APPENDIX A

Joint Management Task Force Charter
Accountability, Communications and Oversight Task Force Charter
Fiscal Task Force Charter

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[1] and to consult with the state agencies regarding development of practice tools, training curriculum, practice improvement protocols, and quality control systems.[2] 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.[3] 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.[4] 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.

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

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

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 CDS**S** 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."[5]

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.

<u>Consulting on the Development of Supportive Systems and Practices</u>

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

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

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."[6] 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.[7]

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 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.

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[6] Agreement at paragraph 20(e).

[7] Agreement at paragraph 20(d).

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[8] 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;[9] (2) fosters delivery of effective, quality mental health services, including intensive mental health services to subclass members, within the Core Practice Model;[10] (3) efficiently monitors, measures, evaluates, and communicates access, quality, effectiveness, costs and outcomes at the individual services, program and system levels.[11]

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 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.

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[8] ¶¶19(a), (b), (c); 20(d), (e), (h) and (j).
[9] ¶¶19(b), (c); 20(d), (d)(2), (d)(3), (e), (h) and (h)(4)(C).
[10] ¶¶ 19(a), (b), (c), (d); 20(d), (e), (h)(4), (h)(4)(C), (j)(1), (j)(2) and (j)(3).
[11] ¶¶ 19(c); 20(d), (e), (h), (h)(3), (h)(4), (j)(1), (j)(2), (j)(3) and (j)(4).

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), (h) 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").[12]

(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;"[13]

(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

[12] Emphasis added.
[13] Emphasis added.

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.

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),[14] (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.[15] 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.[16] 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 recommendations must be submitted to the parties by June 15, 2012.[17]

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.

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

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."[18]

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

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.

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

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:[19]

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:[20]

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.

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

APPENDIX B

Suggested Qualifications for Transformation Manager

TRANSFORMATION MANAGER

Suggested Qualifications

- Lived experience as a youth or biological or adoptive parent – or kin or other "forever" person in the parent role – who has been the primary caregiver of a child with emotional or behavioral challenges is a preferred qualification. To qualify as a person with lived experience foster parents would need to have had long term relationships with their youth

- Must have experience understanding and navigating the public Mental/Behavioral Health, Child Welfare systems.

- Must be willing to use their own experiences to share pertinent insights and solutions towards the Community Team process

- Must be able to engage and collaborate with people from diverse backgrounds, systems and perspectives.

- Must be able to maintain a non-judgmental attitude, be open about team members' concerns and not let the perfect hinder implementation of the project.

- Must have at least a Bachelor's degree or equivalent experience working in or with the child welfare and mental health systems.

- Must have excellent communication skills and experience as a facilitator.

- Experience in wraparound and/or systems of care is preferred but not required.

This is an adaptation of a template borrowed from the NWI.
http://www.nwi.pdx.edu/pdf/qualifications-for-family-partners.pdf

APPENDIX C

Katie A. et. al. v. Bonta et. al. Service Delivery Action Plan

Katie A. Joint Management Taskforce: Accountability and Oversight
Short-term, Mid-term & Long-term Goals (Draft)

EXHIBIT A: Katie A. et al. v. Diana Bontá et al. Service Delivery Action Plan

This document constitutes the State Defendants' Service Delivery Action Plan that is required by the *Katie A.* Court Order dated December 3, 2013 (Doc. 877), and is intended to be responsive to the Special Master's Amended Recommendation 1, filed as Exhibit A to the Special Master's Status Report, filed January 15, 2014 (Doc 878). In consultation with Plaintiffs' counsel, the State departments developed, and posted on their respective websites, this plan to address the actions the State will take to ensure that subclass members in the 56 Mental Health Plans (MHPs) will receive Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), when medically necessary. The components of this Service Delivery Action Plan are intended to function as an integrated whole and should not be read in isolation. This plan does not replace the State's Court Approved Implementation Plan (Doc Nos. 819-1 and 828-1), but rather supplements Phase II of the Implementation Plan, Section IV ("Service Delivery and Rollout"). In addition to the development of this Service Delivery Action Plan, other implementation activities are well underway. For example, 37 counties are currently providing services and submitting claims and another four counties have been providing services but have yet to submit claims. DHCS is on track to submit a State Plan Amendment (SPA) by March 31, 2014 to implement Therapeutic Foster Care (TFC) services once federally approved as a Medi-Cal service. Training and technical assistance efforts are ongoing. There will be a statewide conference held on June 4 – 6, 2014, entitled "Partnerships for Well-Being" that will focus on Katie A activities.

Reco #	Actions	Targeted Approach	Timeline
1.1	**Actions the State departments will take to further instruct counties to identify and count subclass members, provide them ICC, assess their needs for IHBS, and provide them with IHBS, when medically necessary.** Objective: Ensure consistent identification of potential subclass members.	The State will: A. Analyze Semi-Annual Progress Report estimates against state estimate of potential subclass size. B. Revise the Semi-Annual Progress Report template to clarify instructions for reporting the process of calculating projections of subclass members receiving ICC and IHBS. C. Provide as part of the instructions to the template and/or in policy directives such as All County Letters (ACLs) or Mental Health Services Division Information Notices (MHSD INs), a methodology for identifying potential subclass members that will be reported in the counties progress reports. Counties may use an alternative methodology but must describe their methodology in their reports and must demonstrate that its results are consistent with the State's results had the	(A) February 28, 2014 (completed) (B) March 14, 2014 (C) March 14, 2014

EXHIBIT A: Katie A. et al. v. Diana Bontá et al. Service Delivery Action Plan

Reco #	Actions	Targeted Approach	Timeline
		State's methodology been used. D. Revise the template to reflect the difference between the estimated total number of subclass members in the county and the projected total number of subclass members served at a given point in time. E. (a) Provide instructions to counties as to the State's expectations to provide ICC and IHBS to subclass members by: 1) Review what action steps and timelines the county has proposed in its progress report to provide ICC and IHBS to the subclass. Request from any counties who have not provided information on a specific time frame to do so and take follow-up action to ensure this occurs, with time frames, including corrective action steps or other mechanisms available to the Departments. 2) Determine if each county's action steps and timelines are appropriate for implementation. To the extent a county's action and timelines will not result in timely provision of ICC and IHBS as medically necessary, provide additional targeted technical assistance (TA) and require the county to address these concerns through quality assurance tools, corrective action or other mechanisms (e.g.,TA, site visits, PIPS (Performance Improvement Plans) and SIPS (System Improvement Plans) Taking into consideration local factors and needs.	(D) March 14, 2014 (E) Ongoing (E)(a)(1) June 1, 2014 and ongoing (E)(a)(2) June 1, 2014

