State of California—Health and Human Services Agency

TOBY DOUGLAS
DIRECTOR

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GOVERNOR

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DIRECTOR

March 28, 2014

MHSUDS INFORMATION NOTICE NO.: 14-012
ALL COUNTY LETTER NO.: 14-29

TO: ALL ADOPTION DISTRICT OFFICES
ALL CHIEF PROBATION OFFICERS
ALL COUNTY ADOPTION AGENCIES
ALL COUNTY WELFARE DIRECTORS
ALL FOSTER FAMILY AGENCIES
ALL GROUP HOME PROVIDERS
ALL TITLE IV-E AGREEMENT TRIBES
COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATORS
COUNTY MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH BOARDS

SUBJECT: REPORTING SERVICE DELIVERY ACTIVITIES RELATED TO PROVIDING MENTAL HEALTH SERVICES TO CHILDREN IN FOSTER CARE FOR THE PERIOD OF SEPTEMBER 1, 2013 THROUGH FEBRUARY 28, 2014, DUE ON MAY 1, 2014 (*REVISED PROGRESS REPORT TEMPLATE*)

REFERENCE: ACL 13-73/MHSD INFORMATION NOTICE 13-19, ISSUED SEPTEMBER 9, 2013

The California Department of Social Services (CDSS) and California Department of Health Care Services (DHCS) are issuing this notice to provide counties with a revised progress report template for reporting their activities and progress related to implementation of Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (once federally approved as a Medi-Cal service) for children and youth who meet Katie A. subclass criteria.[1] As specified in ACL 13-73/MHSD Information Notice 13-19, under federal and state Early and Periodic Screening Diagnosis and Treatment law, state law governing Specialty Mental Health Services (SMHS), and their current contract with DHCS, Mental Health Plans (MHPs) are required to provide SMHS as determined medically necessary. Pursuant to the *Katie A.* Settlement Agreement, Implementation Plan, and related court orders, ICC and

[1] As defined in the *Katie A. v. Bonta* Settlement Agreement.

Department of Health Care Services
California Department of Social Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 440-7570

IHBS are SMHS that must be provided to members of the subclass, when medically necessary, and delivered in a manner consistent with the Core Practice Model (CPM).

The purpose of the progress reports is to support successful statewide implementation of these services by providing instructions to counties for identifying children who are members of the subclass and report on what is occurring in the counties with respect to the implementation of ICC and IHBS. For DHCS and CDSS, the progress report is an important tool that assists the State in identifying barriers around implementation that may need further clarification and opportunities for improvement at the state and county level.

Following the analysis of the progress reports for the first reporting period (May 15 through August 31, 2013), DHCS and CDSS revised the progress report template to clarify certain elements and provide more detailed instructions. In addition, revisions to the template are intended to address concerns that some children in the child welfare system with mental health needs are not being identified as subclass members through existing processes. Specifically, counties are now required to report on the number of potential subclass members identified. A potential member of the subclass is a child who meets at least one of the eligibility criteria for the subclass. A proposed methodology for identifying potential subclass members is provided below. This methodology is intended to be over-inclusive in order to ensure that all children in foster care who need intensive mental health services are identified.

Revisions to the progress report were made primarily on Enclosure 1, Parts A, B, and C. A system and capacity section was added to Enclosure 1, Part C, in order to address implementation barriers that arose in the statewide analysis of the progress reports that were submitted for the May 15 to August 31, 2013, reporting period. Responses to these questions will enable the State to monitor progress and provide counties with guidance and support. The instructions, provided below, have been revised to reflect these changes to the report. Enclosure 2 is unchanged.

Reporting Potential Subclass Members

To ensure that all children in foster care who have mental health needs are identified, counties are asked to determine and report the number of potential subclass members. The State developed a methodology, specified below in sections A, B, and C, for counties to utilize in the identification of subclass members. It includes criteria that is more inclusive than the subclass criteria to allow counties to identify the children and youth who will need to be reviewed for subclass eligibility.

Counties may use an alternative methodology for gathering this information; however, a full description of the methodology used must accompany the completed progress

report when submitted. If an alternate methodology is used, counties must demonstrate in their description how a similarly over-inclusive approach is used to produce a result consistent with the State's methodology, which is provided below. Again, the intent is to ensure that all children and youth in foster care who have mental health needs are identified and provided with appropriate mental health services.

Instructions

Collaboration and coordination between Child Welfare Departments (CWDs) and MHPs are critical components of any methodology applied to this purpose. CWDs and MHPs need to collaborate to identify children and youth receiving mental health services in order to ensure they are counted. CWDs and MHPs should establish a process and timelines for completing this work and exchanging information appropriately. At a minimum, this process should be completed every six months in order for CWDs and MHPs to complete and submit the semi-annual progress report.

