UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

KATIE A. et al.,	)	CASE NO. CV-02-05562 JAK-SH
	)	
Plaintiffs,	)	SPECIAL MASTER'S
	)	PROGRESS REPORT ON THE
v.	)	IMPLEMENTATION OF THE
	)	KATIE A. PLAN
	)	
	)	The Honorable John A. Kronstadt
DIANA BONTA, et al.,	)	Courtroom 750
	)	
Defendants.	)	

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PART ONE

INTRODUCTION

This Progress Report is submitted to the Court in accordance with the Katie A. Court's Order dated May 30, 2013, directing the Special Master to file a report 'with respect to progress in the case, including with respect to those matters described in the Letter and in its five-page exhibit and propose further dates for implementation and a status conference with respect to such efforts'.

Before filing the Progress Report with the Court, the Special Master provided the Parties with a copy of a draft Special Master Report on July 18, 2013, for their review and collective comments. The views expressed in the Special Master's report on the State's progress in implementing the Katie A. Implementation Plan, hereafter referred to as the Plan, are those of the Special Master only and do not necessarily represent the views of the various parties and partners involved in implementing the Katie A. Plan. The Parties are required to file a joint report as ordered by the Court "in which their collective and/or respective views are presented with respect to the Special Master's July 29, 2013, report, including as to what future dates should be set in this matter with respect to the implementation of the settlement agreement."

The Special Master is pleased to report that initial implementation of the Plan is off to a good start. The Departments of Health Care Services (DHCS) and Social Services (DSS) Katie A. Implementation Plan -Update May 29, 2013, Exhibit 2, together with the Special Master's request for a Continuance, Crt. Dkt. # 851-1, provided an excellent summary of implementation accomplishments since the March 13, 2013, hearing. These early and aggressive efforts at providing statewide orientations, technical assistance calls and information dissemination are commendable. Reports from the counties suggest that at least two counties are submitting claims for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), while other counties are working together to prepare for implementation.

There is additional good news. DHCS recently filled the Mental Health Division Chief, a position that has been vacant for over a year, and moved very quickly to replace the retiring Deputy Director of the Division of Mental Health Services, Vanessa Baird. The new Deputy Director, appointed by Governor Brown, is the former Mental Health

Director from San Luis Obispo County, Karen Baylor. Ms. Baylor will start in September, 2013. On September 5, 2013, the Special Master will meet with Toby Douglas, Director, DHCS and Will Lightbourne, Director, DSS as well as new Deputy Director and Chief of the Mental Health Division, to provide a status report, discuss their roles and relationship with Katie A. and to review goals and priorities for the upcoming year.

The Special Master wants to acknowledge the contributions of Dina Kokkos-Gonzales, Chief, who has done double duty at DHCS representing the Director on Katie A. since DHCS began to assume responsibility for the former Department of Mental Health, while at the same time continuing to carry her regular full time job as Chief for the Medi-Cal Rates-Waiver Unit. Ms. Kokkos-Gonzales recently changed positions to assume responsibility for the Program Policy and Quality Assurance Branch of the Mental Health Division. Without Dina's knowledge, skill, passion and desire to do the right thing, the Katie A. Implementation Plan would not have been successfully developed. The Special Master is pleased for her to have the support of the new Chief and Deputy Director.

The Parties, however, recognize that there remains significant work left to be done over the next three months to ensure these early trainings, technical assistance and promotion will lead to ICC and IHBS being provided to Subclass Members statewide. Strategies and activities to promote Statewide Adoption of the Core Practice Model (CPM) and the implementation of the remainder of the Plan continue to move forward. The implementation activities identified and prioritized by the State, identified later in the Special Master's report, reflect that effort. The Special Master has also made a number of recommendations (at pages 51 through 53) concerning primarily the provision of ICC and IHBS to subclass members and the implementation of Therapeutic Foster Care (TFC) as a Medi-Cal covered service.

The Purpose Of This Report

This report has two purposes: (1) inform the Court regarding the progress on the implementation the Katie A. Plan since the March 13, 2013, Court Hearing; and (2)

provide the Court with additional recommendations regarding the implementation of the Plan.

Katie A. Negotiation Workgroup Composition

The Negotiation Workgroup had its final meeting on April 18, 2013. During that meeting the Negotiation Workgroup reflected on its accomplishments and identified areas that needed to be addressed to ensure the success of Katie A. The Negotiation Workgroup provided the Parties advice and guidance regarding the role, expectations and membership for an advisory group to support and guide the implementation of Katie A. After considerable discussion between the Parties and Special Master, it was determined that setting a date for the first meeting of the Implementation Advisory Group would be premature at this time and will be addressed at a later stage of implementation. In the interim, emphasis has been placed on prioritizing bi-weekly meetings between the Parties and Special Master to maximize communication, planning and adapting implementation strategies and activities. The Special Master anticipates that a date will be set in the fall to convene the Implementation Advisory Group.

