

**EXHIBIT 2**

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

**INTRODUCTION**

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

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

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

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

1  
2 Family and youth voice contributes a unique and valuable perspective and is most effective when  
3 used to balance decisions as they are made on a system and practice level. Therefore, as an integral  
4 part of implementation of this plan at all levels, the family and youth voice has been incorporated  
5 into each section of the Implementation Plan. Consequently, each section reflects the objective of  
6 including family and youth voice and experience, which models the teaming of systems, practice  
7 and family.  
8

9 This plan is intended to be a living document that guides the parties forward towards successful  
10 implementation of the Settlement Agreement. There are elements of the plan and Settlement  
11 Agreement that require additional work product by certain taskforces and advisory groups. The  
12 parties will continue to work together, with the assistance of the Special Master, to integrate  
13 additional recommendations and contributions by these groups consistent with the Settlement  
14 Agreement to guide and inform implementation.  
15

16 The parties appreciate the assistance and guidance of the Negotiation Workgroup in the  
17 development of the Katie A. Implementation Plan. Following the submission of the complete  
18 Implementation Plan to the Court in December of 2012, the Negotiation Workgroup will convene  
19 no less frequently than once every quarter for the remainder of the jurisdictional period to provide  
20 further direction and guidance, as necessary, to the Implementation Plan activities.  
21

22 The California Department of Health Care Services (DHCS) and the California Department of  
23 Social Services (CDSS) recognize the importance of maintaining transparency and open  
24 communication throughout the process of implementation and beyond. The dissemination of  
25 information to County Mental Health Plans (MHPs) and County Social Services (CSS) Directors  
26 will continue to be a priority for both departments and will include, but is not limited to: program  
27 instructions, the release of data and website postings, All County Letters (ACLs) and All County  
28 Information Notices (ACINs).  
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30

## 31 **THE PATHWAYS TO MENTAL HEALTH SERVICES OBJECTIVES**

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### 34 **SECTION I. SHARED MANAGEMENT STRUCTURE (SMS)**

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37 A shared management structure, at both the state and county levels, is important for the integration  
38 of essential elements of the settlement into current practice and to the long term sustainability and  
39 evolution of these practice changes. DHCS and CDSS will establish a shared management structure  
40 consistent with the CPM and develop a shared vision and mission statement, policy and program  
41 direction, clear and consistent guidance, and outcomes and accountability measures.  
42

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

1 the work of the Joint Management Taskforce (JMT), Accountability, Communications and  
2 Oversight (ACO) and CPM Fiscal taskforces to ensure that service delivery is supported and  
3 improved over time by governance, quality/accountability, and fiscal systems and structures that are  
4 consistent with the CPM values, goals and services.  
5  
6

7 OBJECTIVES  
8

- 9 1. To create cross-system processes and procedures to support and manage the  
10 shared responsibility between DHCS and CDSS for engaging and delivering  
11 services to children with an open child welfare case that is consistent with the CPM  
12 at the county/local level.  
13  
14 2. To develop and provide models for local agencies to consider in order working more  
15 effectively together consistent with the CPM and that involves families and youth in  
16 decision-making.  
17  
18 3. To align policies and procedures and revise them jointly as needed to ensure a  
19 shared practice that is consistent, avoids duplication and provides a process for  
20 quickly resolving conflicts.  
21  
22 4. Develop and provide models for local departments to consider in order to work more  
23 effectively together.  
24  
25 5. To reduce barriers to services that arise due to a lack of understanding of federal  
26 and state rules and regulations and to eliminate local rules that impede access to  
27 care and the adoption of the CPM.  
28  
29 6. To ensure that the shared management approach purposefully builds productive  
30 collaboration with youth and their families and involves them in decision-making and  
31 in implementing solutions.  
32  
33

34 Action Items for JANUARY 2013 AND BEYOND  
35

36 In March 2012, DHCS and CDSS filed a Joint Leadership Plan with the Court, which identified a  
37 representative from each department to have direct authority for policy decision-making and to  
38 communicate with their respective Directors regarding the Katie A. Settlement. Since the plan was  
39 filed, the two departments have continued to meet weekly to collaborate and coordinate efforts, as  
40 well as provide policy leadership and direction to the Negotiation Workgroup and the Special  
41 Master (please see **Appendix A** for specific steps accomplished to date).  
42

- 1 1. Continue convening the JMT and CPM Fiscal Taskforces with representatives from each  
2 department and representatives from youth, parent partner, county, provider and advocacy  
3 groups.  
4
- 5 2. By January 15, 2013, the JMT and the CPM Fiscal Taskforces will develop work plans  
6 consistent with the approved charters that will organize and sequence the work of the  
7 taskforces and result in the required reports to DHCS and CDSS.  
8
- 9 3. The taskforces will meet for approximately six to eight months to accomplish the tasks  
10 articulated in the charters.  
11
- 12 4. The JMT will develop recommendations for an SMS to support the establishment of  
13 formalized, county-level shared management structures between county child welfare and  
14 mental health agencies that also involves youth and their families in decision-making. The  
15 JMT will consider the recommendations set forth in the CPM Fiscal Taskforce's strategic  
16 plan:  
17
  - 18 a) to refine and/or augment the Implementation Plan activities;
  - 19 b) in developing its recommendations for the SMS; and
  - 20 c) in carrying out its obligations under the JMT Charter.
- 21  
22 The JMT will develop and provide a recommended mechanism to identify and measure local  
23 collaborative structures. This mechanism will also serve to identify any barriers that may  
24 prevent improved collaboration, the establishment of local collaborative structures, or access  
25 to services.  
26
- 27 5. The JMT shall consider using the county readiness assessment tool as a mechanism for  
28 achieving the forgoing. The JMT shall ensure family and youth voice in this process, and  
29 utilize the findings to provide additional guidance or technical assistance relating to local  
30 agencies.  
31
- 32 6. The JMT and/or SMS will consider the findings of the ACO Taskforce's study on utilization  
33 and timely access to care in developing its recommendations.  
34
- 35 7. 90 days after DHCS and CDSS receive the recommendations from each taskforce, the  
36 departments will evaluate the recommendations for possible adoption by the State and for  
37 inclusion in an ACL/ACIN to the counties describing options for the counties to consider.  
38
- 39 8. DHCS and CDSS will issue communication statements and guidance regarding the state and  
40 county shared management structure recommendations and will make administrative  
41 changes necessary to successfully implement and support the SMS. The two departments  
42 will also promote the SMS and ACO Taskforce and CPM Fiscal strategies statewide.  
43