A. Enclosure 1, Part A: Establish estimate of potential subclass members using the following steps:

I. CWDs identify children and youth with an open child welfare case who are full-scope Medi-Cal beneficiaries.

II. From this group, CWDs determine an unduplicated count of children and youth who, during the reporting period, meet one the following criteria:
   a. Received or were considered for at least one of the following:
      i. Any mental health service(s);
      ii. Wraparound, Full Service Partnership services, or specialized care rate;
      iii. Placed in a group home with an RCL 10 or above; or
      iv. Placed in a psychiatric hospital or 24-hour mental health facility.

   OR

   b. Experienced three or more placements in a 24-month period.

III. A list of children and youth who are eligible for full-scope Medi-Cal (Step I) and met at least one of the criteria above (Step II, a or b) during the reporting period is generated by CWD and shared with the county MHP.

IV. Children identified through Steps I-III are considered potential members of the subclass.
   a. Enter this information on Enclosure 1, Part A – Item 1.

V. MHPs will use the list of potential subclass members (see Step IV) to determine how many children were in each of the following categories for the reporting period:

a. Children and youth on the list who, during the reporting period, received a full mental health assessment and were determined not to meet medical necessity criteria for SMHS are not subclass members.
    i. Enter this information on Enclosure 1, Part A - Item 2.
b. Children and youth on the list who, during the reporting period, were referred to receive a full mental health assessment to determine medical necessity criteria for SMHS, and had not yet been assessed.
    i. Enter this information on Enclosure 1, Part A - Item 3.
c. Children and youth on the list who, during the reporting period, were unknown to county MHP.
    i. Enter this information on Enclosure 1, Part A - Item 4.

VI. Counties must describe the collaborative process used to further assess the mental health needs of children and youth identified above in Step V, Items b, and c. Enter this information on Enclosure 1, Part A, Column 2.

B. Enclosure 1, Part B: Identify Subclass Members and Service Utilization:

I. MHPs will use the list of potential subclass members (see Section A, Step IV) to determine how many children were in each of the following categories for the reporting period:
    a. Children and youth on the list who, during the reporting period, were receiving SMHS and were either determined to meet medical necessity criteria for any intensive SMHS (including, but not limited to, Therapeutic Behavioral Services and crisis stabilization/intervention) or were identified as meeting a (ii), (iii), (iv) or b from Section A, Step II are counted as subclass members.
        i. Enter this information on Enclosure 1, Part B, Item 1.

    CWDs and MHPs must collaborate and work together to determine if the child/youth on the list meets the Katie A. subclass criteria specified in the Medi-Cal Manual, page 3.

II. Enter the total number and breakdown of service utilization of children and youth who, during the reporting period, are subclass members, as identified on Enclosure 1, Part B, as follows:
    a. Enter in Item 2 the number of subclass members receiving ICC;
    b. Enter in Item 3 the number of subclass members receiving IHBS;
    c. Enter in Item 4 the number of subclass members receiving intensive SMHS, but not ICC and IHBS, through Wraparound and FSP Program/providers;
    d. Enter in Item 5 the number of subclass members receiving other intensive SMHS, but not ICC, IHBS, Wraparound, or FSP;
    e. Enter in Item 6 the number of subclass members receiving mental health services and not identified and counted in a, b, c, or d above (include

children receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources);

f. Enter in Item 7 the number of subclass members not receiving mental health services (neither through Medi-Cal nor through any other program or funding source); and
g. Enter in Item 8 the number of subclass members who declined to receive ICC and/or IHBS.

Enclosure 1, Part B, of the progress report should build on the information counties provided in Section I of their Service Delivery Plans and the previous progress report regarding identification of subclass members and the process used to determine their needs.

If the information or numbers requested in Section B, Step II, a-g, above, are not available, please provide an explanation of why that data cannot be collected or provided, as well as a timeframe of when this information will be available. The state will work with MHPs and CWDs to ensure that these dates are appropriate and to provide guidance and support.

C. Enclosure 1, Part C – Projections

As in the previous progress report, counties are again asked to provide projections for the number of children they expect to serve by the next reporting period. Enter the numbers of confirmed subclass children and youth expected to receive ICC and IHBS for the next reporting period of March 1 through August 31, 2014. Data from the current reporting period and other relevant factors should be used to calculate projected numbers for the next reporting period of March 1 through August 31, 2014.