EXHIBIT A: Katie A. et al. v. Diana Bontá et al. Service Delivery Action Plan

Reco #	Actions	Targeted Approach	Timeline
		(b) Remind the counties of their legal obligations (referencing ACL from Sept. 2013) and inform counties that that state will be taking actions to monitor rollout and provision of these services based on information in the progress reports and the state's own data or other information.	(E)(b) March 14, 2014
		F. Share any promising practices and materials created by counties regarding confidentiality, information sharing, and subclass identification processes.	(F) In progress and ongoing
		G. Identify any potential barriers occurring in the Learning Collaborative counties and disseminate processes counties have used to ameliorate this issue.	(G) August 20, 21014
		H. Post on each department's website the county semi-annual progress reports and State analysis summary.	(H) March 28, 2014 for October 2013 reports
		I. Host a Webinar to provide counties with guidance around the process for screening, referral, assessment and provision of ICC and IHBS and disseminate promising practices of counties currently implementing services.	(I) April 9, 2014
		J. Conduct regional trainings (36 are currently planned for Jan – June 2014) to provide instructions, guidance and best practices on the provision of ICC and IHBS within the Core Practice Model (CPM).	(J) In progress
		K. Update Frequently Asked Questions (FAQs) to include information on providing ICC and IHBS to subclass members.	(K) April 15, 2014

EXHIBIT A: Katie A. et al. v. Diana Bontá et al. Service Delivery Action Plan

Reco #	Actions	Targeted Approach	Timeline
		General L. Provide solution focused TA to better understand the specific barrier(s) counties are experiencing as necessary. M. Connect the counties that are experiencing challenges with a comparable peer county for solutions and/or to provide examples. N. Create a compendium of existing tools and resources for counties to utilize. O. California Social Work Education Center (CalSWEC), Regional Training Academies (RTAs), Resource Center for Family Focused Practice (RCFFP), California Institute of Mental Health (CiMH) and the Chadwick Center for Children and Families will provide regional and/or training and TA.	(L) In progress (M)Ongoing as needed (N) May 1, 2014 and ongoing (O) In progress
1.2	**Actions to transition subclass members who are currently receiving intensive mental health services through a Wraparound program or a Full Service Partnership Program that provides a child and family team, into ICC and IHBS.** Objective: Ensure consistency regarding the transition of services (such as Wraparound, FSP, and SMHS services) to ICC	The State will: A. Provide guidance to the counties as to how they are to appropriately provide and bill to ICC and IHBS services currently provided through Wraparound or Full Service Partnership programs which have the components and/or meet the requirements of ICC and IHBS within the CPM framework. B. Provide guidance to counties as to how to appropriately assess/re-assess subclass member children within the CPM framework who may be receiving "less intensive" mental health services through Wraparound, or Full Service Partnership programs, to ensure they receive ICC and IHBS within the CPM when	(A) April 30, 2014 (B) April 30, 2014

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Reco #	Actions	Targeted Approach	Timeline
	and IHBS within a CPM framework.	medically necessary and taking into account the family's and/or beneficiary's voice and choice. C. Provide additional guidance through conference calls, written instruction, FAQs and/or Webinars on Medi-Cal billing for providers and counties to assist in the transition of services to ICC and IHBS within the CPM framework from other Specialty Mental Health Services (SMHS) billing codes and from Wraparound or Full Service Partnership programs when appropriate to ensure that services are provided and claimed appropriately. This includes clarifying that all components of ICC and IHBS must be present in order to bill such services (for example, if a provider/county is providing IHBS in a Wraparound or Full Service Partnership Program but there is no Child and Family Team or team meetings, those services cannot be billed as ICC unless those components are added to the service). D. Disseminate information on best practices via Webinars, county letters, regional and/or individual county TA and through the Learning Collaborative efforts.	(C) In progress (D) June 1, 2014

EXHIBIT A: Katie A. et al. v. Diana Bontá et al. Service Delivery Action Plan

Reco #	Actions	Targeted Approach	Timeline
1.3	**Actions the State departments will take to review and determine the adequacy of the counties' semi-annual progress reports, including standards or criteria the departments will apply in evaluating the adequacy of counties' actions to identify and count sub-class members and provide them with ICC and with IHBS, as medically necessary.** Objective: Assist the counties in producing progress reports that accurately reflect the status of Katie A implementation including identification of subclass, projected need, and current capacity.	The State will: A. Establish a process to run data for a proxy class estimate and compare proxy class data to county estimates. Share discrepancies with counties if necessary. Contact counties on an individual basis to address inconsistencies, questions or concerns. Request follow-up actions by county as needed. B. Analyze counties' Semi-Annual Progress Reports with previously submitted reports, as well as the Service Delivery Plan and Readiness Assessment to determine the level of progress achieved towards implementation. Determine the adequacy of county efforts, including: i. Whether all of the questions in the reports and plans are adequately answered and requested data are provided. ii. Whether the county subclass estimate is within 25% of the state proxy estimate. iii. Whether the county has identified children/youth who have been screened by child welfare and are in the process of receiving a mental health assessment. iv. Whether the county has identified subclass members receiving ICC and/or IHBS.	(A) October 30, 2014 for October progress reports (B) June 13, 2014 and ongoing

Reco #	Actions	Targeted Approach	Timeline
		v. Whether the county has identified children who may/will need ICC/IHBS but are not receiving them (the "service gap"). If so, why? vi. Whether the county has a plan for increasing service capacity in the provider community sufficient to meet the known and potential demand for ICC and IHBS. vii. Whether the county child welfare and mental health agencies have a policy and practice regarding how to collaborate when serving subclass members. viii. If the county has a method for analyzing local data on service delivery. C. Determine if the counties action steps and timelines are appropriate for implementation. To the extent a county's action and timelines will not result in timely provision of ICC and IHBS as medically necessary, provide additional targeted TA and require the county address these concerns through quality assurance tools, corrective action or other mechanisms (e.g., TA, site visits, PIPS and SIPS) taking into consideration local factors and needs. D. Post semiannual progress reports within 60 days of receipt. E. Continue to share information regarding implementation activities with Plaintiffs' counsel and the Special Master.	(C) In progress and ongoing

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Reco #	Actions	Targeted Approach	Timeline
1.4	**Actions the State departments will take to ensure the data provided by the counties are accurate, consistent and reliable.** Objective: Strengthen counties' ability to collect and provide data.	The State will: A. Issue guidance as described in section 1.1 B-D. B. Identify and provide promising practices related to data and information sharing (including legal rationales) and make available to all counties (via the individual county TA process, webinars and/or All County Information Notices (ACINs)). C. Compare state produced proxy class estimate to county estimates of subclass and share discrepancies with counties. Contact counties on an individual basis to address any inconsistencies, questions or concerns that arise from data submitted by a county. Request follow-up actions by county as needed. D. Compare the number of subclass members reported by counties to be receiving ICC/IHBS with claims billed to the Short Doyle/Medi-Cal Phase 2 (SD2) claiming system. E. Match data (see reco 1.7) and verify with random samples from case reviews.	(A) March 14, 2014 (B) In progress (C) May 2014 and ongoing (D) Within 45 days of execution of the DHCS/CDSS data sharing agreement referenced in 1.5(B) (E) Within 30 days of completion of tool described in 1.7(F)