1 9. DHCS and CDSS shall take the necessary steps to implement the strategic plan or proposal  
2 for financing of the CPM and direct services consistent with the efforts of the Continuum of  
3 Care Reform recommendations.  
4

5  
6 ANTICIPATED RESULTS  
7

8 Family and youth participation will be an integral component to shared DHCS and CDSS decision-  
9 making, resources and activities and consistent with the CPM values and goals.  
10

11 Coordinated policy and program direction will provide clear and consistent guidance to program  
12 managers, service providers, families and youth and other stakeholders. Outcomes and  
13 accountability measures will be aligned with the mental health and child welfare needs of the Katie  
14 A. class members.  
15

16 The SMS will exist at the state and local levels providing better integration of counties' decision-  
17 making, resources, activities, and family and youth participation. The SMS will improve  
18 coordination, broaden perspectives, improve accountability, strengthen existing relationships among  
19 child-serving agencies, increase community engagement, and include family and youth participation  
20 and increased satisfaction.  
21

22 Each department will collect data elements from their respective data systems specific to the  
23 subclass and evaluate utilization (patterns, types, frequency and intensity of services) and timely  
24 access to care. Data, reports and timelines will be posted on both the DHCS and CDSS websites.  
25

26  
27 RESPONSIBLE PARTIES  
28

29 DHCS, CDSS, Negotiation Workgroup, ACO Taskforce and CPM Fiscal Taskforce, Joint  
30 Management Taskforce  
31  
32  
33

34 **SECTION II. CORE COMPONENTS**  
35  
36

37 The purpose of the CPM is to develop a shared model of practice to better integrate services and  
38 supports for children, youth, families and communities. In addition, the purpose is to provide  
39 responsive, efficient and high quality services that promote safety, permanence, well-being and self-  
40 sufficiency.  
41

42 This section consists of two parts:  
43

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

1 needs-driven, strength-based, family-focused, culturally competent, individualized and  
2 delivered in a multi-agency collaborative approach.  
3

- 4 • Part B describes the departments' commitment to work with plaintiffs' counsel and  
5 consultants to determine which components of TFC are covered by Medi-Cal or Title  
6 IV-E and to design a plan to implement TFC statewide.  
7

8  
9 OBJECTIVES

- 10 1. To facilitate the provision of an array of services delivered in a coordinated,  
11 comprehensive, community-based fashion that combines family and youth  
12 engagement, service access, planning, delivery and transition into a coherent and  
13 all-inclusive approach referred to as CPM.  
14
- 15 2. To address the need for subclass members with more intensive needs to receive  
16 medically necessary mental health services that include IHBS, ICC and TFC.  
17 (Please refer to Appendices B and C for service definitions for IHBS and ICC as  
18 described in the Settlement Agreement).  
19
- 20 3. To support the development and delivery of a service structure and a fiscal system  
21 that supports the core practices and services model described in Part A of this  
22 section.  
23
- 24 4. To establish a CPM Fiscal Taskforce to guide and inform implementation to the  
25 fullest extent practicable consistent with the time available, that focuses on do-able,  
26 achievable and fiscally sound incentives to deliver IHBS, ICC and TFC within the  
27 Core Practice Model framework and reduce the use of group homes and other  
28 institutional placements.  
29
- 30 5. To develop a CPM Guide that is easily understood by multi-agency teams and  
31 stakeholders.  
32
- 33 6. To identify components of TFC services/model program that are Medi-Cal  
34 reimbursable and components that are covered by Title IV-E, and to determine all  
35 steps necessary to implement the services/model.  
36
- 37 7. To foster a statewide practice model where representatives of family and youth  
38 organizations are included in opportunities to advise administrators, contribute to  
39 policy development, provide systematic feedback on agency performance, and  
40 participate in staff development and program evaluation.  
41  
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4 **Part A: Core Practice Model Guide and Adoption**  
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6 The CPM Guide will describe the core practice model adopted in the Settlement Agreement that  
7 is based on family-centered values and principles and describe how they should be utilized by  
8 the child welfare and mental health systems for the class. The core practice components are  
9 identified as: engaging, assessing, service planning and implementation (including child and  
10 family teaming), monitoring and adapting and transition. These five components continuously  
11 interact and rely on one another to support the CPM. All counties, agencies and individuals  
12 who serve children and families that are the clients of both child welfare and mental health  
13 agencies will be expected to utilize the CPM Guide to assist with the adoption of the CPM. The  
14 CPM Guide components will be reflected in the Documentation Manual and referenced where  
15 appropriate to promote the application of the CPM in delivering mental health services to class  
16 and subclass members.