1. Enter the number of children and youth projected to be receiving ICC in Item 1(a).
2. Enter the number of children and youth projected to be receiving IHBS in Item 1(b).

The analysis of the first progress report for the May 15 through August 31, 2013, reporting period revealed that system, programmatic and capacity issues may have an effect on the provision of ICC and IHBS. In order to better identify and understand these factors, and to ensure that counties are successful in the implementation of ICC, IHBS, and TFC (once federally approved as a Medi-Cal service), the progress report (Enclosure 1, Part C) includes system and programmatic questions that will enable the State to monitor progress and provide counties with guidance and support.

Determining the Adequacy of Progress Reports

The progress report is an important and necessary tool for the State and counties to determine if children and youth who are subclass members have access to and receive ICC, IHBS, and TFC (once determined to be a Medi-Cal service). The State's goal is to provide support and guidance to counties, as well as monitor them, to ensure that children, youth, and their families receive effective, appropriate, and timely services that are consistent with the CPM. In order for the State to determine progress at the local level, and to provide the necessary support, the State will monitor the adequacy of the progress reports by taking the following actions:

A. Compare the number of subclass members reported to be receiving ICC and IHBS in the current report with the number of children projected to be receiving those services in the previous report, in order to determine possible capacity issues.

   For example, the number of subclass members reported to be receiving services in Enclosure 1(s), Part C, Item 1, of the May 1, 2014, progress report will be compared to the number of subclass members projected to receive those services, as reported in Enclosure 1, Part B, Item 1, on the October 18, 2013, progress report. This is intended to serve as a straightforward and transparent approach to measure progress toward meeting the mental health needs of children in the child welfare system.

B. Compare 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 are answered and data are provided as requested in the progress report.
   ii. If the county needs to increase service capacity sufficient to meet the known and potential demand.
   iii. If the county uses a collaborative approach to serve subclass members (e.g., co-located services, multidisciplinary meetings).
   iv. If the county has a method for analyzing local data on service delivery.

C. In the event that county progress reports insufficiently address the areas above, the State will work with counties via technical assistance calls, webinars, and direct outreach, as needed, to request and obtain necessary information.

D. To the extent a county's action and timelines will not result in timely provision of ICC and IHBS as medically necessary, DHCS and CDSS will provide additional targeted technical assistance and require the county to address these concerns through quality assurance tools, corrective action or other mechanisms.

Timeframes and Due Dates for Submitting Semi-Annual Progress Reports

The semi-annual progress reports are due on April 1 and October 1 each year. Due to the necessary revisions to the progress report template, the current report is due on May 1, 2014. Reporting periods and due dates for the progress reports are shown below for reference.

Report Period	Due Date
May 15 - August 31, 2013	October 18, 2013
September 1, 2013 – February 28, 2014	May 1, 2014
March 1 – August 31, 2014	October 1, 2014
September 1, 2014 – February 28, 2015	April 1, 2015
March 1 – August 31, 2015	October 1, 2015

The progress report should be jointly prepared by MHPs and CWDs and submitted electronically to either State agency at the e-mail address below:

California Department of Health Care Services at: KatieA@dhcs.ca.gov *or*
California Department of Social Services at KatieA@dss.ca.gov

DHCS and CDSS will continue to work with MHPs and CWDs on implementing ICC, IHBS, and upon federal approval, TFC, within the CPM framework.

If you have any questions regarding this information, please contact the DHCS, Mental Health Services Division, Litigation Support Unit, at (916) 650-6486 or KatieA@dhcs.ca.gov, or the CDSS, Resources Development and Training Support Bureau, at (916) 651-6600 or KatieA@dss.ca.gov.

Sincerely,

Original signed by:

Karen Baylor, PhD, LMFT
Deputy Director
Mental Health & Substance Use
Disorder Services
Department of Health Care Services

Original signed by:

Gregory E. Rose
Deputy Director
Children and Family Services Division
California Department of Social Services

Attachments

County: Trinity **Date:** 05/01/14

☑ May 1st Submission (September 1st through February 28th Reporting Period)

☐ October 1st Submission (March 1st through August 31st Reporting Period)

Name and Contact Information County Child Welfare Department Representative					
Name:	Julia Ashton-Boyd, LMFT				
Title:	Clinical Director				
Agency Name:	Trinity County Behavioral Services				
Address:	PO Box 1640				
City:	Weaverville	State:	CA	Zip Code:	96093
Phone:	530 623-8313	E-mail:	jashton-boyd@trinitycounty.org		

Name and Contact Information County Mental Health Department Representative					
Name:	Julia Ashton-Boyd, LMFT				
Title:	Clinical Director				
Agency Name:	Trinity County Behavioral Services				
Address:	PO Box 1640				
City:	Weaverville	State:	CA	Zip Code:	96093
Phone:	530 623-8313	E-mail:	jashton-boyd@trinitycounty.org		

County: Trinity **Date:** 05/01/14

If your answer below is blank or zero, please provide an explanation.

