest extent practicable consistent with the time available.

B. CDSS and DHCS will consult with the JMT on their obligation to develop and endorse practice tools, training curriculum, practice improvement protocols and quality review systems to support the shared CPM in order to support service integration and coordination for mental health services for class members.

C. By January 2013, develop basic orientation and adoption strategies for the CPM guide in order to promote the understanding by stakeholders (State partners, counties and providers, beneficiaries and family members) about the practice

model for serving children in the Katie A. class and adoption of the CPM by counties and child welfare and mental health provider agencies.

D. By January 31, 2013, issue an ACL/All County Information Notice (ACIN) to describe IHBS and ICC services within a CPM approach.

E. By (date to be determined), once the TFC services model and Medi-Cal coverage have been determined, TFC will be addressed in the CPM Guide through an update or addendum.

ANTICIPATED RESULTS

The adoption and use of the CPM will transform practice associated with the delivery of services by child welfare and mental health services staff. The practice will be utilized by all agencies and individuals who serve the Katie A. class members and their families.

RESPONSIBLE PARTIES

DHCS and CDSS

II. FAMILY AND YOUTH INVOLVEMENT

OBJECTIVES

- To ensure that family and youth involvement is integrated at the practice, program and system levels and phases of implementation as envisioned by the CPM. CDSS and DHCS will ensure the use of family and youth partnerships to assist with identifying the appropriate orientation, training, and other strategies needed to strengthen and/or change the State and local systems to meet the terms of the settlement agreement.

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

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

IMPLEMENTATION ACTIVITIES AND TIMELINES

Phase One: July 2012 – December 2012

A. Continue to engage youth peers in joining the Katie A. Negotiation Workgroup.

B. Provide youth peers with a Katie A. orientation and partner them with parent peers.

C. Develop funding sources to continue to support the participation of family and youth peers in order to include them in the design and development of the Implementation Plan.

D. Engage family and youth peers to provide input on implementing each of the six objectives of the Implementation Plan.

Phase Two: January 2013 and Beyond

A. Family and youth peers will continue to provide input on implementing each of the six objectives of the Implementation Plan.

B. The State and counties will work to incorporate family and youth peers in the implementation, roll out and trainings to ensure the integrity of family and youth strengths and focus.

ANTICIPATED RESULTS

Services will be delivered by counties and their providers in a manner that promotes a strengths-based, family focused and child-centered approach. Quality assurance indicators will be consistent with consumers' needs and the service delivery system will place children, youth and families at the center. Enhancements to the system will be made to directly benefit consumers. By incorporating family/youth involvement in both implementation and outcomes throughout the processes, there will be an increase in engagement, service utilization, collaboration among team members, stable family structures and sustainable recovery.

RESPONSIBLE PARTIES

DHCS and CDSS

III. SERVICE DELIVERY AND ROLLOUT

OBJECTIVES

- To have completed all steps necessary to ensure that IHBS and ICC are available to the subclass members and can be claimed by county Mental Health Plans (MHPs) on or before January 1, 2013.

- To develop a process to identify class members in order to link them firmly to services.

- To conduct a statewide readiness assessment of counties to develop and model child welfare and mental health service delivery systems that can be successful in implementing the CPM.

- To address how the CPM and IHBS, ICC and TFC will be brought to scale statewide.

IMPLEMENTATION ACTIVITIES AND TIMELINES

Implementation will occur in two phases. The purpose of Phase One is to detail the steps the departments need to take to ensure that IHBS and ICC (and after (date to be determined), TFC) are available to subclass members and can be claimed by county MHPs to Medi-Cal. The purpose of Phase Two is to detail the steps the Departments need to take to implement, measure and sustain the CPM approach in delivering mental health and child welfare services and to ensure subclass members have access to and receive medically necessary IHBS, ICC and TFC.

CPM: As a component of Service Delivery and Rollout, the Early Implementer County Strategy will be used to identify those counties who agree to be Early Implementers in using the CPM, which will give them access to technical assistance and training. In addition to the Early Implementer Counties receiving training, CDSS and DHCS will integrate the technical assistance needed to support Early Implementers into their ongoing work with counties. Specifically, the Departments will be prepared to respond to individual county questions as they arise. The Negotiation Workgroup is currently developing the details of the selection process to identify the Early Implementer Counties.

The Negotiation Workgroup has proposed to develop and use a CPM Readiness Assessment Tool for counties to self-assess their capability and capacity to implement the CPM. A process will be determined in consultation with the California Mental Health Directors Association (CMHDA) and the County Welfare Directors Association (CWDA) on how best to assess and utilize the information reported in the tool in order to determine the training and support needed to roll out services. The intent of the CPM Readiness Assessment Tool is to assist both the State and counties in effectively preparing and planning for CPM implementation.

IHBS/ICC/TFC: Consistent with the above objective, implementation activities and timelines will need to be developed regarding statewide rollout of IHBS and ICC (and after [date to be determined], TFC) to the subclass.

Phase One Timeframe: July 2012 – December 2012

For specific steps accomplished to date, please refer to **Appendix A**.

By December 31, 2012, CDSS and DHCS will do the following:

1. Work with CMHDA, CWDA, provider associations and family and youth organizations to develop information regarding a CPM Readiness Tool to assist counties in identifying their ability for implementing the CPM.
2. Finalize and disseminate statewide the CPM Readiness Tool.
3. In consultation with the Negotiation Workgroup, develop and issue an ACL and/or Information Notice to notify counties that IHBS and ICC are an entitlement under federal and state law, describe who the services should be provided to in the subclass, as well as how youth will be identified and referred to a provider.
4. Provide county MHPs and providers with the Medi-Cal claiming and documentation requirements for IHBS and ICC through the issuance of the Documentation Manual.
5. Determine IHBS and ICC billing codes and ensure that State systems are able to process claims submitted by counties.
6. Implement IHBS and ICC for availability statewide.

Phase Two Timeframe: January 2013 and Beyond

1. Encourage counties and providers to utilize the CPM Guide in the delivery of all services, including IHBS and ICC.
2. CDSS and DHCS will provide consultation and guidance for counties to assist them in determining subclass members for whom IHBS and ICC services are medically necessary.
3. CDSS and DHCS, in consultation with the Negotiation Workgroup, will develop activities and timelines for ensuring that IHBS, ICC (and after [date to be determined], TFC) are available to subclass members.
4. CDSS and DHCS, in consultation with the Negotiation Workgroup, will select Early Implementer Counties to adopt the CPM.
5. Continue to utilize feedback from Early Implementer Counties of the CPM to determine potential areas for improvement and develop a plan to disseminate and promote statewide adoption of the CPM using lessons learned from Early Implementer Counties.
6. Continue to provide technical assistance and support to counties regarding the CPM Readiness Assessment Tool and implementation activities.
7. Determine TFC billing code.
8. Implement TFC statewide.

ANTICIPATED RESULTS

IHBS and ICC (and after [date to be determined], TFC) will be made available statewide and adoption of the CPM will result in a single model of care that children, youth and families receive when served by both agencies.