17  
18 Statewide adoption of the CPM is intended to develop a single model of delivery of intensive  
19 home and community based services to subclass and class members within the CPM framework,  
20 and to reduce the use of group homes and institutional placements. Additionally, the CPM  
21 Guide will enable and promote the adoption of a single model of service delivery that children  
22 and families receive when served by both Child Welfare and Mental Health agencies. The CPM  
23 Fiscal Taskforce will develop a strategic plan or proposal using fiscally sound incentives and  
24 reduced administrative barriers. The CPM Fiscal Taskforce's plan or proposal will guide and  
25 inform implementation to the fullest extent practicable consistent with the time available.  
26

27 Action Items for JANUARY 2013 AND BEYOND  
28

- 29 1. By January 31, 2013, DHCS and CDSS will issue an ACL/ACIN to all County MHPs and  
30 CSS Directors which will include background information regarding the Katie A.  
31 Settlement, purpose and goals for the CPM Guide and timeline for statewide implementation  
32 and initial and ongoing expectations for its use. The ACL/ACIN will emphasize the  
33 importance of engaging families and youth in decision-making at the practice, program, and  
34 policy levels.  
35  
36 2. By January 31, 2013, DHCS and CDSS will release the final CPM Guide for  
37 implementation.  
38  
39 3. By January 31, 2013, DHCS and CDSS will have released a schedule for basic orientation  
40 and training for the CPM Guide. CDSS will contract to provide the initial training and will  
41 also be prepared to provide technical assistance to answer questions by counties, providers  
42 and other stakeholders regarding the CPM Guide.  
43  
44 4. DHCS and CDSS will consult with the JMT on their obligation to develop and endorse  
45 practice tools, training curriculum, practice improvement protocols and quality review  
46 systems to support the shared CPM in order to support family and youth engagement and

1 decision-making, service integration and coordination for child welfare and mental health  
2 services for subclass/class members.  
3

- 4 5. By January 31, 2013, develop basic orientation and adoption strategies for the CPM  
5 guide in order to promote understanding by stakeholders (State partners,  
6 Administrative Office of the Courts (AOC), counties and providers, beneficiaries and  
7 family members) about the practice model for serving children in the Katie A. class  
8 and adoption of the CPM by counties and child welfare and mental health provider  
9 agencies.  
10
- 11 6. By January 31, 2013, issue an ACL/ACIN to describe IHBS and ICC services within  
12 a CPM approach.  
13
- 14 7. By September 30, 2013, the CPM Fiscal Taskforce will submit a strategic plan or  
15 proposal to finance the implementation of the CPM. The recommendations shall  
16 include fiscally sound incentives to county agencies and shall be aligned with the  
17 Continuum of Care Reform efforts and recommendations to the extent possible.  
18 The recommendations must support the following desired outcomes:  
19
- 20 a) Reduction in administrative barriers;
  - 21 b) Statewide delivery of the CPM;
  - 22 c) Support training and coaching activities necessary to rollout the CPM and to  
23 support parent and youth participation in all aspects of implementation (e.g.,  
24 child care, transportation and meeting attendance, etc.);
  - 25 d) Delivery of ICC and IHBS to subclass members within the CPM framework;  
26 and
  - 27 e) Reduction in the use of group homes and institutional placements.  
28
- 29 8. By December 31, 2013, TFC (once determined to be a Medi-Cal covered service, but no  
30 later than December 31, 2013) will be addressed in the CPM Guide through an update or  
31 addendum.  
32  
33

## 34 **PART B: Therapeutic Foster Care Model and Coverage**

35  
36 DHCS and CDSS, in concert with the plaintiffs' counsel and consultants, will determine which  
37 components of TFC are covered under Medi-Cal or Title IV-E, the preferred service model, and  
38 how the service should be claimed to Medi-Cal or Title IV-E. The TFC Model will seek to  
39 reflect ongoing partnership with the child/youth, birth parents, extended maternal and paternal  
40 family, and support communities in solution and outcome focused planning and decision-  
41 making. Once the TFC model and coverage have been determined, TFC will be added as an  
42 update or addendum to the Documentation Manual and the CPM Guide. While TFC  
43 implementation may commence after the rollout of IHBS and ICC, these services will not be  
44 hindered as a result of the TFC evaluation and implementation process.

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3  
4 Action Items for JANUARY 2013 AND BEYOND  
5

- 6 1. Continuing through January 2013, the TFC Consultants will meet with DHCS, CDSS, the  
7 Special Master and plaintiffs' counsel, to provide research and information on other state  
8 models and provide a recommended model for California.  
9
- 10 2. By January 31, 2013, DHCS and CDSS shall determine if any state law changes are  
11 necessary to implement TFC in California, and, if so, propose spot legislation in the regular  
12 legislative session by February 22, 2013 to enact such necessary changes.  
13
- 14 3. By February 28, 2013, DHCS, CDSS and plaintiffs' counsel shall provide the model to the  
15 TFC subgroup for review.  
16
- 17 4. By February 28, 2013, DHCS and CDSS shall reconvene the TFC Subgroup and the  
18 consultants to discuss the model. Continuing through May 2013, CDSS, and DHCS and  
19 plaintiffs' counsel will meet and continue to work with the consultants and the TFC  
20 Subgroup to modify and adopt a proposed TFC model to implement in California.  
21
- 22 5. By June 30, 2013, the following activities will be completed:  
23 a) Identify components of TFC services/model program that are Medi-Cal reimbursable  
24 and any components that are covered by Title IV-E.  
25 b) Identify costs of the TFC program for which Title IV-E funds may be claimed.  
26 c) Determine all steps necessary to implement the services/model, including any  
27 necessary federal approvals (e.g. Medicaid State Plan Amendment (SPA) and Title  
28 IV-E SPA).  
29
- 30 6. By July 31, 2013, submit any initial requests for federal approvals necessary, which may  
31 include submission of a SPA.  
32
- 33 7. By September 30, 2013, provide first draft of the TFC Addendum to the Documentation  
34 Manual to the subgroup and Negotiation Workgroup and review and consider incorporating  
35 input and feedback.  
36
- 37 8. Upon securing any necessary federal approvals, and with a target date by November 30,  
38 2013, provide the final draft of the TFC update or addendum of the Documentation Manual  
39 and the CPM Guide to the TFC Subgroup and review and consider incorporating feedback  
40 received.  
41
- 42 9. Upon securing any necessary federal approvals, and with a target date by December 31,  
43 2013, provide final draft to the Negotiation Workgroup for review and consider  
44 incorporating feedback received.  
45