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Reco #	Actions	Targeted Approach	Timeline
1.5	**Actions the State departments will take to monitor the counties' progress in providing ICC and IHBS to subclass members, as medically necessary.** Objective: Evaluate county progress on service delivery through the use of quantitative data and qualitative processes.	The State will: A. Utilize the data obtained through the progress reports and follow the steps identified in 1.1. B. Upon execution of a Memorandum of Understanding (MOU) between the departments, use DHCS and DSS data matches to analyze needs and use of services, and Child Welfare Services (CWS) outcomes to assess progress. Analysis will be done by county, region. CWS outcomes analysis will consider age, ethnicity, placement type and service array. C. Use Performance Outcome Systems (POS) to identify clinical progress (when the functional assessments become available). D. Identify the number of Child Welfare and Mental Health staff trained and in training on the CPM. Special emphasis will be given to supervisors as they are critical to support transfer of learning. E. Utilize the External Quality Review Organization (EQRO) process to monitor and evaluate progress at the practice and system levels by incorporating Katie A. focused questions and discussions consistent with ACO and POS recommendations once completed, into the on-site interview process. Areas of focus include shared management, stakeholder process, child and family teams, identification of the subclass,	(A) Ongoing (B) October 31, 2014 and ongoing (D) October 31, 2014 (E) In progress and ongoing

Reco #	Actions	Targeted Approach	Timeline
		provision and claiming of ICC and IHBS, and CPM training. These areas are also tailored to each county based on where they are in implementation of services. The State will use this information to identify areas where additional or targeted follow-up is needed. F. Utilize the California Child and Family Services Review (C-CFSR) process and modify the case reviews to evaluate and monitor long term implementation of services and fidelity to the CPM. Counties will be encouraged to use the stakeholder process to examine the community and consumer perspectives of services to the subclass. G. Specific performance outcome and quality assurance measures will be developed by the Joint Management Task Force/ Accountability Communication and Oversight (JMT/ACO) in collaboration with the POS workgroup and used by the counties. H. The State will remind counties that all subclass members are required to receive ICC services. IHBS services should be provided to subclass members when medically necessary. In addition, subclass members should also receive other specialty mental health services as medically necessary. I. Continue to share information regarding implementation activities with Plaintiffs' counsel and the Special Master.	(F) In progress and ongoing. (G) In progress and ongoing (H) May 1, 2014

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Reco #	Actions	Targeted Approach	Timeline
1.6	**Actions the State departments will take to improve the performance of those counties that are not making sufficient progress in providing ICC and IHBS to subclass members, as medically necessary.** Objective: To clarify performance and progress expectations to support county success in the delivery of services.	The State will: A. Provide instructions to counties as to the State's expectations to provide ICC and IHBS to subclass members by: 1) Review what action steps and timelines the county has proposed in its progress report to provide ICC and IHBS to the subclass. Request from any counties who have not provided information on a specific time frame to do so and take follow-up action to ensure this occurs, with time frames, including corrective action steps or other mechanisms available to the Departments. 2) Determine if the counties action steps and timelines are appropriate for implementation. To the extent a county's action and timelines will not result in timely provision of ICC and IHBS as medically necessary, provide additional targeted technical assistance and require the county address these concerns through quality assurance tools, corrective action or other mechanisms (e.g., technical assistance, site visits, PIPS and SIPS) taking into consideration local factors and needs. 3) These processes will similarly be applied as needed to implement each section of this service delivery action plan. B. Remind counties via policy directives such as ACLs/MHSD Ins of their legal obligations (referencing ACL from Sept. 2013) and inform	(A) Ongoing as needed (B) May 1, 2014

Reco #	Actions	Targeted Approach	Timeline
		counties about the state's expectations and actions that the state will be taking to monitor rollout and provision of these services based on information in the progress reports and the state's own data or other information.	
		C. Using data from the SD2 claiming system, determine whether the 12 counties with the largest CWS/foster care caseload are likely to serve the number of children projected to receive services in the counties' semi-annual progress reports.	(C) June 1, 2014 and ongoing
		D. Use the departments' existing oversight practices and technical assistance process, prioritize assisting these counties in meeting their projected service delivery estimates. Activities may include, but are not limited to: on-site visits, trainings and teleconferences with various county child welfare and mental health staff and providers.	(D) June 1, 2014 and ongoing
		E. Continue to work with remaining counties to determine the level of support needed to adequately address challenges and barriers.	(E) June 1, 2014 and ongoing
		F. Utilize the Learning Collaborative work to identify and compile references or documents of successful strategies to share statewide.	(F) In progress and ongoing
		G. Develop FAQs and begin the process of updating the CPM and Medi-Cal documentation manuals as needed, to	(G) In progress

Reco #	Actions	Targeted Approach	Timeline
		provide additional guidance and assistance on areas requiring additional clarification. H. Identify county MOUs, policies and procedures, interagency agreements, etc. that have been established to guide collaboration, communication and sustainability particularly between child welfare and mental health agencies. Make these available to counties as part of the TA process. I. In order to assess the utility of ICC and IHBS, absent functional assessment data (which will be available upon the completion of the ACO and/or POS process), the State will rely on an analysis of traditional child welfare outcomes as a proxy for a wellbeing measure (e.g. one would expect to see subclass members stepped down from congregate care to family-based care; improved placement stability; reduced reentry post reunification; increased sibling placements). J. Consider employing other incentives including recommendations made by the CPM Fiscal Task Force, to increase access in low performing counties.	(H) In progress and ongoing (I) September 1, 2014
1.7	**Actions the State departments will take to complete development of outcomes and accountability measures and quality control systems consistent with the Core**	The State will: A. Develop and implement quality measures and processes as described in 1.5 B. Incorporate review by DHCS and CDSS of recommendations into the ACO/JMT recommendations process, and within no	Q3 2014 and Ongoing