RESPONSIBLE PARTIES

CDSS, DHCS and the Negotiation Workgroup

IV. TRAINING AND TECHNICAL ASSISTANCE

OBJECTIVES

- To develop cross-system training curriculum and educational materials for child welfare and mental health staff.
- To develop training and/or technical support for a child welfare and mental health leadership and workforce that is in line with the CPM to support the integration and coordination of how child welfare and mental health workforces can deliver consistent and quality services and to include families in the training process.
- To develop and endorse practice tools, training curriculum, practice improvement protocols and quality control systems to support the shared CPM in order to support service integration and/or coordination for mental health services for class members.

IMPLEMENTATION ACTIVITIES AND TIMELINES

Training and technical support may be targeted and orchestrated using various methods and processes including but not limited to the CDSS statewide training and education system. Other training may be specialized and targeted to particular stakeholders and delivered based on specific contracts managed at the State and/or local level. Family and youth involvement should be included in all aspects of training and support development and activities.

Phase One: July 2012 – December 2012

For specific steps accomplished to date, please refer to **Appendix A**.

A. By September 2012, CDSS will initiate a request to the Statewide Training and Education Committee (STEC), which is the CDSS process for developing and coordinating all

Statewide Training for county social workers. The STEC process will convene a training subgroup comprised of parent partners, providers, foster parents, mental and social work staff, clinicians, former foster youth, Court Appointed Special Advocates and other stakeholders set timelines for development of training and curriculum products.

B. By December 31, 2012 DHCS will instruct appropriate State and County auditors to follow the billing and documentation guidelines in order to ensure appropriate and consistent audit standards are being utilized to review provider billing claims.

C. Beginning December 31, 2012 and ongoing, DHCS and CDSS will provide training for county MHPs and specialty mental health providers regarding the Documentation Manual and Medi-Cal coverage and billing of IHBS and ICC.
   1. Training will coincide with the release of the Documentation Manual.
   2. Trainings will be targeted to reach MHPs and providers. Plans for where the trainings will occur, who will conduct the trainings, what materials will be used and additional pertinent information will be drafted by October 31, 2012.
   3. Presentation materials and webinars will be posted on both the DHCS and CDSS websites.
   4. Additional technical assistance needs (i.e. webinars, in-person trainings, or conference calls/meetings) will be determined following the manual release.
   5. The Documentation Guide training will be coordinated with the Core Practice Model Guide training.

D. DHCS and CDSS will work collaboratively with the counties to provide on-going technical assistance and support on activities identified in the readiness tool.

Phase Two: January 2013 and Beyond

A. Determine what curriculum and coaching products needs to be developed based on the CPM Guide for mental health, social services and other stakeholders.

B. Determine the content of a County Implementation Team Guide based on the CPM Guide.

C. Identify Statewide Training Plan to share the CPM.

D. The Early Implementer Counties begin using the Implementation Team Guide, curricula and coaching tools.

E. The Implementation Team Guide, curricula and coaching materials are revised based on the feedback and experience of the Early Implementer Counties.

F. Additional cohorts of counties begin utilizing the materials.

G. CDSS and DHCS will develop educational materials, including a tool kit, in consultation with parent /family input to be used by counties and providers.

H. Continue to provide technical assistance and support for the Documentation Manual, CPM Guide and needs identified in the readiness tool.

I. Continue to provide policy guidance, education and training, service development and fidelity in alignment with the principles of the CPM.

ANTICIPATED RESULTS

Technical assistance and training will help county leadership and providers offer services based on the CPM approach. Technical assistance and training will be system-wide and/or targeted based on needs assessments conducted at the local level. It will be informed and revised based on experience from the early implementing counties.

Training and/or technical support for child welfare and mental health will be in line with the CPM and supportive of the integration and coordination of child welfare and mental health workforces that deliver consistent and quality services and include families in the training process.

Technical assistance and training products including, but not limited to, practice tools, cross-system training/coaching curricula, practice improvement protocols, and quality control systems will support a shared Core Practice Model. Training for the Documentation Manual will be integrated with the training on the Core Practice Model Guide. CDSS and DHCS, in consultation with the Joint Management Taskforce, will endorse training products.

RESPONSIBLE PARTIES

DHCS and CDSS

V. DATA AND QUALITY ASSURANCE

OBJECTIVES

- To establish an Accountability, Communications and Oversight (ACO) Taskforce and produce a report with recommended actions and timelines.

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

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

- To collect existing data specific to the class (and subclass) in order to evaluate utilization (patterns, type, frequency, intensity of services) and timely access to care.

- To facilitate a stakeholder meeting to solicit ideas from stakeholders and counties about what data concerning the class DHCS and CDSS should routinely produce and post.

- To establish a procedure and timeline to produce and post data that is useful to counties, stakeholders and State departments in addressing the needs of children in the class.

IMPLEMENTATION ACTIVITIES AND TIMELINES

Phase One: July 2012 – December 2012

For specific steps accomplished to date, please refer to **Appendix A**.

A. The Negotiation Workgroup will finalize the ACO charter and make recommendations for ACO Taskforce membership.

B. DHCS and CDSS will establish the ACO Taskforce based on recommendations from the Negotiation Workgroup.

C. The State will identify existing data systems and resources (Special Projects Code, Client Services Information) that are capable of measuring who needs and is receiving services, including the type, intensity and duration. The State will encourage counties to use and report these measures pending further development of the Data and Quality Assurance component in Phase Two of the Implementation Plan.

Phase Two: January 2013 and Beyond

A. DHCS and CDSS will establish and convene an ACO Mapping Group to inventory and report on the current array of ongoing statewide data efforts by CDSS and DHCS.

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

C. The ACO Taskforce will produce a report with recommended action and timelines to:

1. Identify the method to track the use of IHBS and ICC (and after [date to be determined], TFC) service arrays for subclass members.
2. Consider utilizing the External Quality Review Organization (EQRO) and California Child and Family Services Review (C-CFSR) requirements in developing a plan for the collection of data and information about children in the class who receive mental health services.
3. Devise a process to measure the interface and inclusion of families at the planning and implementation phases by counties and providers.
4. Collect data elements in DHCS and CDSS data systems specific to the class (and subclass) in order to evaluate utilization (patterns, types, frequency, intensity of services) and timely access to care.

D. The Joint Management Structure IPT will:
1. DHCS and CDSS will establish a shared management structure to develop outcomes and accountability consistent with the Core Practice Model linking accountability to the ACO Taskforce and Joint structure based on data.
2. DHCS and CDSS, in consultation with the Joint Management Taskforce, will develop and endorse quality review systems to support the shared Core Practice Model.
3. DHCS and CDSS will develop a proposal to incorporate the production and posting of data including relevant information for the class into the implementation.
4. Facilitate a stakeholder meeting to solicit ideas from stakeholders about what data concerning the class (and subclass) the departments should routinely produce and post.
5. Post all reports and timelines on DHCS and CDSS websites.

ANTICIPATED RESULTS

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

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

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

RESPONSIBLE PARTIES

DHCS and CDSS

VI. JOINT MANAGEMENT STRUCTURE

OBJECTIVES

- To establish a shared management structure to develop a shared vision and mission statement, policy and program direction, clear and consistent guidance and outcomes and accountability measures consistent with the CPM.
- To create cross-system processes and procedures to support and manage the shared responsibility between CDSS and DHCS for delivering services to foster youth that is consistent with the CPM at the county/local level.
- To develop and provide models for local agencies to consider in order to work more effectively together.