1 10. Upon securing any necessary federal approvals, and with a target date by December 31,  
2 2013, add final TFC services/model and billing rules to the Documentation Manual. Issue an  
3 ACL providing the TFC portion of the Documentation Manual and any other instructions  
4 necessary to counties to begin claiming TFC services under Medi-Cal and to begin claiming  
5 Title IV-E Federal Financial Participation to pay for allowable costs for foster youth in TFC  
6 facilities.  
7

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

10  
11 ANTICIPATED RESULTS

12  
13 The CPM Guide will result in improved coordination of resources and services, greater family and  
14 youth engagement and participation, as well as greater uniformity in statewide practices by child  
15 welfare and mental health agencies and providers serving children and youth with an open child  
16 welfare case. Additionally, the CPM Guide will enable and promote the adoption of a single model  
17 of service delivery that children and families receive when served by both Child Welfare and  
18 Mental Health agencies.  
19

20 The adoption and use of the CPM will transform practice associated with the shared governance and  
21 delivery of services by child welfare and mental health services staff and the engagement and  
22 participation of families and youth. The practice will be adopted by all state and county departments  
23 and individuals who serve the Katie A. class members and their families.  
24

25 The TFC update or addendum will result in improved statewide implementation of TFC services  
26 and will provide essential information regarding coverage, claiming and documentation.  
27

28 The Documentation Manual developed in Phase I, the TFC update or addendum and the CPM  
29 Guide will be used together in order to promote integration and alignment between practice and  
30 services. Additionally, training and technical support will be provided by the State in a manner that  
31 is intended to underscore the importance of using the Documentation Manual and the CPM Guide in  
32 unison.  
33

34 RESPONSIBLE PARTIES

35 DHCS and CDSS  
36  
37  
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39 **SECTION III. FAMILY AND YOUTH INVOLVEMENT**  
40  
41

42 For the purposes of this plan, family and youth involvement means that state departments, counties  
43 and providers engage and involve youth, parents, and family members in decision-making at the  
44 practice, program, and policy levels, and that youth and families have meaningful influence in the  
45 design, delivery, and evaluation of services consistent with the values and principles of the CPM.  
46

1 Family and youth involvement will not happen spontaneously in a historically prescriptive and  
2 agency based mental health and child welfare culture. State departments, counties and providers  
3 must proactively create environments or processes that welcome youth, parents, family and  
4 community partnership.  
5

6  
7 OBJECTIVES  
8

- 9 1. To ensure that family and youth involvement is prioritized and integrated at the  
10 practice, program and system levels and phases of implementation as envisioned  
11 by the CPM.  
12
- 13 2. To ensure DHCS and CDSS utilize family and youth partnerships to assist with  
14 identifying the appropriate orientation, training, and other strategies needed to  
15 strengthen and/or change the State and local systems to meet the terms of the  
16 Settlement Agreement.  
17
- 18 3. To improve service delivery practices by ensuring that family culture, strengths and  
19 vision are incorporated into services.  
20
- 21 4. To improve service outcomes by including satisfaction and quality review measures  
22 that are meaningful, easily understandable and reflective of the family and youth  
23 perspective in measuring success.  
24  
25

26 Action Items for JANUARY 2013 AND BEYOND  
27

- 28 1. By January 31, 2013, outreach, recruit and actively engage youth participation in all aspects  
29 of the implementation process.  
30
- 31 2. By January 31, 2013, draft a joint ACL/ACIN to encourage and support specific strategies  
32 for involving family and youth, which may include, but are not limited to:  
33
- 34 a) Provide specific orientation and training, as well as ongoing assistance to  
35 parents regarding administrative, budgetary, and other elements of in  
36 planning social services. Support, encourage and value parents, youth and  
37 communities agencies at meetings.
  - 38 b) Provide contract and community grant opportunities with parent and youth  
39 advocacy groups or community-based organizations that employ parents or  
40 youth to develop and direct a process that ensures sustained and thoughtful  
41 participation in planning.
  - 42 c) Build collaborative working relationships by reaching out to parent and youth  
43 organizations, as well as agencies that work with parents and youth (e.g.,  
44 schools, child care centers) to recommend parents and youth to participate in  
45 planning.

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

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

ANTICIPATED RESULTS

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

RESPONSIBLE PARTIES

DHCS and CDSS

1 **SECTION IV. SERVICE DELIVERY AND ROLLOUT**

2  
3  
4 The purpose of the service delivery and rollout section is to support the development and  
5 implementation of a service structure and fiscal system for counties to support the implementation  
6 of a core practices and services model in a coordinated, comprehensive and community-based  
7 approach.  
8

9  
10 **OBJECTIVES**

- 11  
12 1. To develop and guide implementation of a process or processes to identify/screen,  
13 refer and firmly link class members to services (refer to Section VI, Objective 8 for  
14 additional information).  
15  
16 2. To ensure statewide implementation of ICC and IHBS. County mental health and  
17 social services agencies will jointly develop and submit an ICC and IHBS service  
18 delivery plan to the State.  
19  
20 3. To ensure a forum is available to provide timely response to county and provider  
21 reports of challenges in implementing ICC and IHBS services.  
22  
23 4. To coordinate the work of the JMT, ACO and CPM Fiscal taskforces to ensure that  
24 service delivery is supported, and improved over time by governance,  
25 quality/accountability, and fiscal systems and structures that are consistent with the  
26 CPM values, goals and components.  
27

28  
29 **Action Items for JANUARY 2013 AND BEYOND**

30  
31 DHCS and CDSS will consult with counties and providers, including parent and youth partners, to  
32 promote utilization of the CPM Guide in the delivery of all services, including IHBS and ICC (and  
33 TFC, once determined to be a Medi-Cal covered service, but no later than December 31, 2013) by:  
34