PART A: Potential Subclass Members Identified During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Next Steps/Timelines**
1	Potential Subclass Members	4	Follow subclass members who are open to services.
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	6	No further action is needed though potential subclass members can always be re-referred if symptoms become evident or changes warrant intervention.
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.	0	No subclass members identified have gone unevaluated as of this reporting
4	Potential subclass members who were unknown to the MHP during the reporting period.	0	All possible subclass members open to CPS have been indentified.

County: Trinity **Date:** 05/01/14

If your answer below is blank or zero, please provide an explanation.

PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Timelines**
1	Subclass Members	2	Monthly meeting with CPS
2	Receiving Intensive Care Coordination (ICC).	2	Monthly meeting with CPS
3	Receiving Intensive Home Based Services (IHBS).	2	Monthly meeting with CPS
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. *Do not include youth already counted in 2 or 3 above.*	0	None to report on
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC). *Do not include youth already counted in 2, 3, or 4*	0	None to report on
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).	1	Monthly meeting with CPS
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	0	None to report on
8	Declined to receive ICC or IHBS.	0	None to report on

County: Trinity **Date:** 05/01/14

If your answer below is blank or zero, please provide an explanation.

PART C: Projected Services			
Item #	**Service**	**Projected number of subclass members to be receiving services by August 31st**	**Strategy/Timeline Description** Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (a)	ICC	4	Via a monthly interactive meeting with CPS staff and BHS staff, Subclass members are identified, referred and assessed as needed. This process is completed within 30 days of retaining the individual and subsequently identifying need via pre screening tool at CPS.
1 (b)	IHBS	4	Via a monthly interactive meeting with CPS staff and BHS staff, Subclass members are identified, referred and assessed as needed. This process is completed within 30 days of retaining the individual and subsequently identifying need via pre screening tool at CPS.

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	Yes	No
County Contracting Process	Yes	No

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.

Utilizing professional staff in an extremely remote county can make recruitment difficult to locate and maintain both in the CPS and BHS agencies. As well, time away from the front line makes training somewhat difficult although collaborative trainings and webinars have been useful in such instances.

County: Trinity **Reporting Period:** 09/01/13-02/28/14 **Date Completed:** May 1, 2014

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the state is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county's child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Agency Leadership *Leadership's experience implementing family-centered services in a collaborative setting.*	Since the implementation of Katie A., CPS and BHS have tightened the interactivity regarding open youth in services and monitor monthly the progress as well as changing need to services and supports.	☑
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	Meetings are conducted with CPS staff as well as mental health providers and family members (and or other interested parties such as school personnel) to establish and monitor a working plan for the benefit of the youth in services as well as the family as a whole.	☑
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	While our collective strength as administrative staff in the small county is cordial, trained for the task and open to the changing landscape, it is true that we are all limited in number, stretched to capacity and working very hard to stay up to date on requirements and compliance.	☑
Service Array *Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.*	Service array includes to date, an appropriate level of cultural competency indicated for our area though some training would be useful in the area of Eastern practices. BHS is currently looking at Trauma Focused CBT to help address cases of extreme trauma. Evidence based practices include attachment theory, behavioral, Incredible Years trainings, Ther-a-play, Strategic family interventions and multicultural sensitivity.	☑

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	The Core Practice Model of family-centered principles offer more specific agency collaboration as well as family involvement with a focus on sharing the load and the successes. It is strength based leading the entire team to think in terms of success and the future. There is more oversight and communication as well as virtually no instances in which CPS or BHS are not informed readily of any changes or needs.	☑
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	Due to the remote county constraints, we have few cross cultural issues. No known cases currently involve any cross cultural family settings though both agencies have trainings to reflect identification and sensitivity to cultural needs. There is a county language line available to support individuals who may prefer to have their own "representative" present.	☑
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	CPS is currently running spreadsheets on the number of youth in services as a way of monitoring number/need. Outcomes for BHS are mainly in the adult population though we are eager to extend our tracking services of outcomes "strength based recovery" to all individuals in services.	☑
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	CPS provides supports to families in need to help access services, maintain family contact and BHS has transportation available to services to prevent disruption of counseling or communication with family participants.	☑