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Reco #	Actions	Targeted Approach	Timeline
	Practice Model. Objective: Develop a permanent process to ensure continuous quality improvement in Katie A services.	later than 160 days but sooner if possible, establish action items to be completed consistent with the Settlement Agreement and Implementation Plan. C. Implement action items established in B above, as necessary to track the provision, quality and outcome of services provided to subclass members. D. Complete the work of the Accountability, Communications and Oversight (ACO) Task Force and implement recommendations as necessary to track the provision, quality and outcome of services provided to subclass members. E. Memorialize the state shared management structure and processes in a document between DHCS and CDSS. Make document available to local agencies for use as they deem appropriate for developing their own shared management structure. F. Conduct data matches from the CWS/CMS, SD2, and Pharmacy databases to analyze service utilization and the use of psychotropic medications in the subclass. These factors will be analyzed with respect to the aforementioned child welfare outcomes. i. Match children and youth in foster care with data regarding the utilization of all specialty MH services, ICC, and IHBS (and TFC when implemented) and psychotropic medication.	(E) Q4 2014 (F) Data matches and analysis will occur every 6 months starting 45 days after the execution of the DHCS/CDSS data sharing agreement referenced in 1.5(B)

Reco #	Actions	Targeted Approach	Timeline
		ii. Analyze MH services, mental health needs including diagnoses, psychotropic medication utilization by race, gender, type of placement, length of time in out of home care, and other traditional CWS outcome measures. iii. Analyze by county, region, and county size. iv. Match any other specific performance outcome measures as developed by the ACO and POS. G. Post county level descriptive statistics and update after each data match. H. DHCS will post monthly claiming reports using SD2 approved claims information to display client counts and service totals for the specialty mental health services provided to subclass members, including ICC, IHBS, and, once approved, TFC. **Enhance/Coordinate C-CFSR/EQRO processes** I. Revise the C-CFSR case review tool to identify and assess for CPM implementation and fidelity. Instruct counties who have failed to implement or who have considerable problems implementing the CPM to address in their System Improvement Plans as part of continuous quality improvement. J. Encourage MHPs to conduct a PIP to focus on Katie A implementation (assess capacity issues, CPM implementation and service utilization, and look at quality and outcome	(H) Beginning March 2014 (I) Revision of case review tool in progress, due October 2014 (J) As needed

Reco #	Actions	Targeted Approach	Timeline
		measures). K. Initially encourage counties, and later modify the C-CFSR guide, to focus on mental health services to youth in foster care (ICC, IHBS, TFC). Initiate discussions as guided by JMT recommendations about coordinating External Quality Review Organization (EQRO) and C-CFSR activities with an emphasis on specialty mental health services including ICC/IHBS for foster youth. Use qualitative techniques such as focus groups or surveys to assess whether consumers are aware of services and determine the quality of care. L. Leverage POS project by incorporating data elements related to Katie A.; specifically integrate the functional assessment information/data at the individual level into the data match process and methodology. M. Consider the following and identify the need for statutory and/ or regulatory changes: i. Implementing a Statewide PIP over a three-year period; ii. The EQRO site visit could include review of the Statewide PIP; iii. Allow CDSS to have the option to reduce other C-CFSR and SIP requirements for counties that may be duplicated in the mental health PIP or in county-adopted equivalent CFSR measures and activities; N. Convene an implementation advisory group or consider similar recommendations from	

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Reco #	Actions	Targeted Approach	Timeline
		the JMT.	

Katie A. Joint Management Taskforce: Accountability and Oversight
Short-term, Mid-term & Long-term Goals (Draft)

In the Accountability, Communications and Oversight (ACO) charter as well as the Katie A. Joint Management Taskforce (JMT) charter, it references the Katie A. Settlement Agreement and its commitment to develop a strategic plan for data collection and sharing, quality control and accountability. This plan should be a data-informed system of oversight that efficiently monitors, measures, evaluates, and communicates the quality, effectiveness and outcomes of the data.
There are targeted actions the State departments can do to support its commitment to provide accountability and oversight. These next steps can be broken down into short-term goals, mid-term goals and long-term goals or aspirations.

The following are actions identified as **short-term** goals. These can be accomplished in the immediate future by the State departments and on an ongoing basis.

1. To ensure the data provided by the counties is accurate, consistent and reliable:
    a. Compare the number of subclass members reported by counties to be receiving ICC/IHBS with claims billed to the SD/MC billing system.
    b. Match data and verify with random samples from case reviews.

2. To monitor the counties' progress in providing ICC and IHBS to subclass members, as medically necessary:
    a. Utilize the data obtained through the progress reports. Analyze estimates against state estimate of potential subclass size, provide instruction to counties as to the State's expectations, determine if each county's action steps and timelines are appropriate for implementation and provide additional targeted technical assistance if necessary.
    b. Utilize the External Quality Review Organization process to monitor and evaluate progress at the practice and system levels by incorporating Katie A. focused questions and discussions into the on-site interview process. Areas of focus include shared management, stakeholder process, child and family teams, identification of the subclass, provision and claiming of ICC and IHBS and CPM training. These areas are also tailored to each county based on where they are in implementation of services. The State will use this information to identify areas where additional or targeted follow-up is needed.
    c. Utilize the C-CFSR process and monitor the case reviews to evaluate long term implementation of services and fidelity to the CPM. Counties will be encouraged to use the stakeholder process to examine the community and consumer perspectives of services to the subclass.

3. To improve the performance of those counties that are not making sufficient progress in providing ICC and IHBS to subclass members, as medically necessary:
    a. Use the departments' existing oversight practices and technical assistance process to assist counties in meeting their projected service delivery estimates.

Activities may include, but are not limited to: on-site visits, trainings and teleconferences with various county child welfare and mental health staff and providers.

b. In order to assess the utility of ICC and IHBS, absent functional assessment data (which will be available upon the completion of the POS process), the State will rely on an analysis of traditional child welfare outcomes as a proxy for a wellbeing measure (e.g. one would expect to see subclass members stepped down from congregate care to family-based care; improved placement stability; reduced reentry post reunification; increased sibling placements).

4. To complete development of outcomes and accountability measures and quality control systems consistent with the Core Practice Model:

    a. Conduct date matches from the CWS/CMS, SD/MC II, and Pharmacy databases to analyze service utilization and the use of psychotropic medications in the subclass. These factors will be analyzed with respect to the aforementioned child welfare outcomes.
        i. Match children and youth in foster care with data regarding the utilization of all specialty MH services, ICC, and IHBS (and TFC when implemented) and psychotropic medication.
        ii. Analyze MH services, mental health needs including diagnosis, psychotropic medication utilization by race, gender, type of placement, length of in out of home care, and other traditional CWS outcome measures.
        iii. Analyze by county, region, and county size.
    b. Post county level descriptive statistics and update after each data match.
    c. Coordinate C-CFSR/EQRO processes:
        i. Revise the C-CFSR case review tool to identify and assess for CPM implementation and fidelity. Instruct counties who have failed to implement or who have considerable problems implementing the CPM to address in their System Improvement Plans as part of continuous quality improvement.
        ii. Encourage MHPs to conduct a PIP to focus on Katie A implementation (assess capacity issues, CPM implantation and service utilization).
        iii. Use qualitative techniques such as focus groups or surveys to assess whether consumers are aware of services and determine the quality of care.