Organization of this Document

The remainder of this report to the Court is divided into the following parts. *Part Two* presents the Special Master's observations and comments on key milestones and other activities required by the Plan. The Special Master's Summary Comments and Findings are made at the conclusion of Part Two. *Part Three* presents the Special Master's Recommendations to the Court.

PART TWO
SPECIAL MASTER'S PROGRESS REPORT ON KATIE A. PLAN IMPLEMENTATION

The Special Master provides the Court with the following observation and comments on the progress being made in implementing the Court Approved Plans dated August 24, 2012, Crt. Dkt. No. 819-1, November 29, 2012, Crt. Dkt. No. 828-1 and Revised Plan Timelines, March 13, 2013, Crt. Dkt. No. 843.

In this Report, to better illustrate the progress being made in implementing the Plan, the Special Master has organized and aligned observations and comments with the Objectives, Intended Results, and Timelines identified in each of the six sections of Court approved Plan, Phases One and Two. The Special Master Report also elected not to duplicate similar or identical objectives, intended results or timelines/milestones that were specifically identified in both Phase One and Two sections of the Plan.

Section I. Shared Management Structure (SMS)

Objectives

1. *To establish a shared management structure to develop a shared vision and mission statement, policy and program direction, clear and consistent guidance and outcomes and accountability measures consistent with the CPM.*

2. *To create cross-system processes and procedures to support and manage the shared responsibility between DHCS and CDSS for engaging and delivering services to children with an open child welfare case that is consistent with the CPM at the county/local level.*

3. *To develop and provide models for local agencies to consider in order working more effectively together consistent with the CPM and that involves families and youth in decision-making.*

4. *To align policies and procedures and revise them jointly as needed to ensure a shared practice that is consistent, avoids duplication and provides a process for quickly resolving conflicts.*

5. *Develop and provide models for local departments to consider in order to work more effectively together.*

6. *To reduce barriers to services that arise due to a lack of understanding of federal and state rules and regulations and to eliminate local rules that impede access to care and the adoption of the CPM.*

7. *To ensure that the shared management approach purposefully builds productive collaboration with youth and their families and involves them in decision-making and in implementing solutions.*

ANTICIPATED RESULTS

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

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

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

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

Implementation Plan Timelines

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

Joint Management Taskforce (JMT):

The purpose of the Katie A. JMT is to develop recommendations for the establishment of a joint management structure (Shared Management Structure –SMS) between DHCS (including the former Department of Mental Health) and CDSS and to consult with the State agencies regarding the development of practice tools, training curriculum, practice improvement protocols and quality control systems. These activities are key parts of the implementation

of the Katie A. Settlement Agreement, including developing and supporting a CPM delivering child welfare and mental health services to children in or at risk of foster care placement.

<u>Core Practice Model Fiscal Taskforce (CPM):</u>

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

<u>Phase Two: Action Items for January 2013 and Beyond</u>

1. *Continue convening the JMT and CPM Fiscal Taskforces with representatives from each department and representatives from youth, parent partner, county, provider and advocacy groups.*

2. *By January 15, 2013, the JMT and the CPM Fiscal Taskforces will develop work plans consistent with the approved charters that will organize and sequence the work of the taskforces and result in the required reports to DHCS and CDSS.*

3. *The taskforces will meet for approximately six to eight months to accomplish the tasks articulated in the charters.*

4. *The JMT will develop recommendations for a Shared Management Structure (SMS) to support the establishment of formalized, county-level shared management structures between county child welfare and mental health agencies that also involves youth and their families in decision-making. The JMT will consider the recommendations set forth in the CPM Fiscal Taskforce's strategic plan:*

   a) to refine and/or augment the Implementation Plan activities;
   b) in developing its recommendations for the SMS; and
   c) in carrying out its obligations under the JMT Charter.

   The JMT will develop and provide a recommended mechanism to identify and measure local collaborative structures. This mechanism will also serve to identify any barriers that may prevent improved collaboration, the establishment of local collaborative structures, or access to services.

5. *The JMT shall consider using the counties' Readiness assessment tool as a mechanism for achieving the forgoing. The JMT shall ensure family and youth voice in this process, and utilize the findings to provide additional guidance or technical assistance relating to local agencies.*

6. *The JMT and/or SMS will consider the findings of the ACO Taskforce's study on utilization and timely access to care in developing its recommendations.*

7. *90 days after DHCS and CDSS receive the recommendations from each taskforce,* **Date Modified, Crt Dkt No. 843, recommendations received by November 1, 2013,** *the departments will evaluate the recommendations for possible adoption by the State and for inclusion in an ACL/ACIN to the counties describing options for the counties to consider.*

8. *DHCS and CDSS will issue communication statements and guidance regarding the state and county shared management structure recommendations and will make administrative changes necessary to successfully implement and support the SMS. The two departments will also promote the SMS and ACO Taskforce and CPM Fiscal strategies statewide.*

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

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

Special Master's Observation and Comments:

Although at this time a shared management structure has not been adopted, nor required, an exceptional and extensive level of collaboration and sharing of resources between DHCS and DSS has occurred resulting in significant accomplishments and progress in implementing the Plan. Staff from both departments have begun to operate as if they already are part of a shared management structure. DHCS and DSS staff meet multiple times each week in person and by phone to discuss the actions necessary to achieve the Objectives of the Plan, coordinate the departments' efforts in training and technical assistance, problem solving, aligning policy and procedures, issuing All County

Letters and Information Notices (ACL/ACIN) and managing the allocation of resources. The CDSS and DHCS Directors have been meeting on a biweekly basis to discuss Katie A. implementation efforts and activities. Without this level of collaborative effort between departments and staff at all levels, success in achieving the Objectives of the Agreement would be out of reach.