IMPLEMENTATION ACTIVITIES AND TIMELINES

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

Phase One: July 2012 – December 2012

A. In October 2012, CDSS and DHCS will begin convening monthly meetings of the Joint Management Taskforce (JMT) and the Core Practice Model (CPM) Fiscal Taskforce. Upon completion of the taskforces, CDSS and DHCS will consider adoption of the JMT and CPM Fiscal recommendations to inform the design, development and support of a JMS that will also be implemented at the county level and continue through post exit of jurisdiction. The purposes of these two taskforces are the following:

Joint Management Taskforce (JMT):

The purpose of the Katie A. JMT is to develop recommendations for the establishment of a joint management structure between DHCS (including the former Department of Mental Health) and CDSS and to consult with the State

agencies regarding the development of practice tools, training curriculum, practice improvement protocols and quality control systems. These activities are key parts of the implementation of the Katie A. Settlement Agreement, including developing and supporting a CPM delivering child welfare and mental health services to children in or at risk of foster care placement.

Core Practice Model Fiscal Taskforce:

The purpose of the Core Practice Model Fiscal Taskforce is to develop a strategic plan or proposal using fiscally sound incentives and reduced administrative barriers to (1) accomplish statewide adoption of the CPM, (2) deliver intensive home and community based services to subclass member within the CPM framework, and (3) reduce the use of group homes and institutional placements. The parties will incorporate the CPM Fiscal Taskforce's plan or proposal into the Implementation Plan to the fullest extent practicable consistent with the time available.

Phase Two: January 2013 and Beyond

A. The JMS will incorporate the CPM through system multi-agency collaboration and client service collaboration. This management structure will guide and manage service delivery to foster youth with mental health needs in a manner consistent with the CPM. A JMS will be encouraged at the county level and continue through post-exit of jurisdiction.

B. CDSS and DHCS will issue communication statements and guidance regarding the State and County joint management structures. The two departments will also promote the JMS and ACO structures and CPM fiscal strategies statewide.

C. CDSS and DHCS will analyze and evaluate utilization (patterns, types, frequency and intensity of services) and timely access to care based on data elements in both departments' data systems specific to the class and subclass. The data and subsequent analysis and evaluation of utilization will be shared publicly with counties, providers and all stakeholders through postings on both departments' websites.

ANTICIPATED RESULTS

CDSS and DHCS decision-making, resources and activities are integrated consistent with the CPM.

Coordinated policy and program direction will provide clear and consistent guidance to program managers and stakeholders. Outcomes and accountability measures are aligned with the mental health needs of the Katie A. class members.

The JMS exists at the state and local levels with better integration of counties' decision-

making, resources and activities. The shared management structure has increased coordination, broadened perspectives, improved accountability and strengthening of existing relationships.

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

RESPONSIBLE PARTIES
CDSS, DHCS, Negotiation Workgroup, ACO Taskforce and CPM Fiscal Taskforce members

Appendix: A

Core Components: Tasks Accomplished

Task	Responsible Party	Date Accomplished
Developed Documentation Manual Table of Contents	Documentation Manual Subgroup	March 2012
Developed draft Documentation Manual chapters 1-4	DHCS Documentation Manual Writing Team	March – April 2012
Convened Documentation Manual technical assistance meetings to complete draft sections	DHCS Documentation Manual Writing Team	April – July 2012
Developed the Core Practice Model Guide Table of Contents	Core Practice Model Guide Subgroup	March 2012
Identified and analyzed how the child welfare and mental health systems operate and service availability for foster children for CPM Guide	Core Practice Model Guide Subgroup	May 2012
Identified and analyzed TFC resources and incorporated them into TFC resource matrix	TFC Subgroup	April 2012
Drafted TFC program description	TFC Subgroup	May 2012
Identified and commenced working with national TFC consultants to evaluate TFC models and to determine Medicaid coverage	State, Special Master and Plaintiff's Counsel Subgroup	June 2012

Service Delivery and Rollout: Tasks Accomplished

Task	Responsible Party	Date Accomplished
Draft Charters for Service Delivery Subgroup developed	Negotiation Workgroup, Core Components IPT	April 2012

Training and Support: Tasks Accomplished

Task	Responsible Party	Date Accomplished
Charter for Training and Support Subgroup developed	Negotiation Workgroup Core Components IPT	May 2012

Data and Quality Assurance: Tasks Accomplished

Task	Responsible Party	Date Accomplished
CDSS and DHCS engaged the Goldman School of Public Policy at UC Berkeley to conduct an assessment of existing data, accountability, and quality assurance efforts across both child welfare and mental health services at the State and County levels. The assessment focused on measures and processes currently being utilized and the extent to which they can be coordinated or combined to better identify the effectiveness of the Katie A. effort	Negotiation Workgroup CDSS and DHCS	May 2012

Developed a draft Accountability, Communication and Oversight (ACO) Charter and proposed ACO Mapping Group to inventory the current State and County level array of data, accountability and quality resources	Negotiation Workgroup	May 2012

Joint Management Structure: Tasks Accomplished

Task	Responsible Party	Date Accomplished
DHCS and CDSS filed a Joint Leadership Plan to the Court	CDSS and DHCS	March 2012
JMT and ACO Taskforce charters drafted	CDSS, DHCS and Negotiation Workgroup	March 2012
Members of the JMT identified	CDSS, DHCS and Negotiation Workgroup	March 2012
DHCS and CDSS held regular joint leadership meetings with their respective Directorates for briefings, policy decision making and issue resolution	CDSS and DHCS	Ongoing since January 2012

DHCS and CDSS held ongoing, regularly scheduled meetings to discuss status and planning of the Implementation Plan	CDSS and DHCS	Ongoing since January 2012
DHCS and CDSS representatives provide policy leadership and direction to the Negotiation Workgroup and Special Master	CDSS and DHCS	Ongoing since January 2012
DHCS and CDSS representatives continue to meet weekly to collaborate and coordinate efforts	CDSS and DHCS	Ongoing since January 2012
DHCS and CDSS representatives have started facilitating interagency commitment and collaboration between the state departments and at the county and subcontractor levels to implement the core practice model, intensive services and training, and accountability efforts	CDSS and DHCS	Ongoing since January 2012

APPENDIX: B

Intensive Home-Based Services

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

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

IHBS includes, but is not limited to:

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

IHBS are highly effective in preventing a child being removed from home (biological,

foster, or adoptive) through admission to an inpatient hospital, residential treatment facility or other residential treatment setting.