The following are actions identified as **mid-term** goals. These can be accomplished in the next few years or the foreseeable future by the State departments.

1. Leverage the POS project by incorporating data elements related to Katie A.

2. Integrate the functional assessment information/data at the individual level into the data match process and methodology.

The following are actions identified as **long-term goals or aspirations**. These are goals to aspire to or will take time to implement. It is important to note that some systems and processes are subject to Federal requirements so what may be the ultimate goal may not be possible to fully integrate.

1. Integrate the Quality Assurance processes, C-CFSR and EQRO. Consider the following and identify the need for statutory and/or regulatory changes:
    a. Implementing a Statewide EQRO Performance Improvement Plan (EQRO PIP) over a three-year period.
    b. The EQRO site could include review of the Statewide PIP.
    c. Allow CDSS to have the option to reduce other C-CFSR and SIP requirements for counties that may be duplicated in the mental health PIP or in county-adopted equivalent CFSR measures and activities.

APPENDIX D

Core Practice Model Fiscal Task Force
Final Recommendations
October 2013

Core Practice Model Fiscal Task Force
Final Recommendations
October 2013

1. Statewide Adoption of the Core Practice Model

The Core Practice Model (CPM) Fiscal Task Force considered fiscal strategies that would support counties with implementing the CPM statewide. This section of the strategic plan contains recommended actions related to two strategies that support implementation of the CPM. The first strategy relates to training, coaching, and supervision. The plan includes recommended actions to finance the provision of training, coaching, and supervision that support line staff in delivering child welfare and mental health services to Katie A. class and subclass members within the CPM framework, and to support supervisors in sustaining implementation of the CPM. The second strategy relates to aligning child welfare and mental health program policy. The strategic plan includes recommended actions to better align child welfare and mental health program policy.

1.1. Financing Training, Coaching, and Supervision

County child welfare and mental health departments need to work with each other and the State to coordinate the consistent content of training and coaching to assist line staff, subcontractors, families, and other support persons acquire the skills needed to implement the CPM with fidelity. Training and coaching are also needed for supervisors to provide ongoing supervision necessary to sustain the CPM over time. Counties should consider the inclusion of stakeholders in such activities for the benefit of all parties involved in the CPM framework.

County child welfare and mental health departments may not have the resources needed to purchase the kind of focused and coordinated training and coaching that is needed for their line staff, subcontractors, families, and other support persons to acquire the skills necessary to implement the CPM and for supervisors to sustain implementation of the CPM. It is recognized that extensive initial and ongoing resources are needed for training, coaching, and supervision to ensure fidelity to the CPM. All parties involved in the CPM should be encouraged to review the resources that additionally may be available for these purposes. Providing services through the CPM also is expected to result in better outcomes for children and youth at a lower cost, which will free up resources that could be invested in the provision of ongoing training and supervision. The following recommended actions are intended to invest additional resources into training, coaching, and supervision of the CPM.

Recommendation 1.1.1 – The California Department of Social Services and Department of Health Care Services Should Work with the County Welfare Directors Association, California Mental Health Directors Association, and Other Stakeholders to Develop a Plan that Invests Existing Resources into the Provision of Coordinated and Aligned Training and Coaching that Assists Line Staff, Supervisors, Subcontractors, Family Members, and Other Support Persons with Acquiring the Skills Needed to Implement and Sustain the Core Practice Model Statewide

The California Department of Social Services (CDSS), Department of Health Care Services (DHCS), county child welfare departments, and county mental health departments have resources that may be used to finance the provision of training and/or coaching. A number of private foundations are interested in financing projects that align with the values, principles, and intended outcomes of the CPM. The challenge is to coordinate all of these resources to provide consistent training and coaching to county child welfare staff and supervisors, county mental health staff and supervisors, subcontractors, family members, and other support persons that are integral to implementing the CPM with fidelity.

The CPM Fiscal Task Force recommends that CDSS and DHCS work with the County Welfare Directors Association (CWDA), California Mental Health Directors Association (CMHDA), and other stakeholders to develop a plan that invests available federal, state, and county resources, including private foundation grants, into the provision of coordinated and aligned training and coaching for county child welfare and mental health line staff and supervisors, subcontractors, family members, and other support persons to acquire skills needed to implement and sustain the CPM. This plan should explore, but need not be limited by, the following resources:

The Department of Health Care Services' Training Contract with the California Institute for Mental Health (CIMH): The DHCS contracts with CIMH to provide training and technical assistance to county mental health departments. In the past, this contract funded a Wraparound community development team that provided training and coaching to assist five counties implement and administer a Wraparound program. The CIMH worked with experts from Vroon Vandenberg, LLP to provide coaching and experts from the University of Washington to monitor fidelity to the model. The CPM Fiscal Task Force recommends that DHCS explore opportunities to include integrated training and coaching of the CPM in its contract with CIMH.

The California Department of Social Services' Existing Contracts with the Regional Training Academies: The CDSS contracts with several universities to administer four regional training academies, which provide training and technical assistance to county child welfare departments. The CPM Fiscal Task Force recommends that CDSS work with the universities that administer these four regional training academies to explore opportunities

to include integrated training for county child welfare employees, county mental health employees, other service providers, and family members to implement the CPM.

The California Mental Health Services Authority (CalMHSA): CalMHSA is a Joint Powers Authority (JPA), whereby member counties act collectively as a single entity. Part of its mission is to provide member counties with a flexible, efficient, and effective administrative and fiscal structure focused on collaborative partnerships and pooling efforts in development and implementation of common strategies and programs. As a result, there may be opportunities for counties to develop projects that support joint training and coaching through the CalMHSA JPA. The CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to explore opportunities to partner with CalMHSA at a state, regional, or county level in order to develop shared approaches to training and coaching on the CPM.

Private Foundation Grants: Private foundations typically fund projects for a short time with the expectation the grantee will be able to sustain the project over the long-term. County child welfare and mental health departments need training and coaching to support the acquisition of knowledge and skills necessary to implement the CPM with fidelity. Once line staff and supervisors acquire the knowledge and skills to implement the CPM, the county should be able to sustain the project with savings. There are a number of private foundations interested in funding projects that are intended to improve outcomes for children in the child welfare system, which is the goal of the CPM. The Zellerbach Foundation, Casey Family Programs, and the California Wellness Foundation are some foundations that counties might approach.

While counties may not be able to use private foundation grants for the non-federal share of Title IV-E training costs, counties might partner with a training organization, such as CIMH or institutions of higher education, to seek private foundation grants that leverage existing funding that might come from other sources. The counties or state agencies might also contract with CIMH to leverage funding from private foundations or other sources to expand their capacity to provide training and coaching. The CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to issue a joint document advising county mental health and child welfare departments to explore private foundation grants in partnership with private and/or public training organizations to fund training and coaching of the CPM.