- 35 1. DHCS and CDSS will provide a forum for problem resolution including, but not limited to:  
36 a) EPSDT billing or claiming barriers for MHPs and their contractors and make  
37 recommendations to DHCS and CDSS on steps to resolve.  
38 b) Addressing barriers related to sharing confidential juvenile court information  
39 with non-professionals.  
40 c) Clarifying the parameters and legal basis for counties to share child welfare  
41 and mental health data and qualitative information related to class and  
42 subclass members.  
43  
44 2. Provide consultation and guidance for counties to determine subclass members for whom  
45 IHBS and ICC (and TFC, once determined to be a Medi-Cal covered service, but no later

1 than December 31, 2013) services are medically necessary. A Katie A. Subclass  
2 Certification Form (in the Documentation Manual) will include criteria for identifying  
3 subclass members.  
4

- 5 3. By January 31, 2013, DHCS and CDSS will issue an ACL/ACIN to inform counties of the  
6 criteria and selection process for designating Learning Collaborative Counties (previously  
7 referred to as Early Implementer Counties) with input from the Negotiation Workgroup,  
8 CMHDA, CWDA, and the family and youth partners.  
9
- 10 4. By March 1, 2013, the MHPs and child welfare agencies will have lead responsibility for  
11 jointly completing a readiness assessment tool and developing a service delivery plan.  
12 Nothing in this requirement, or in the service delivery plan or planning process, is intended  
13 to impede timely access, or waive a child's entitlement to medically necessary Specialty  
14 Mental Health Services as required by law or the Settlement Agreement.  
15

16  
17 a) Readiness Assessment Tool

18 For the readiness assessment tool, MHPs and child welfare agencies will be  
19 encouraged to seek stakeholder input, and will be encouraged to incorporate  
20 input of youth, families and parent partners. The elements of the readiness  
21 assessment tool will include, but are not limited to:

- 22 i. Organizational leadership  
23 ii. Systems and interagency collaboration  
24 iii. Systems capacity  
25 iv. Service array  
26 v. Children, youth and families  
27 vi. Fiscal funding resources  
28

29 b) Service Delivery Plan

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

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

- 1           iii. Identification of the strength of the connectivity and collaboration
- 2                 between child welfare and mental health to administer an array of
- 3                 services to support IHBS, ICC and TFC.
- 4           iv. A description of stakeholder involvement in the implementation of ICC,
- 5                 IHBS and TFC, specifically how youth and families will be continuously
- 6                 involved in implementation, policy development, practice issues and
- 7                 continuous quality improvement.
- 8           v. An analysis to identify gaps between the needs of the subclass and
- 9                 services provided, and if such a gap is identified, a plan to address it.
- 10          vi. A services capacity assessment to determine the capacity of the MHP
- 11                 to provide ICC and IHBS to subclass members.
- 12

13          c) Semi-Annual Progress Reports

14           Beginning August 1, 2013, county mental health and child welfare agencies will

15           jointly prepare and submit implementation progress reports on a semi-annual basis

16           which will include:

- 17           i. Reporting on mental health service utilization
- 18           ii. Action plans to address areas identified for improvement
- 19           iii. Specified need for technical assistance or state support
- 20
- 21

- 22          5. DHCS and CDSS will consult with counties to ensure that each county has an ICC and
- 23                 IHBS service delivery plan that is capable of achieving the Objectives above. Establish and
- 24                 communicate guidance or standards for what is sufficient process or results for this action
- 25                 item.
- 26
- 27          6. By April 30, 2013, select Learning Collaborative Counties that will adopt the CPM
- 28                 and provide feedback, to identify barriers and determine potential areas for
- 29                 improvement to support continued rollout and promote statewide CPM adoption.
- 30                 The selection process for designating Learning Collaborative Counties will be based
- 31                 on a foundation of implementation science. The concept of implementation science
- 32                 allows for the appropriate grouping of peer counties based on their various levels of
- 33                 development/readiness, with special allowance for county size. This model allows
- 34                 counties to transfer "lessons learned" during the phases of implementation, how to
- 35                 build and deliver the services county wide and model the strong collaboration
- 36                 between mental health and child welfare for other counties.
- 37
- 38          7. By June 1, 2013 (and by April 30, 2014 for TFC, once determined to be a Medi-Cal covered
- 39                 service) DHCS and CDSS will complete a statewide analysis of the information provided by
- 40                 the counties as described in activity D above to (1) develop and model child welfare and
- 41                 mental health service delivery systems based on the CPM, (2) identify opportunities for and
- 42                 challenges to providing full access to services for subclass members and broad, statewide
- 43                 application of the CPM, and (3) provide an initial framework for an ongoing process of
- 44                 communication, engagement, collaboration, and problem-solving with county partners and
- 45                 other stakeholders.
- 46

1 8. By June 30, 2013, the county-selected Implementation Teams comprised of county  
2 child welfare, mental health, youth and family support partners and providers will be  
3 required to participate as part of the learning collaborative process for implementing  
4 the CPM. The Learning Collaborative Counties will be grouped based on their level  
5 of readiness, and will be oriented to the coaching materials and receive joint training  
6 and technical assistance in exchange for providing feedback about the  
7 implementation of the CPM training, coaching and other materials developed by the  
8 MDT training subgroup.  
9

10 9. DHCS and CDSS are committed to continuously:

- 11 a) Identifying state supportive activities, resources, incentives, sanctions and  
12 guidance that may be available to increase access to ICC, IHBS and TFC.
- 13 b) Developing an ongoing state, county, provider and parent and youth  
14 problem-solving, opportunity-developing dialog/process focused on  
15 expanding service capacity at the county level.
- 16 c) Establishing program priorities and developing population-specific strategies  
17 including geographic, resource, training, and workforce challenges for  
18 increasing access to services over time.
- 19 d) Setting annual or bi-annual performance goals or targets based on  
20 appropriate localized conditions or circumstances.
- 21 e) Regularly communicating with stakeholders and developing solutions to  
22 identify challenges.
- 23 f) Borrowing/sharing resources from other successful efforts to adopt CPM or  
24 similar system of care/ wraparound methods.
- 25 g) Seeking out federal and private resources to support this effort.
- 26 h) Exploring ways to develop and/or support centers of excellence that can  
27 provide strategic, logistic, and technical support for developing and  
28 sustaining CPM systems and core elements. Such organizations could also  
29 address workforce challenges.  
30

31 10. Additional training and technical assistance guidance is referenced in Section V.  
32  
33

34 ANTICIPATED RESULTS  
35

36 IHBS and ICC (and once determined to be a Medi-Cal covered service, but no later than December  
37 31 2013, TFC) will be provided statewide to eligible youth pursuant to the guidelines and  
38 procedures provided in the Documentation Manual and CPM Guide. Progressive adoption of the  
39 CPM will result in a joint practice model of care that children, youth and families receive when  
40 served by their local mental health and child welfare agencies and providers. Services that are  
41 delivered respond explicitly to the culture and beliefs of youth and families.  
42

43 RESPONSIBLE PARTIES  
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45 CDSS, DHCS, Negotiation Workgroup, County MHPs and County Child Welfare Services.

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4 **SECTION V. TRAINING AND TECHNICAL ASSISTANCE**  
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7 The purpose of the training and technical assistance activities is to support adherence to a  
8 sustainable core practice model which will facilitate the transformation of child welfare and mental  
9 health systems. Training activities alone are not enough to sustain the adherence to the CPM.  
10 Solutions also need to be hands on and practical to meet technical and adaptive challenges in order  
11 to achieve meaningful changes in values, beliefs, attitudes, family and youth inclusion and  
12 paradigms in real time.  
13

14 **OBJECTIVES**  
15

- 16 1. To develop cross-system training and coaching curriculum and educational materials for  
17 child welfare and mental health staff, youth, family support partners, providers and  
18 parents/caregivers and to include families/caregivers in the development of training.  
19
- 20 2. To develop joint training and/or technical support for a child welfare and mental health  
21 leadership and workforce that is in line with the CPM to support the integration and  
22 coordination of child welfare and mental health leadership and workforces in order to  
23 deliver consistent and quality services that include families and youth in the training  
24 process.  
25
- 26 3. To clarify and provide guidance on state and federal laws as needed to implement  
27 the Settlement Agreement so that counties, providers, families and youth, and other  
28 stakeholders can understand and consistently apply them.  
29
- 30 4. To develop and endorse practice tools, training and coaching curriculum, practice  
31 improvement protocols and quality control systems to support the shared CPM in order to  
32 support service integration and/or coordination for mental health services for class members.  
33
- 34 5. To ensure family and youth involvement is included in all aspects of training and support  
35 development and activities.  
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1 Action Items for JANUARY 2013 AND BEYOND

- 2
- 3 1. The statewide training plan for the adoption of the Documentation Manual includes
- 4 the following:
- 5 a) By January 16, 2013, Documentation Manual training materials will be
- 6 drafted.
- 7 b) Starting January 16, 2013 DHCS will host weekly technical assistance calls
- 8 to address questions, needs regarding the use of the Documentation Manual
- 9 and to set time aside for CDSS to answer questions related to the core
- 10 practice model following the release of the CPM Guide.
- 11 c) By February 1, 2013, DHCS will establish a webpage for Documentation
- 12 Manual frequently asked questions and update the information on a monthly
- 13 basis.
- 14 d) By February 28, 2013, CDSS will contract to facilitate the identification of
- 15 locations for four regional trainings (Los Angeles, Bay, Sacramento and
- 16 Redding). The trainings will consist of three hours of CPM training and four
- 17 hours of Documentation Manual training.
- 18 e) By March 31, 2013, DHCS will schedule two train-the-trainers sessions (one
- 19 in Sacramento and one in Los Angeles.)
- 20 f) By December 31, 2013, DHCS will host two Promising Practices Webinars.
- 21 County MHPs and County Child Welfare Services organizations that are
- 22 identified as demonstrating strong implementation will be recruited to share
- 23 their experiences.
- 24 2. The statewide training plan for the adoption of the CPM includes the following:
- 25 a) Thirty days after the issuance of the CPM Guide, the Statewide Training and
- 26 Education Committee's Multi-Disciplinary Training (MDT) subgroup
- 27 comprised of counties, providers, parents and youth, training academies,
- 28 caregivers and other stakeholders will assemble and begin the process of
- 29 developing curricula, educational materials and peer support training.
- 30 b) Thirty days after the issuance of the CPM Guide, review the CPM guide and
- 31 determine if existing training curricula and coaching materials can be
- 32 enhanced or if new curricula and coaching materials need to be developed
- 33 for use by mental health, child welfare, family and youth partners and
- 34 providers and other stakeholders, including assessing the need for
- 35 educational materials and/or an implementation toolkit.
- 36 c) By May 1, 2013, the MDT will finalize the training curricula, coaching and
- 37 educational materials and the implementation toolkit and schedule the four
- 38 Regional Trainings for Trainers.
- 39 d) By June 30, 2013, the county Implementation team comprised of child
- 40 welfare, mental health, family and youth partners and providers will be
- 41 required to participate as part of learning collaborative for implementing the
- 42 CPM. The Learning Collaborative Counties will be grouped based on their
- 43 level of readiness, and will be oriented to the coaching materials and receive
- 44 joint training and technical assistance in exchange for providing feedback
- 45 about the implementation of the CPM training, coaching and other materials
- 46 developed by the MDT training subgroup.