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

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

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

APPENDIX: C

Intensive Care Coordination

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

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

ICC service components consist of:

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

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

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

service activities:

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

Transition: ICC also includes:

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

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

Katie A Implementation Plan Timeline 8/24/12

	Activity/Milestone	Phase
1	OBJECTIVE 1: CORE COMPONENTS (CC)	1&2
2	⊟ Part A: Core Components Elements (CCE)	1&2
3	CCE/DM1 - Develop draft Documentation Manual (DM) table of contents	1
4	CCE/DM2 - Hold DM technical assistance meetings	1
5	CCE/DM3 - Develop draft DM sections & submit to DM Subgroup for review	1
6	CCE/DM4 - Revise draft per Subgroup's input	1
7	CCE/DM5 - Submit draft to CCIPT	1
8	CCE/DM6 - Submit initial draft to Negotiation Workgroup	1
9	CCE/DM7 - Post draft DM for 30-day public comment	1
10	CCE/DM8 - Submit final DM to Negotiation Workgroup for review & approval	1
11	CCE/DM9 - Distribute DM statewide	1
12	CCE/DM10 - Provide basic orientation & schedule webinars/trainings	1
13	CCE/CPM1 - Identify & analyze child welfare and mental health systems operations & service availability	1
14	CCE/CPM2 - Develop draft CPM Guide	1
15	CCE/CPM3 - Submit draft CPM Guide to CCIPT	1
16	CCE/CPM4 - Submit initial draft to Negotiation Workgroup	1
17	CCE/CPM5 - Post draft CPM Guide for 30-day public comment	1
18	CCE/CPM6 - Review feedback, revise & finalize CPM Guide	1
19	CCE/CPM7 - Submit final CPM Guide to Negotiation Team for review & approval	1
20	CCE/CPM8 - Distribute CPM Guide Statewide	2
21	CCE/CPM9 - Issue communications regarding CPM Guide	2
22	CCECPM10 - Release final CPM Guide	2
23	CCE/CPM11 - Release schedule for basic orientation & training on CPM Guide	2
24	CCE/TFC1 - Identify components of TFC & determine Medicaid Coverage	2

Start	Finish	2012				2013				2014			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
03/01/12	12/01/14												
03/01/12	03/01/12	DM Subgroup, DHCS & CDSS											
03/01/12	08/15/12	DM Subgroup, DHCS & CDSS											
03/01/12	07/16/12	DM Subgroup, DHCS & CDSS											
07/17/12	07/31/12	DM Subgroup, DHCS & CDSS											
09/17/12	09/30/12	DM Subgroup, DHCS & CDSS											
09/17/12	09/30/12	DM Subgroup, DHCS & CDSS											
09/30/12	10/31/12	DHCS & CDSS											
11/15/12	11/22/12	DM Subgroup, DHCS & CDSS											
11/30/12	11/30/12	DHCS & CDSS											
12/01/12	12/31/12	DHCS & CDSS											
03/01/12	03/01/12	CPM Guide Subgroup, CDSS & DHCS											
03/01/12	08/01/12	CPM Guide Subgroup, CDSS & DHCS											
09/01/12	09/28/12	DHCS & CDSS											
09/30/12	10/15/12	CCIPT											
10/30/12	11/30/12	CPM Guide Subgroup, CDSS & DHCS											
12/01/12	12/31/12	CPM Guide Subgroup, CDSS & DHCS											
12/31/12	01/15/13	DHCS & CDSS											
01/15/13	01/31/13	DM Subgroup, DHCS & CDSS											
01/15/13	01/31/13	DHCS & CDSS											
01/15/13	01/15/13	DHCS & CDSS											
01/15/13	01/31/13	DHCS & CDSS											
04/01/12	TBD	TFC Subgroup, DHCS & CDSS											

	Activity/Milestone	Phase
25	CCE/TFC2 - Work with TFC Consultants to identify risks & benefits & determine best model for implementation	2
26	CCE/TFC3 - Identify & initiate dialogue with national TFC consultants	2
27	CCE/TFC4 - Evaluation options for model & billing/claiming	2
28	CCE/TFC5 - Develop TFC information & materials for DM	2
29	CCETFC6 - Develop draft TFC Addendum & submit to TFC/DM Subgroups for review	2
30	CCE/TFC7 - Revise draft per Subgroups' input	2
31	CCE/TFC8 - Submit draft to CCIPT	2
32	CCE/TFC9 - Submit initial draft to Negotiation Workgroup	2
33	CCE/TFC10 - Post draft for 30-day public comment	2
34	CCE/TFC11 - Submit final DM to Negotiation Workgroup for review & approval	2
35	CCE/TFC12 - Integrate TFC Addendum into DM	2
36	CCE ALL1 - Issue communication & guidance//technical assistance on above, as needed	1&2
37	⊖ **Part B: Core Practice Model Adoption (CPM)**	2
38	CPM1 - Develop strategic plan	2
39	CPM2 - Consult with JMT to support CPM & support service integration	2
40	CPM4 - Once TFC model/coverage is determined, address in CPM Guide	2
41	CPM3 - Develop basic orientation and release strategies for CPM Guide	2
42	OBJECTIVE 2: FAMILY AND YOUTH INVOLVEMENT (FYI)	1&2
43	FYI1 - Join NW & receive orientation	1
44	FYI2 - Provide input on implementing Implementation Plan	1
45	FYI3 - Continue to provide input on implementing Implementation Plan	2
46	FYI4 - Work to incorporate peers at the state and county levels	2
47	OBJECTIVE 3: SERVICE DELIVERY & ROLLOUT (SDR)	1&2
48	SDR1 - Subgroup charter developed	1
49	SDR2 - Identify & select "Early Implementer" (EI) Counties	2
50	SDR3 - Finalize & disseminate a Readiness Assessment Tool to determine county readiness for implementing IHBS, ICC & TFC	1
51	SDR4 - Develop and issue communications for counties regarding IHBS and ICC	2