The California Child Welfare Co-Investment Partnership: The California Child Welfare Co-Investment Partnership is a collaborative group of state agencies – including CDSS and CWDA, foundations, and other non-profit organizations whose purpose is improving the lives of children and families in or are at risk of entering the State's child welfare system. One of the Partnership's co-investment activities is to connect child welfare and mental health services. This co-investment activity might be leveraged to invest in training

and coaching to implement the CPM. The CPM Fiscal Task Force recommends that CDSS and CWDA explore opportunities with the California Child Welfare Co-Investment Partnership to develop a project that encourages investment in integrated training and coaching to implement the CPM.

1.2. Align and Clarify Child Welfare and Mental Health Programs

Many service providers deliver both mental health and child welfare services to children in the child welfare system. These service providers often experience difficulty reconciling or integrating the multiple and, at times, competing or conflicting program expectations of county child welfare and mental health departments. Many providers deliver services under contracts with multiple county mental health departments. Some of these providers experience difficulty as a result of county mental health or child welfare departments using different interpretations of the same program policies. Aligning and clarifying programs among, as well as across, county mental health and child welfare departments, is expected to incentivize providers to deliver integrated child welfare and mental health services that are consistent with the CPM. This section of the strategic plan contains recommendations that are intended to better align and clarify child welfare and mental health programs and procedures to encourage full adoption and implementation of the CPM by service providers.

Recommendation 1.2.1 – The Department of Health Care Services Should Publish a Comprehensive EPSDT Documentation Manual Similar to the Documentation Manual prepared by the California Institute for Mental Health

Providers of mental health services should have clear and consistent rules related to Medi-Cal billing and documentation. This would help minimize confusion for providers that contract with multiple counties to provide mental health services to Medi-Cal beneficiaries, and also for families and youth who interact with more than one county.

The CPM Fiscal Task Force recommends that the State publish a comprehensive manual that builds on the ICC & IHBS Manual and the CPM Guide, and which addresses services, activities and appropriate documentation, as they are defined in state plans, for which federal reimbursement may be available to a county mental health department. Specifically, this documentation and billing manual should provide clear guidance regarding what is and is not an allowable specialty mental health service. The CPM Fiscal Task Force recommends that this documentation manual be similar in scope to the documentation manual previously prepared by CIMH, and be written for use by quality assurance coordinators, line staff and supervisors who deliver mental health services to children and families. Doing so would assist efforts to achieve consistent interpretation of rules statewide, and help avoid unnecessary negative impacts to service delivery. As part of this recommendation, the CPM Fiscal Task Force further recommends that, to the extent feasible, efforts be made to align the goals, objectives, and terms and conditions

that are included in provider contracts. Furthermore, counties should be encouraged to identify and document any procedures or policies that vary from the state and federal guidance in this new comprehensive manual.

Recommendation 1.2.2 – The Department of Health Care Services and California Department of Social Services Should Prepare Clear Written Guidance for Counties and Providers Regarding Proper Cost Allocation

County programs and contract providers that render both child welfare and specialty mental health services are uniquely situated to integrate the planning and delivery of those services through the CPM. Appropriately allocating costs to child welfare and specialty mental health programs is critical to avoid potential audit exceptions. Clear guidance from the State regarding proper cost allocation will assist counties and providers to avoid errors and potential audit exceptions. The CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to prepare clear written guidance for counties and providers regarding proper cost allocation between child welfare and mental health programs.

2. Reducing Group Home and Other Institutional Placements

The CPM Fiscal Task Force explored methods and options for reducing reliance on group homes and other institutional placements. This section of the proposal contains the CPM Fiscal Task Force's recommendations for reducing group home and other institutional placements. The section is organized into four methods and options, which are (a) shortening the length of stay in group homes and other institutional placements using crisis stabilization and short-term treatment services, (b) pilot programs that demonstrate the effectiveness of alternatives to group homes for high needs and/or high-risk youth, (c) ensuring the availability of community-based services that support successful transition from higher levels of care, and (d) reconfiguring multi-agency screening committees both to provide timely access to mental health services and supports and to reduce the use of or reliance on group home care. Although not included here, the cover letter transmitting these recommendations notes other efforts underway in this area, as well.

2.1. Shortening the Length of Stay in Group Homes Using Crisis Stabilization and Short-Term Treatment Services

Knowledge gained from previously implemented pilot programs in California, as well as national research in the field of child welfare, indicate that long-term group home placements are not in the best interests of children and youth, and do not effectively meet their mental health needs. County child welfare departments may be better supported to meet the needs of children and youth in the child welfare system if group home placements are available for short-term treatment and/or crisis stabilization.

The CPM Fiscal Task Force fully recognizes that this model may pose a financial challenge for group home providers due to increased risks of vacancies, as well as a need to reconfigure regulations and payment structures for group home providers. Current rules do not enable a group home provider to bill while a bed is not occupied. Therefore, fiscal models need to be developed that support availability on an as-needed basis. Regulations and payment structures for group home providers may need to be re-configured in a manner that results in short-term treatment and/or crisis stabilization beds being available when needed and might be based upon the model used in other 24-hour licensed crisis residential treatment facilities.

Recommendation 2.1.1 – The California Department of Social Services Should Consider Updating Current Regulations and Payment Structures for Group Home Providers in a Manner that Results in Short-Term Treatment and/or Crisis Residential Beds Being Available When Needed

The current AFDC-FC group home rate-setting system might be reconfigured to better support the provision of short-term treatment and/or crisis residential services to children and youth in the child welfare system. The current rate-setting system was developed in the late 1980s when the average length of stay in a residential facility was 24 months or longer. The rates were developed based upon the premise that, on average, 90 percent of the beds in these programs would be occupied. The average length of stay in a group home that provides short-term residential treatment or crisis stabilization services is expected to be much less than 24 months, with far higher rates of resident turnover, and a significantly higher risk of vacancies. A new rate-setting system and other regulatory modifications might better support the provision of short-term residential treatment and/or crisis residential services for children and youth in the child welfare system.

Recommendation 2.1.2 – The California Department of Social Services and California Department of Health Care Services, with Input from Stakeholders, Should Explore Opportunities to Build Upon the Knowledge Gained from Prior Efforts to Shorten the Length of Stay in Group Homes and Other Institutional Placements

Alternative approaches to reduce the length of stay or eliminate placements in group homes have been piloted in California over the past 15 to 20 years. These efforts include, but are not limited to, California Wraparound (Senate Bill 163, Chapter 795, Statutes of 1997) and Residentially Based Services (Assembly Bill 1453, Chapter 466, Statutes of 2007). Both of these efforts increased flexibility to participating counties related to foster care funding and rates, with the requirement that the program not increase state General Fund costs. The California Wraparound program has been implemented in 47 counties and is no longer considered a pilot. The program has demonstrated significant improvements in outcomes and financial savings. The alternative model implemented through AB 1453 is currently being evaluated.

The CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to explore opportunities to build upon the knowledge gained from prior efforts to reduce the length of stay in group homes.

2.2. Pilot Programs that Demonstrate Effective Alternatives to Group Homes

A number of alternatives to group home care have been tested and shown to be effective in California and nationally. Based upon this experience, the CPM Fiscal Task Force believes that CDSS and DHCS already understand what is needed to implement effective alternatives to group home care, and does not believe it is necessary to establish pilot programs to demonstrate this further. While the CPM Fiscal Task Force has not developed any recommendations in this subsection, it should be noted that counties might need assistance in bringing known best practices to scale across the State.

2.3. Enabling Services That Support Successful Transitions to Permanency

Providing mental health services to children, youth, and their families to facilitate a more rapid transition into the community is critical to ensuring permanency. When a child is adjudicated a dependent and is placed out of home, that child is eligible for Medi-Cal. While enrolled in Medi-Cal, the child or youth is entitled to medically-necessary specialty mental health services. Sometimes, a child loses Medi-Cal eligibility when he or she returns to his or her family. At that time, the child or youth may lose access to the kind of medically-necessary services that are needed to ensure a successful transition home. Alternative funding or continuance of Medi-Cal eligibility is needed to continue to provide mental health services to that child. Implementation of the Patient Protection and Affordable Care Act (ACA) is expected to expand access to mental health services for children and youth and positively impact this issue in the future.

Recommendation 2.3.1 – The Department of Health Care Services Should Work with County Child Welfare and Mental Health Departments to Produce an Information Notice that Encourages Counties to Invest Mental Health Services Act or 1991 Realignment Funds into Transition Programs Designed to Increase Placement Stability

Counties receive funding from the Mental Health Services (MHS) Fund and 1991 Realignment to provide services to individuals who meet the target population criteria found in California Welfare and Institutions Code (W&IC), Section 5600.3.[1] As long as a child meets the target population criteria in W&IC, Section 5600.3, counties may use funding from the MHS Fund or 1991 realignment to provide needed mental health services to assist that child to remain at home.

[1] The majority of funding distributed from the Mental Health Services Fund is intended to provide mental health services to children, youth, adults, and older adults who meet the target population in W&IC Section 5600.3. A smaller percentage of the funds (e.g., funds for prevention and early intervention programs) are not limited to services provided to the target population.

Counties may establish programs that are intended to increase the rates of stable situations. If continued mental health services provided to individuals who are no longer involved in the child welfare system is part of a strategy to increase stable situations, county mental health departments might invest in those services. The CPM Fiscal Task Force recommends that DHCS work with counties to produce an information notice that outlines the benefits of transition services and encourages county mental health departments to invest available 1991 Realignment and MHSA funds into the provision of those types of services.

Recommendation 2.3.2 – The California Department of Social Services and Department of Health Care Services, with Input from Stakeholders, Should Explore Opportunities Under the Affordable Care Act to Increase Access to Mental Health Services to Increase Placement Stability

In addition to expanding enrollment in health insurance and expanding access to mental health services, the ACA includes other opportunities that might improve care provided to children in the child welfare system, and thereby increase the number of permanent placements. For example, there are a number of provisions within the ACA that may support implementation of a Medical Home Model. The CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to explore opportunities under the ACA to increase access to mental health services to increase permanency for children and youth leaving the child welfare system.

2.4. Reconfiguring Interagency Placement Committees

Interagency Placement Committees (IPCs) are established in W&IC, Section 4096. Each county IPC is required to establish a procedure to assess children and youth who are to be placed in a group home with Rate Classification Level (RCL) 13 or 14 to determine whether or not they have a serious emotional disturbance, as defined in W&IC Section 5600.3, and need the level of care provided in RCL 13 or 14 group homes. W&IC Section 11462.01 requires RCL 13 or 14 group home providers to agree not to accept children and youth for placement unless the IPC has approved the placement as described in Section 4096. Some counties also use their IPCs to manage out of home placements for youth with lower level needs.

The IPC process should not limit access to appropriate mental health services because of the availability of resources rather than the child or youth's needs. This part of the proposal includes recommendations intended to help resolve this concern. Access to appropriate mental health services should be consistent with a county mental health department's obligation to provide all medically-necessary mental health services to children and youth enrolled in the Medi-Cal program.

Recommendation 2.4.1 – The California Department of Social Services and the Department of Health Care Services, with Input from Stakeholders, Should Explore the Role and Continued Viability of Interagency Placement Committees and Propose Any Necessary Statutory Amendments to Clarify Their Role

The CPM Fiscal Task Force believes that decisions regarding the placement of a child should be made by a child and family team and within the framework of the CPM. The child and family team includes individuals who are invested in and responsible for the child's and family's well-being. The CPM Fiscal Task Force believes these are the people who should make decisions regarding a child's placement.

An IPC should not supersede decisions about placement made by a properly constituted child and family team acting in compliance with the CPM. While decisions made by the child and family team are expected to be based upon the goals and needs of the child and family, decisions made by the IPC may instead be driven by available resources.

The CPM Fiscal Task Force believes that access to needed out of home care should be based upon need rather than available resources. The role and continued use of IPCs should be reviewed and updated to ensure access to out-of-home care is not based upon the availability of resources. Therefore, the CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to explore the role and continued viability of IPCs, and to propose any necessary statutory amendments to clarify their role.

3. Resources to Provide Additional Services

This section of the proposal contains recommendations intended to assist counties with identifying resources to provide additional mental health and other non-traditional[2] services to children and youth in the child welfare system. One component discusses strategies to reinvest cost savings realized from reduced group home placements into mental health services. A second component discusses strategies to maximize federal financial participation (FFP) in the delivery of child welfare and mental health services. The third component recommends existing funding sources that might be used to provide non-traditional services.

3.1. Reinvesting Savings into Child Welfare and Mental Health Services

As counties experience savings from reduced group home placements and improved child well-being, they may want to reinvest those savings into programs and services that benefit children in the child welfare system who need mental health treatment. This

[2] Non-traditional services refer to those services that are not typically eligible for federal reimbursement. For example, in the California Wraparound program, these kinds of services might have been paid for with what is referred to as flexible funds.

section includes recommendations intended to assist county child welfare and mental health departments with reinvesting cost savings into programs and services that benefit children and youth in the child welfare system who need community support and mental health treatment.