- 1 e) Curricula and coaching materials will be revised by the training subgroup
- 2 based on the feedback and experience of the Learning Collaborative
- 3 Counties.
- 4 f) All curricula and coaching materials will be finalized and made available for
- 5 all counties, other training entities and stakeholders and accessible by
- 6 posting to appropriate websites.
- 7 g) Additional training for trainers and webinars will be scheduled by DHCS and
- 8 CDSS leveraging the Statewide Training and Education Committee's system
- 9 of coordination in addition to identifying other training opportunities from
- 10 mental health entities. The learning collaborative will provide a county peer to
- 11 peer learning environment that will include joint planning, common technical
- 12 assistance themes, modeling for other counties and address emerging
- 13 barriers, with solutions for county sites.
- 14 h) DHCS and CDSS will coordinate and stage additional rollout efforts based on
- 15 counties' identified area of need for technical support based on their
- 16 readiness assessment and from information on the notice of the service
- 17 delivery plan that will be submitted to the State.
- 18 i) A transfer of knowledge process will be targeted to County supervisors and
- 19 managers from child welfare and mental health agencies in order to further
- 20 their understanding and skills about what the CPM is supposed to
- 21 accomplish with their support. Materials will be developed to enhance their
- 22 knowledge and skills through a variety of methods that may include but are
- 23 not limited to: the use of learning agreements, curricula, online materials,
- 24 webinars, technical assistance from Federal, State, contracted consultants,
- 25 and coaching or mentoring support.
- 26 j) To further encourage transfer of learning, social workers and mental health
- 27 staff and their supervisors will be guided on how to develop a learning plan
- 28 that includes pre and post training goal setting, follow-up and assessment.
- 29 k) Advanced Training modules will be developed and made available which will
- 30 assist social worker and mental health staff in delivering the CPM approach.
- 31

- 32 3. Continuous and ongoing technical assistance will include but not be limited to:
- 33 a) Assessing and evaluating coaching and mentoring needs and developing a plan to
- 34 assist the counties in meeting these needs.
- 35 b) Developing policy guidance on the interrelationship between ICC, IHBS, TFC and
- 36 the CPM.
- 37 c) Continuing to issue communications to describe and provide guidance regarding the
- 38 expectations for and benefits of delivering services in a child/youth-centered, family-
- 39 focused, community-oriented manner (e.g., ACL/ACIN) and participate in
- 40 calls/meetings/presentations with stakeholders and associations (e.g. California
- 41 Mental Health Directors Association, California Welfare Directors Association,
- 42 Chief Probation Officers of California and the California Alliance of Child and
- 43 Family Services).
- 44 d) Targeting specific audiences, such as: county leadership, courts, and counties that
- 45 have an identified area of need for technical support based on readiness assessment.

- 1 e) Leveraging additional resources and the State Regional Training Academies to  
2 support integrated training for child welfare and mental health.  
3  
4

5 ANTICIPATED RESULTS  
6

7 County leadership from mental health and child welfare agencies will be informed and advised  
8 based on experience from the Learning Collaborative Counties. Families and youth will be  
9 included throughout the development of the training materials process.  
10

11 Training for the Documentation Manual will be coordinated with the training on the Core Practice  
12 Model Guide.  
13

14 RESPONSIBLE PARTIES  
15

16 DHCS and CDSS  
17  
18

19 **SECTION VI. DATA AND QUALITY ASSURANCE**  
20

21 Several activities related to data, accountability, quality assurance, and the establishment of an ACO  
22 Taskforce are necessary to ensure clear and consistent guidance and that outcomes, satisfaction and  
23 accountability measures are consistent with the CPM. These include adoption and statewide use of  
24 a data-informed system of performance oversight, accountability and communication that efficiently  
25 monitors, measures and evaluates access, quality, satisfaction, effectiveness, costs and outcomes at  
26 the individual, program and system levels.  
27  
28

29 OBJECTIVES  
30

- 31 1. To establish an ACO Taskforce and produce a report with recommended actions  
32 and timelines.  
33  
34 2. To engage youth and families in all aspects of data and quality assurance planning,  
35 design, decision-making and implementation.  
36  
37 3. To establish a method to track the use of IHBS, ICC and TFC services for subclass  
38 members.  
39  
40 4. To facilitate a stakeholder meeting to solicit ideas from youth and families,  
41 providers, advocates, counties, and other stakeholders about the data DHCS and  
42 CDSS should routinely produce and post on both departments' websites.  
43

- 1 5. To establish a procedure and timeline to produce and post data that is useful to  
2 counties, stakeholders and State departments in addressing the needs of children in  
3 the class, including information and data regarding the use of less restrictive,  
4 informal services, and natural linkages used to address youth and families'  
5 strengths and needs.  
6
- 7 6. To develop a plan for the collection of data and information about children in the  
8 class who receive mental health services.  
9
- 10 7. To collect existing data specific to the class (and subclass) in order to evaluate  
11 utilization (patterns, type, frequency, intensity of services) and timely access to  
12 appropriate care, including informal services and natural linkages.  
13
- 14 8. To measure the success of the processes to identify/screen, refer and firmly link  
15 class members to services and to adapt and modify Implementation Plan strategies  
16 to resolve problems or eliminate barriers that may arise and impede access to  
17 IHBS, ICC, TFC, or the application and use of the CPM.  
18
- 19 9. Using the ACO and/or JMT taskforces, identify monitoring, measuring, evaluating,  
20 reporting and adapting mechanisms that will be used to assure that local efforts  
21 meet Section IV, Objective 1 and 2 as appropriate.  
22