Start	Finish	2012				2013				2014			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
05/01/12	TBD		TFC Subgroup Advisors										
05/01/12	TBD		TFC Subgroup, DHCS & CDSS										
11/01/12	TBD					TFC Subgroup, DHCS & CDSS							
TBD	TBD												
TBD	TBD												
TBD	TBD												
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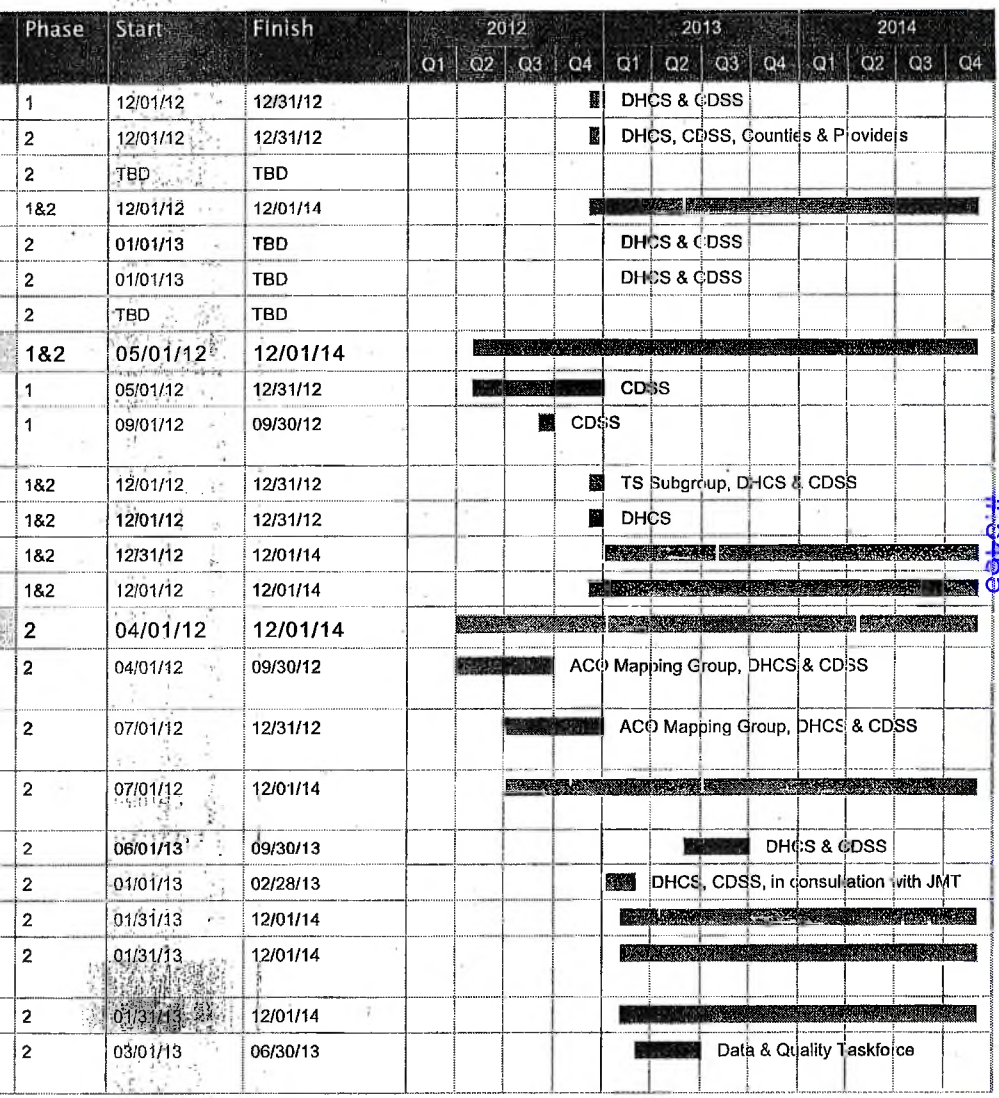
TBD	TBD												
TBD	TBD												
TBD	TBD												
01/01/13	01/31/13					DHCS & CDSS							
07/11/12	12/01/14												
07/11/12	12/31/12					Youth							
08/01/12	12/31/12					Family & Youth Peers							
01/01/13	12/01/14												
01/01/13	12/01/14												
07/01/12	12/01/14												
07/01/12	12/31/12					SD Subgroup, DHCS & CDSS							
01/01/13	TBD					SD Subgroup, DHCS & CDSS							
12/01/12	12/31/12					DHCS & CDSS							
12/01/12	12/31/12					ACO Mapping Group, DHCS & CDSS							

	Activity/Milestone
52	SDR5 - Determine IHBS and ICC billing codes
53	SDR6 - Implement IHBS and ICC Services
54	SDR7 - Implement TFC Services
55	SDR8 - Issue communication & guidance regarding service delivery & implementation
56	SDR9 - Provide consultation and guidance for counties
57	SDR10 - Continue to utilize feedback from EI Counties
58	SDR11 - Determine TFC billing code
59	OBJECTIVE 4: TRAINING & TECHNICAL ASSISTANCE (TTA)
60	TTA1 - Subgroup charter drafted
61	TTA2 - Request Statewide Training & Education Committee (STEC) to develop and coordinate statewide training
62	TTA3 - Develop educational materials for counties & providers & toolkit for Child & Family Teams
63	TTA4 - Instruct auditors to follow billing and documentation guidelines
64	TTA5 - Provide technical assistance, webinars & support DM & CPM Guide & policy guidance
65	TTA6 - Issue communication & guidance
66	OBJECTIVE 4: DATA & QUALITY ASSURANCE (DQA)
67	DQA/MAP1 - Engage Goldman School to conduct assessment of existing data, accountability & quality assurance efforts
68	DQA/MAP2 - Inventory current array of ongoing statewide quality efforts by CDSS, DMH & DHCS to determine existing data, accountability and quality resources available
69	DQA/MAP3 - Develop resource map to address client/case level and address agency/system level quality and accountability approaches
70	DQA/MAP4 - Post data on CDSS and DHCS websites
71	DQA/ACO1 - Establish an ACO Taskforce
72	DQA/ACO2 - Produce a report with recommended action and timelines
73	DQA/ACO3 - Establish a shared management structure to develop outcomes and accountability consistent with the CPM
74	DQA/ACO4 - Develop and endorse quality control systems to support the shared CPM
75	DQA/ACO5 - Develop a proposal to incorporate the production and posting of data including relevant information for the class



Phase	Start	Finish
1	12/01/12	12/31/12
2	12/01/12	12/31/12
2	TBD	TBD
1&2	12/01/12	12/01/14
2	01/01/13	TBD
2	01/01/13	TBD
2	TBD	TBD
1&2	05/01/12	12/01/14
1	05/01/12	12/31/12
1	09/01/12	09/30/12
1&2	12/01/12	12/31/12
1&2	12/01/12	12/31/12
1&2	12/31/12	12/01/14
1&2	12/01/12	12/01/14
2	04/01/12	12/01/14
2	04/01/12	09/30/12
2	07/01/12	12/31/12
2	07/01/12	12/01/14
2	06/01/13	09/30/13
2	01/01/13	02/28/13
2	01/31/13	12/01/14
2	01/31/13	12/01/14
2	01/31/13	12/01/14
2	03/01/13	06/30/13

	Activity/Milestone	Phase	Start	Finish	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
76	DQA ALL1 - Develop ACO Charter and establish ACO Mapping Group	2	01/01/13	03/31/13					DHCS & CDSS							
77	DQA ALL2 - Issue communication & guidance, as needed	2	01/31/13	12/01/14												
78	OBJECTIVE 5: JOINT MANAGEMENT STRUCTURE (JMS)	1&2	01/01/12	12/01/14												
79	JMS1 - Create charters and convene monthly Taskforce (Joint Management, Core Practice Fiscal & ACO) meetings	1	10/31/12	12/31/12					DHCS, CDSS, Negotiation Workgroup & GIS IPT							
80	JMS2 - Incorporate CPM through multi-agency collaboration	2	TBD	TBD												
81	JMS3 - Issue communication statements and guidance re JMS	2	TBD	TBD												
82	JMS4 - Analyze and evaluate utilization and timely access to care	2	TBD	TBD												
83	JMS5 - File a Joint Leadership Plan to the Court	2	03/01/12	12/01/14												
84	JMS6 - Hold regular joint leadership meetings with Directorates	2	03/01/12	12/01/14												
85	JMS7 - Hold ongoing joint leadership meetings to discuss status and planning of Implementation Plan	2	03/01/12	12/01/14												
86	JMS8 - Provide Policy leadership and direction to the Negotiation Workgroup and Special Master	2	01/01/12	12/01/14												
87	JMS9 - Consider taskforces' recommendations	2	03/01/13	12/01/14												
88	JMS10 - Design and develop models of management structures	2	10/31/12	03/31/13					DHCS & CDSS							
89	JMS11 - Design, develop & support a JMS for the state & local levels	2	02/15/13	12/01/14												
90	JMS12 - Issue communication & guidance	2	03/01/13	12/01/14												
91																

EXHIBIT 2

Exhibit 2: Katie A. Negotiation Workgroup Members

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

Children and Families, Sacramento.