Recommendation 3.1.1 – The California Department of Social Services and the Department of Health Care Services Should Explore with Stakeholders Opportunities for County Child Welfare and Mental Health Departments to Share Resources in Providing Care to Children and Youth in the Child Welfare System Who Need Mental Health Treatment

Some county child welfare and mental health departments have jointly implemented programs that serve children in the child welfare system who need mental health treatment that resulted in reductions in group home placements and improvements in child well-being. As the number of placements and/or average lengths of stay declined and child well-being improved, counties may have realized cost savings. These cost savings may have been reinvested into jointly administered programs that serve children in the child welfare system who need mental health treatment.

The CDSS and DHCS, in consultation with stakeholders, should explore how counties realized cost savings from these jointly administered programs, how those cost savings were reinvested, and identify any barriers that county child welfare and mental health departments experience when attempting to share resources. The CPM Fiscal Task Force further recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to explore opportunities to reduce such barriers to reinvesting savings into jointly administered programs. Title IV-E waivers may provide opportunities for participating counties to reinvest cost savings, as well.

Recommendation 3.1.2 – The California Department of Social Services and California Department of Health Care Services Should Explore with Stakeholders Jointly Publishing a Document that Describes how County Child Welfare and Mental Health Departments May Negotiate Agreements to Share the Fiscal Risks and Benefits Associated with Group Home Placements

As a tool for facilitating expansion of mental health services for children at risk of placement in group homes or for children who could be transitioned out of group homes, county child welfare and mental health departments may pursue arrangements that share in the financial risks and benefits of strategies designed to reduce the use of group homes and improve child well-being. These arrangements recognize the joint responsibility of county child welfare and mental health departments for a child's permanent placement and well-being. Counties may pursue strategies to mitigate risks and share in the benefits to build partnerships between county child welfare and mental health departments.

For example, county child welfare departments might reinvest known savings from reduced out of home care into expanded mental health or other services that are designed to prevent out-of-home care, including group home placements. This is an example of sharing in the benefits of reduced out of home care. County child welfare departments might invest anticipated savings into expanded mental health or other services that are designed to prevent out-of-home care, including group home placements, and the mental health department might agree to share in the financial risk associated with such an arrangement. A Title IV-E waiver may provide new opportunities for these kinds of arrangements, which could be formalized in a memorandum of understanding between the two departments. The CPM Fiscal Task Force recommends that CDSS and DHCS work with CWDA, CMHDA and other stakeholders to explore publishing a document that describes how counties may negotiate agreements to share fiscal risks and benefits associated with group home placements.

Recommendation 3.1.3 – The California Department of Social Services and Department of Health Care Services Should Work with County Child Welfare and Mental Health Departments to Determine how the Core Practice Model will Impact Workload for Child Welfare Workers and Mental Health Clinicians

The CPM will likely result in individual child welfare workers and mental health clinicians screening, assessing, and working jointly together to serve more children, youth, and families than they did prior to implementation of the CPM. As a result, county child welfare and mental health departments will need to increase the overall number of child welfare workers and mental health clinicians, or increase the workload for some of the workforce. These changes may place additional demands on limited county resources.

At the same time, the CPM is expected to generate cost savings by providing services that are more effective. Children and youth are expected to spend less time in out-of-home care and experience improved well-being. Some of the resulting cost savings may be used to support the kind of training and coaching that is needed to sustain the practice model and lower caseloads. However, actual impacts have not been studied. The CPM Fiscal Task Force recommends that CDSS and DHCS work with county child welfare and mental health departments to determine how the CPM will impact the workload of child welfare workers and mental health clinicians.

3.2. Maximizing Federal Financial Participation

County child welfare and mental health departments receive FFP for the cost of providing out-of-home care and specialty mental health services respectively. This section contains recommendations that may assist counties with accessing additional FFP to support the services provided to children and youth in the child welfare system who need mental health treatment.

Recommendation 3.2.1. – The Department of Health Care Services Should Seek Additional Resources to Provide Training and Technical Assistance to County Mental Health Departments to Assist with Proper Documentation and Claiming for Medi-Cal Specialty Mental Health Services

Specialty mental health services are defined in Title 9 of the California Code of Regulations. To be eligible for reimbursement, a service must meet a number of criteria. One of those criteria is proper chart documentation. The DHCS conducts chart audits and disallows claims when a service is not properly documented. With added clinical resources and in consultation with CMHDA, DHCS may be able to provide additional training and technical assistance regarding proper documentation to county mental health departments. The CPM Fiscal Task Force recommends that DHCS seek additional resources in order to provide training and technical assistance to counties regarding proper documentation and claiming for Medi-Cal specialty mental health services. To the extent practicable, such training and related materials should be made available to service providers, as well.

Recommendation 3.2.2. – The California Department of Health Care Services Should Work with the California Mental Health Directors Association to Improve the Provider Enrollment Process

In order to claim reimbursement for the cost of eligible services provided to eligible beneficiaries, a provider must be certified to render Medi-Cal services. Counties are responsible for certifying the majority of their contracted providers. Once a county has certified a contract provider, other counties may submit appropriate paperwork to DHCS to utilize the same provider without needing to certify the provider themselves. The CPM Fiscal Task Force recommends that DHCS work with CMHDA to improve this process.

3.3. Funding Sources for the Non-Federal Share of Title XIX Services and Non-Traditional Services

This section of the proposal catalogues additional sources of funds that may be used as the non-federal share for FFP, as well as to provide non-traditional services.

Recommendation 3.3.1 – The California Department of Social Services and the Department of Health Care Services Should Work with Stakeholders to Prepare for Local Government Agencies and Organizations a Catalogue of Funding Sources Which May be Used to Finance the Non-Federal Share of Title XIX Services, as Well as Non-Traditional Mental Health Services

The State distributes a variety of funds to local government agencies and organizations that may be used to finance the non-federal share of Medi-Cal specialty mental health services and/or to provide non-traditional services. These funding sources include, but are not limited to the following:

- Local Health and Welfare Trust Fund – Social Services Account
- Local Health and Welfare Trust Fund – Mental Health Account
- Local Mental Health Services Fund
- Federal Mental Health Block Grant funds
- School Funding for Educationally Related Mental Health Services

The CPM Fiscal Task Force recommends that CDSS and DHCS work with stakeholders to prepare jointly a catalogue of resources that may be utilized to finance delivery of Medi-Cal specialty mental health services and other non-traditional services, and distribute the catalogue to local government agencies and organizations.

Recommendation 3.3.2 – The California Department of Social Services and the Department of Health Care Services Should Continually Collaborate with County Child Welfare and Mental Health Departments to Seek Federal Grants or Waivers and Foundation Grants that Would Support Implementation of the Core Practice Model

The federal government and foundations offer grants that the State and counties might use to support efforts to implement the CPM. The CPM Fiscal Task Force recommends that CDSS, DHCS, CWDA, CMHDA and other stakeholders continually collaborate to seek federal grants and waivers and foundation grants that support implementation of the CPM.