23 Action Items for JANUARY 2013 AND BEYOND

- 24
- 25 1. By January 1, 2013, DHCS will implement new procedure codes in the SD/MC II  
26 system.  
27
- 28 2. By January 31, 2013, DHCS and CDSS will establish and convene an ACO  
29 Mapping Group to inventory and report on the current array of ongoing state and  
30 county data efforts by CDSS, DHCS and others.  
31
- 32 3. By February 28, 2013, the ACO Taskforce will begin convening monthly meetings.  
33 The ACO Taskforce will support service integration and/or coordination for mental  
34 health services for class members by improving methods and adequacy of data  
35 collection, matching and sharing to support the CPM at the State, county and  
36 provider levels. The taskforce will provide recommendations to DHCS and CDSS to  
37 inform the design, development and support of the SMS.  
38
- 39 4. By April 1, 2013, DHCS and CDSS will analyze and evaluate utilization (patterns,  
40 types, frequency and intensity of services) and timely access to care based on data  
41 elements in both departments' data systems specific to the class and subclass.  
42

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

6 6. By June 30, 2013, data and subsequent analysis and evaluation of utilization (as  
7 described in item A above) will be shared publicly with counties, providers and all  
8 stakeholders through postings on both departments' websites, every six months  
9 through December 31, 2014.  
10

11 7. By September 1, 2013, the ACO Taskforce will produce a report with recommended actions  
12 and timelines related to identifying, devising and collecting:

- 13 a) A method to track the provision of mental health services to the class and the use of  
14 IHBS and ICC (and after December 31, 2013 for TFC) service arrays for subclass  
15 members. Consider utilizing or revising the External Quality Review Organization  
16 (EQRO) and California Child and Family Services Review (C-CFSR) requirements  
17 in developing a plan for the collection of data and qualitative information about  
18 children. Also consider utilization of a nationally recognized fidelity tool to measure  
19 the adoption of the CPM.  
20 b) A process to measure the engagement and participation of youth and families in the  
21 planning and implementation phases by counties and providers.  
22 c) Data elements in DHCS and CDSS data systems specific to the class and subclass in  
23 order to evaluate utilization (patterns, types, frequency, intensity of services) and  
24 timely access to care.  
25  
26

## 27 ANTICIPATED RESULTS

28  
29 Adoption and statewide use of a data-informed system of performance oversight, accountability and  
30 communication that efficiently monitors, measures and evaluates access, quality, satisfaction,  
31 effectiveness, costs and outcomes at the individual, program and system levels.  
32

33 The production of relevant, timely, and understandable measures that report who needs and who is  
34 receiving services, including the type, intensity and duration, at the individual, program, county, and  
35 system levels. Use a continuous quality improvement process to monitor and support service  
36 delivery, utilization and adherence to the Core Practice Model.  
37

38 The State will have and share publicly the necessary information to determine whether  
39 implementation of IHBS, ICC and the CPM is successful, and if not, what measures need to be  
40 taken to achieve success. Data and oversight systems will continue to be used to improve  
41 performance and quality over time.  
42

43 Family and youth satisfaction is a critical component of system evaluation. Families and youth will  
44 be active participants in state system planning. A formal mechanism will be used to address family  
45 and youth concerns.  
46

- 1
- 2 RESPONSIBLE PARTIES
- 3
- 4 DHCS and CDSS
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**APPENDIX: A**

**SECTION I - SHARED MANAGEMENT STRUCTURE**

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

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**SECTION II - CORE COMPONENTS**

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

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**SECTION III - FAMILY AND YOUTH INVOLVEMENT**

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

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**SECTION IV - SERVICE DELIVERY AND ROLLOUT**

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

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**SECTION V - TRAINING AND SUPPORT**

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

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**SECTION VI - DATA AND QUALITY ASSURANCE**

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

identifying service needs		
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4 **APPENDIX: B**

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6 **Intensive Home-Based Services**

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

14  
15 IHBS are delivered according to an individualized treatment plan developed by a care planning  
16 team (see ICC). The care planning team develops goals and objectives for all life domains in  
17 which the child's mental health condition produces impaired functioning, including family life,  
18 community life, education, vocation, and independent living, and identifies the specific  
19 interventions that will be implemented to meet those goals and objectives. The goals and  
20 objectives should seek to maximize the child's ability to live and participate in the community and  
21 to function independently, including through building social, communication, behavioral, and  
22 basic living skills. Providers of intensive home-based services should engage the child in  
23 community activities where the child has an opportunity to work towards identified goals and  
24 objectives in a natural setting. Phone contact and consultation may be provided as part of the  
25 service.

26  
27 **IHBS includes, but is not limited to:**

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

1 interfere with succeeding in an academic program in the community; and  
2 9. Supporting independent living objectives, by identifying and addressing behaviors that  
3 interfere with seeking and maintaining housing and living independently.  
4

5 IHBS are highly effective in preventing a child being removed from home (biological, foster, or  
6 adoptive) through admission to an inpatient hospital, residential treatment facility or other  
7 residential treatment setting.  
8

9 *Settings:* IHBS may be provided in any setting where the child is naturally located, including  
10 the home (biological, foster or adoptive), schools, recreational settings, child care centers, and  
11 other community settings.  
12

13 *Availability:* IHBS are available wherever and whenever needed, including evenings and on  
14 weekends.  
15

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

**Intensive Care Coordination**

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

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

ICC service components consist of:

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

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

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

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

- 1 • Determining whether services are being provided in accordance with the ICP;
- 2 • Determining whether the services in the ICP are adequate to meet the needs of
- 3 the child and family;
- 4 • Determining whether there have been changes in the needs or status of the youth
- 5 and, if so, adjusting the plan of care as necessary in concert with the CFT; and
- 6 • Will identify and actively assist the youth and family in obtaining and monitoring
- 7 the delivery of available services, including medical, educational, mental health,
- 8 social, therapeutic, or other services.
- 9

10 **Transition:** ICC also includes:

- 11
- 12 • Developing with the CFT a transition plan when the youth has achieved goals
- 13 outlined in the ICP; and
- 14 • Collaborating with the other service providers and agencies on behalf of the youth
- 15 and family.
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17 *Settings:* ICC may be provided to children living and receiving services in the community

18 as well as to children who are currently in a hospital, group home, or other congregate or

19 institutional placement as part of discharge planning.

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