- Adrienne Olson, LCSW, Division Chief, Child Welfare Mental Health Services, Bureau of the Medical Director, LA County Department of Children and Family Services.
- Greg Rose, Deputy Director, Children and Family Services Division, California Department of Social Services.
- Richard Saletta, Federal Court Special Master.
- Carmen Snuggs, Deputy Attorney General, Department of Justice, Office of the Attorney General.
- VACANT, Youth Representative.
- Suzanne Tavano Ph.D., Director, Contra Costa County Mental Health, Representing California Mental Health Director's Association.
- Cheryl Treadwell, Bureau Chief, Resource Development and Training Support, California Department of Social Services.
- Barbara Zweig, Senior Staff Counsel, Legal and Forensic Services, California Department of State Hospitals.

EXHIBIT 3

EXHIBIT 3

Core Practice Model Fiscal Task Force (CPM Fiscal TF)

Charter

Approved March 1, 2012

The purpose of the *Katie A.* Core Practice Model Fiscal Task Force (CPM Fiscal TF) is to develop a strategic plan using fiscal incentives and reduced administrative barriers to (1) accomplish statewide adoption of the *Katie A.* Core Practice Model (CPM),[1] (2) deliver intensive home and community based services to subclass members within the CPM framework, and (3) reduce the use of group homes and institutional placements.[2] The parties will incorporate the CPM Fiscal Task Force's plan or proposal into the Implementation Plan to the fullest extent practicable consistent with the time available.[3] The CPM Fiscal TF's specific objectives and guidance from the *Katie A.* Negotiations Work Group for achieving them are detailed below.

The CPM Fiscal TF will be guided by the Deputy Director for Children and Family Services from the California Department of Social Services and the Chief of the Waiver Analysis Branch from the Department of Health Care Services and co-chaired by their respective designees . Additional members may include representatives from county and state health, mental health and social services agencies, health care providers, parent and youth group representatives, and advocates.

The CPM Fiscal TF is expected to begin meeting on March 15, 2012, or as soon thereafter as possible. It is expected that the CPM Fiscal TF will hold monthly in-person meetings, although its members may meet more often, as needed. The CPM Fiscal TF's written

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[1] A complete description of the CPM is attached to the *Katie A.* Agreement as Appendix B.
[2] *Katie A.* Agreement ("Agreement") at paragraph 20(m).
[3] Agreement at paragraph 20(m)(3).

recommendations must be submitted to the parties by June 15, 2012.[4]

CPM Fiscal TF meetings will be organized and coordinated by the DSS and DHCS Co-Chairs, who will develop the agenda, secure the meeting location, prepare materials, and ensure minutes of the meetings are recorded and distributed to CPM Fiscal TF members with the assistance of the Special Master. The Co-chairs, or their designees, will be the CPM Fiscal TF liaisons to other *Katie A.* implementation groups. Members will not be compensated for participating in the CPM Fiscal TF. At the discretion of the Special Master, parent partners and/or youth representatives may be reimbursed for actual expenses incurred to attend in-person meetings.

The CPM Fiscal TF's purpose is to generate a broad and innovative strategy for inclusion by the parties into the *Katie A.* Implementation Plan. As such, the CPM Fiscal TF's strategy should be inclusive of its members' views. The CPM Fiscal TF's decision-making shall be by consensus, wherever possible.

In preparing its strategic plan, task force members should heed the decision-making guidelines adopted by the *Katie A.* Negotiation Work Group: To whit,"… that solutions must be aligned with the [parties' and stakeholders'] interests; assure [child and] family voice; be do-able; be within the law or reasonably achievable law; be sustainable; not let the perfect be the enemy of the good; address the need for accountability and quality; and maximize existing resources."[5]

Additionally, the CPM Fiscal TF will need to coordinate with other *Katie A.* implementation groups, in particular, that which is tasked with developing the Core Practice Model Guide.

Developing a Strategic Plan

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[4] Agreement at paragraph 20(m)(3).

[5] REPORT PURSUANT TO COURT'S ORDER APPOINTING SPECIAL MASTER APRIL 3, 2009, at pg. 4.

The gravamen of the CPM Fiscal TF's charge is to develop a strategic plan or report that describes options for funding or incentivizing the CPM and delivery of *Katie A.* services to the subclass pursuant to the CPM.

In developing the plan, CPM Fiscal TF should be mindful of the goals and specific deliverables, as well as the underlying values of the *Katie A.* Agreement. The Negotiation Work Group has identified several key values and goals to be considered in developing the strategy that include:

1. Replacing less-effective services, and/or better use of existing resources, is preferred to simply adding new services.

2. Using teaming, coordination, and collaboration within a System of Care will reduce service gaps, duplication and conflicts, increase efficiency, tap into informal services and supports; and expand multi-system resources.

3. Full implementation of the CPM is a core strategy as well as a key goal.

4. Effective incentives (e.g., predictable and reliable cash flow and other financial risk-reducing strategies, etc.) and reduced administrative barriers (e.g., audit policies, reporting and tracking documentation rules, etc.) are preferred to top-down mandates.

5. Federal financial participation should be maximized using other system resources - including Mental Health Services Act, TANF, IV-E and IV-B, SAMHSA, and local revenues.

6. Added costs are likely, as are collateral savings.

7. Implementation of the CPM should be coordinated with other initiatives and reforms such as congregate care reform, residential based services reform, California Partners for Permanency, etc.

8. Implementation will be staged to occur over 30 months.

Elements of the Strategic Plan

In addition to the foregoing guidance, the CPM Fiscal TF's strategic plan shall include

specific incentive proposals that:[6]

1. Evaluate[ ] ways to support counties to implement the IHBS and ICC for the sub-class of children, including improving cash flow to counties that serve youth pursuant to the CPM and improving eligibility reliability for providers and counties; and
2. Secure alternative resources for services or state/county EPSDT match.

Also, the CPM Fiscal TF's strategic plan shall include specific out-of-home placement reduction proposals that address:[7]

1. Using group homes primarily for short-term crisis stabilization;
2. Establishing pilot programs that demonstrate the effectiveness of alternatives to group homes for very high needs and/or very high-risk youth;
3. Developing funding models or resources that facilitate the transformation of existing group home beds to intensive home-based services;
4. Enabling transition services in the community to be provided to group home residents to facilitate discharge; and
5. Reconfiguring multi-agency mental health screening committees to provide for timely access to mental health services and supports consistent with the Core Practice Model and to reduce use of, or reliance on, out-of-home care.

The CPM Fiscal TF ends when it provides its final strategic report to the parties.

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[6] Agreement at paragraph 20(m)(2)(a).
[7] Agreement at paragraph 20(m)(2)(b).

EXHIBIT 4

EXHIBIT 4

Katie A Joint Management Taskforce (JMT)

CHARTER

Approved March 15, 2012

The purpose of the *Katie A.* Joint Management Task Force (JMT) is to develop recommendations for the establishment of a joint management structure between the California Department of Health Care Services (including the former Department of Mental Health) and California Department of Social Services[8] and to consult with the state agencies regarding development of practice tools, training curriculum, practice improvement protocols, and quality control systems.[9] These activities are key parts of the implementation of the *Katie A.* Agreement, including developing and supporting a Core Practice Model (CPM) for delivering child welfare and mental health services to children in and at risk of foster care placement.[10] The JMT's specific objectives and guidance from the *Katie A.* Work Group for achieving them are detailed below.

The JMT will be guided or co-chaired by the Deputy Director for Children and Family Services from the California Department of Social Services and the Chief of the Waiver Analysis Branch from the Department of Health Care Services. Additional members include representatives from county mental health and social services agencies, providers, parent or youth groups, and advocates.

The JMT is expected to begin meeting on March 15, 2012, or as soon thereafter as possible. It is expected that the JMT will hold monthly in-person meetings, although its members may meet more often, as needed. The JMT's written recommendations must be submitted to the Departments before September 2, 2012.[11] The Joint Management JMT's consultative role

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[8] *Katie A.* Agreement at paragraph 20(d). Hereinafter, "Agreement".
[9] Agreement at paragraph 20(e).
[10] A complete description of the CPM is attached to the *Katie A.* Agreement as Appendix B.
[11] Agreement at paragraph 20(d).

will be completed when the JMT, in consultation with the Special Master and the parties, determines that the JMT has fulfilled its responsibilities under the Agreement.

JMT meetings will be organized and coordinated by the DSS and DHCS Co-Chairs, who will develop the agenda, secure the meeting location, prepare materials, and ensure minutes of the meetings are recorded and distributed to JMT members. The Co-chairs, or their designees, will be the JMT liaisons to other *Katie A.* implementation groups. Members will not be compensated for participating in the JMT. At the discretion of the Special Master, parent partners and/or youth representatives may be reimbursed for actual expenses incurred to attend in-person meetings.

The JMT's purpose is to generate a broad and innovative array of recommendations and advice for consideration by the departments. As such, the JMT's report and consultations should be inclusive of its members' views. The JMT's decision-making shall be by consensus, wherever possible.

Creating a Joint Program Management System

The JMT's key responsibility is to help realize the goal of creating a joint program management system by considering and making a report on methods to achieve a joint management structure between the state Departments of Social Services and Health Care Services. The joint structure is intended to better integrate the Departments' decision-making, resources, and activities in order to deliver mental health care and social services to children in foster care, or at risk of placement in foster care, in a coordinated and collaborative manner consistent with the Core Practice Model (CPM.) The joint management system will be based on a shared vision and mission statement between DHCS and DSS, and will enable the departments to coordinate policy and program direction, provide clear and consistent guidance to program managers and stakeholders, develop outcomes and accountability measures, and perform other activities consistent with the CPM and the mental health needs of Katie A class members.

More specifically, the Task Force shall prepare a report that provides recommendations on the following:

(1) ***Sustainable means and methods to create a shared management structure for the state departments***

The Agreement calls for: Establishment of the shared management structure between CDMH and CDSS through legislation, and/or regulation, or other means to articulate a shared set of goals, vision and mission statements. Policies and procedures should be prepared and revised jointly as needed to ensure a shared practice is consistent and duplication is avoided, and provide a process for quickly resolving conflicts. Agreement at paragraph 20(d)(1).

(2)***Ways to better coordinate all child-serving agencies' efforts to serve foster youth with mental health needs***

The Agreement calls for: Building upon existing relationships with all state agencies that serve foster youth with mental health needs including the State Department of Education, the California Department of Drug and Alcohol, and the California Department of Correction and Rehabilitation to coordinate information and services in a manner consistent with the Core Practice Model. Existing venues for developing relationships already exist with State Interagency Team, Child Welfare Council, local blue ribbon commissions, etc. Agreement at paragraph 20(d)(2).

(3)***Systems that support equitable sharing of decision-making, resources, and responsibilities***

The Agreement calls for: Creating a cross-system process and procedures to support and manage the shared responsibility between CDMH and CDSS for delivering services to foster youth that is consistent with the Core Practice Model at the county/local level. Agreement at paragraph 20(d)(3).

(4) ***Relevant and effective joint management strategies for Counties that encourage mental health and social services practice consistent with the CPM***

The Agreement calls for: Developing and providing models for local agencies to consider in order to work more effectively together, including, for example,

integration of departments or services, specific coordination management models that oversee the departments, and/or Memoranda of Understandings (MOUs) for specific collaboration. Agreement at paragraph 20(d)(4).

(5)Strategic plan for data collection and sharing, quality control, and accountability

The Agreement calls for: an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, paragraph 19(c); clear and consistent guidance, and outcomes and accountability measures consistent with the Core Practice Model, paragraph 20(d); quality control systems to support the shared Core Practice Model, paragraph 20(e); and, data collection, matching, and sharing to support the Core Practice Model, paragraphs 20 (h) and (j).

In preparing the report and making any recommendations, members should heed the decision-making guidelines adopted by the *Katie A.* Work Group: To whit,"… that solutions must be aligned with the [parties' and stakeholders'] interests; assure [child and] family voice; be do-able; be within the law or reasonably achievable law; be sustainable; not let the perfect be the enemy of the good; address the need for accountability and quality; and maximize existing resources."[12]

Additionally, the JMT will need to coordinate with other *Katie A.* implementation groups, in particular, those that are tasked with developing the Documentation Manual, the Core Practice Model Guide, and quality control.

The JMT's written recommendations must be submitted to the Departments before September 2, 2012.

Consulting on the Development of Supportive Systems and Practices

Conforming children's mental health and social services practice with the CPM involves

[12] REPORT PURSUANT TO COURT'S ORDER APPOINTING SPECIAL MASTER APRIL 3, 2009, at pg. 4.

reforming or transforming many aspects of the systems, management, and mental health and child welfare practice used to care for and support foster youth and children at risk of foster care placement. Reflecting this challenge, as part of the *Katie A.* Agreement, the Departments of Social Services and Health Care Services (Departments) are tasked with developing certain supportive systems and tools. In turn, The JMT is charged with consulting with the departments on these efforts.

Specifically, the Departments will consult with the JMT on the Departments' obligation to "develop and endorse practice tools, training curriculum, practice improvement protocols, and quality control systems to support the shared Core Practice Model in order to support service integration and/or coordination for mental health services for class members."[13] The JMT's consultative role is grounded on its core purpose: to create a joint management system to deliver services to foster youth and youth at risk of foster care placement consistent with the Core Practice Model.[14]

In order to accomplish this charge, the JMT will need to coordinate with the Departments and other *Katie A.* implementation groups in order to identify matters or processes on which the JMT should be consulted. For each identified matter or process, the JMT should:

- Identify and coordinate with the appropriate liaison(s) to the JMT;
- Gather information and educate JMT members on the matter;
- Develop a response consistent with the JMT's charge;
- Communicate the response, formally or informally, as appropriate; and
- Memorialize the proceedings.

In determining whether it is appropriate or necessary for the Departments to consult with the JMT on a particular matter or process, it is preferable that the Departments err on the side of requesting input; but it is also appropriate for the JMT to decline to advise if doing so would be of nominal value in the view of the JMT. Additionally, it is appropriate for the JMT to initiate a consultative exchange in the event that the JMT believes that a matter or process would substantially benefit from the JMT's input.

In instances where the Departments are tasked with developing particular tools or systems that

[13] Agreement at paragraph 20(e).
[14] Agreement at paragraph 20(d).

involve *practice tools or practice improvement protocols, training curriculum, or quality control systems*, consultation is a priority under the Agreement. For example, in developing a cross system *training curriculum* under paragraph 20(f), the Departments must ensure that the JMT has the opportunity to provide input. Consultation is also prioritized under paragraphs 20 (h) and (j) to the extent these requirements raise *quality control systems* issues. Correspondingly, the JMT needs to proactively monitor and/or coordinate with the Departments in these priority areas in order to meet its consultative responsibilities under the Agreement.

The Joint Management JMT's consultative role will be completed when the JMT, in consultation with the Special Master and the parties, determines that the JMT has fulfilled its responsibilities under the Agreement.

EXHIBIT 5

EXHIBIT 5

Accountability, Communication, and Oversight (ACO) Charter
APPROVED – AUGUST 16, 2012

The Katie A. Settlement Agreement requires several activities related to data, accountability, quality assurance, oversight, and a Data Quality Taskforce. Beginning with Paragraph 19(c), the agreement calls for efforts to "support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight." Additional language calls for "clear and consistent guidance, and outcomes and accountability measures consistent with the Core Practice Model" (paragraph 20(d)), and "quality control systems to support the shared Core Practice Model" (20(e)). Subparagraphs 20 (h) and (j) further elaborate data, accountability, and quality activities, and are included at the end of this charter document.

Taken together, the data and quality assurance commitments within the Settlement Agreement call for a statewide data-informed system of oversight, accountability and communication[15] that (1) promotes the development and use of the Core Practice Model for all children served jointly by the child welfare and mental health systems;[16] (2) fosters delivery of effective, quality mental health services, including intensive mental health services to subclass members, within the Core Practice Model;[17] (3) efficiently monitors, measures, evaluates, and communicates access, quality, effectiveness, costs and outcomes at the individual services, program and system levels.[18]

The Settlement Agreement seeks to achieve these goals and outcomes, first by producing an implementation plan that includes specific steps, deliverables, and a timeline for implementation. As part of the implementation planning process, DHCS and DSS will establish a task force and produce a report with recommended actions and timelines. The Task Force shall be convened as necessary and structured as a subcommittee of the JMT or as a

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[15] ¶¶19(a), (b), (c); 20(d), (e), (h) and (j).
[16] ¶¶19(b), (c); 20(d), (d)(2), (d)(3), (e), (h) and (h)(4)(C).
[17] ¶¶ 19(a), (b), (c), (d); 20(d), (e), (h)(4), (h)(4)(C), (j)(1), (j)(2) and (j)(3).
[18] ¶¶ 19(c); 20(d), (e), (h), (h)(3), (h)(4), (j)(1), (j)(2), (j)(3) and (j)(4).

component part of the joint management structure. The Task Force's initial membership should include stakeholder participants recommended by the Negotiation Workgroup, and will include consultants who are specialists in system change, oversight, communication, and accountability. The task force and report are intended to provide concrete recommendations or action items needed to actualize the above goals and outcomes and meet the commitments made in the Settlement Agreement. The report and recommendations shall be amended and updated as needed in order to provide flexibility over time to address changed circumstances and institutional learning.

The above outcomes and goals statement envisions system transformation over time. These goals and outcomes are not expected to be fully achieved before the end of court jurisdiction. Therefore, the Task Force's recommendations and report shall reflect stages of implementation. Three stages shall be specifically addressed:

Stage 1 – Implementation planning

Stage 2 – Implementation during court oversight

Stage 3 - Post court jurisdiction

Specific tasks required of the Accountability, Communication and Oversight Taskforce are detailed in Settlement Agreement paragraphs 20(e), (d), (b) and (j), referenced below:

Paragraph 20:

(d) CDMH and CDSS will establish a shared management structure to develop a shared vision and mission statement, policy and program direction, clear and consistent guidance, and outcomes and accountability measures consistent with the Core Practice Model (Appendix "B").[19]

(e) CDSS and CDMH, in consultation with the joint management task force, will develop and endorse practice tools, training curriculum, practice improvement protocols, and quality control systems to support the shared Core Practice Model in order to support service integration and/or coordination for mental health services for class members;"[20]

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[19] Emphasis added.
[20] Emphasis added.

(h) Seeking to improve methods and adequacy of data collection, matching, and sharing to support the Core Practice Model at the state, county, and provider levels, CDSS and CDMH will develop a proposal to incorporate into the implementation plan to produce and post data including relevant claims information for the class. Proposed methods may include:

(1) Improving data exchange and matching among CDSS and CDMH and other state and local departments;

(2) Developing and disseminating a clear policy on information sharing/privacy issues between child welfare and mental health and other service partners;

(3) Using existing data collection and existing baseline and performance benchmarks to the greatest extent feasible;

(4) Determining what will be measured that reflects intended outcomes. Use the measured outcomes to evaluate progress on implementing the Core Practice Model and access to intensive home-based mental health services and intensive care coordination for mental health services. Relevant data may include:

A. Clinical status data, including assessments of symptoms, risks, functioning, strengths, and other information on how the class member is doing in his or her life;

B. Utilization data, including disposition information such as aftercare from hospitals and group homes, etc.

C. Treatment facility data that reflect what is happening within the episode of treatment. Monitoring the degree to which CFT and intensive home-based mental health services, and intensive care coordination for mental health services are provided and the extent to which they are provided within the Core Practice Model;

(j) DHCS, CDSS and CDMH will establish a Data and Quality Task Force and produce a report with recommended actions and timelines to:

(1) Establish a method to track the use of ICC and IHBS services arrays and TFC for subclass members.

(2) Utilize the External Quality Review and California Child and Family Services Review (C-CFSR) requirements to develop a plan for the collection of data and information about

children in the class who receive mental health services.

(3) Collect data elements in DHCS, CDSS and CDMH data systems specific to the class (and subclass) in order to evaluate utilization (patterns, type, frequency, intensity of services) and timely access to care.

(4) Facilitate a stakeholder meeting to solicit ideas from stakeholders and counties about what data concerning the class the departments should routinely produce and post. Establish a procedure and timeline to produce and post data that is useful to Counties, stakeholders and State departments in addressing the needs of children in the class.

(5) All reports and timelines will be posted on the CDMH and CDSS websites.

CERTIFICATE OF SERVICE

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

I hereby certify that on August 28, 2012, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

EXHIBITS 1 THROUGH 5 TO SPECIAL MASTER'S REPORT ON PROGRESS TOWARD COMPLETION OF THE KATIE A. IMPLEMENTATION PLAN

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

I further certify that some of the participants in the case are not registered CM/ECF users. On August 28, 2012, I have mailed the foregoing document by First-Class U.S. mail, postage prepaid, for delivery within three (3) calendar days to the following non-CM/ECF participants:

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

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

Gerald M. Custis, Esq.
Monterey County Counsel
Children's Services Division
201 Centre Plaza Drive, Suite 1
Monterey Park, CA 91754-2143

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on August 28, 2012, at Los Angeles, California.

M. Chacon
Declarant

/s/M. Chacon
Signature

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