Joint Management Taskforce (JMT). The JMT formally has met three times since October, 2012, and received extensive and constructive comments regarding the formation of a state level SMS that would also be replicable at the county level. After reviewing input from JMT members and other stakeholders on possible models for a Shared Management Structure (SMS) to be implemented at the state and county levels, few SMS models were found to exist at the county level. The Co-Chairs of JMT, building on the feedback and reviewing existing county models, are developing a 'SMS function framework and model' for the JMT to review and build on in its preparation for making recommendations to CDSS and CDHCS for implementation. JMT has not formally meet since January, 2013, due to competing workload demands on the Co-Chairs during the last legislative session. JMT is scheduled to review a draft SMS framework and model in August, 2013. The JMT Taskforce appears on track to finalize its SMS recommendations for DHCS and DSS and meet the October, 2013, deadline.

ACO Taskforce. Although the ACO Taskforce is also referenced later in this report, Section VI, Data and Quality Assurance, the Special Master has chosen to include a discussion here as the ACO Taskforce is anticipated to merge with the JMT Taskforce in August, 2013, and complete the ACO Taskforce charge, as specified in its Charter, by October, 2013.

ACO Mapping Taskgroup, which will be providing reports and recommendations to the ACO Taskforce, has met three times since May, 2013. ACO Taskforce is on track to have a working 'resource map/inventory' of current DHCS and DSS methods of data collection, matching and sharing to support the CPM at the state, county and provider level by August, 2013. This map will identify client/case-level individualized data as well as system accountability and quality processes.

The Taskgroup has also developed a questionnaire, as required in the Plan, to be distributed to stakeholders and solicit ideas about what data relating to the class should DHCS and CDSS routinely produce and post. The approach for the stakeholder input has been slightly modified from what was initially contemplated in the Agreement. DHCS is currently charged by the legislature to develop a Performance Outcome System (POS) for all children and youth receiving mental health services eligible for Early, Periodic Screening, Diagnosis and Treatment (EPSDT) and has already received extensive feedback from stakeholders on data. There appears to be overlap in these data discussions; the POS requirement was not in place when the Plan was developed. The ACO Mapping or the ACO Taskforce will collaborate with the POS effort in order not to duplicate effort in soliciting feedback on relevant data to collect. At this point in time, fidelity to the CPM is one area not currently addressed in the POS effort. Although it is not clear if the results from the stakeholder input on data will be completed prior to August 1, 2013, the stakeholder feedback results will still be provided to the ACO Taskforce.

Additionally, the ACO Mapping Taskgroup will forward a set of recommendations regarding the ACO mapping products with the intent of fast tracking the ACO Taskforce in completing its charge according the ACO Charter by August 1, 2013.

CPM Task Force (CPM). Although the CPM Task Force is identified in Sections I, SMS and II, Core Components of the Plan, the Special Master has chosen to discuss it in this section of the Report because the review and adoption of the CPM Task Force recommendations and/or Strategic Plan will be the responsibility of DHCS/DSS SMS.

CPM Task Force, in March, 2013, refocused its efforts by implementing three CPM Subgroups in order to facilitate the development of products consistent with the CPM Charter. The Subgroups' tasks are: Group 1) recommend financial incentives and strategies to reduce administrative barriers and support implementation of the core practice model with a specific focus on financing training, coaching and supervision and options for integrated child welfare and mental health contracts; Group 2) recommend specific proposals to reduce out of home placements with a specific focus on using group homes primarily for short-term crisis stabilization, and the review the use of multi-agency

screening committees to provide for timely access to mental health services and support and to reduce use of, or reliance on, out of home care; and Group 3) recommend alternative resources for services or the non-federal share of EPSDT services with a specific focus on recommending strategies to reinvest cost savings from reduction in group home placements into mental health services, recommend strategies to maximize federal financial participation and identify other resources that might be used to provide services or the non-federal share of EPSDT and child welfare services.

After a series of meetings, the CPM Task Force Subgroups are in the process of developing their recommendations. The CPM Task Force will be meeting in August 2013, to review Subgroup recommendations, amend as necessary, and present to DHCS, CDSS and Plaintiffs, before September 30, 2013, a strategic plan or proposal to finance the implementation of the CPM.

Additionally, DHCS and CDSS are currently conducting an analysis of the Readiness Assessments and Service Delivery Plans to identify local collaborative structures, and to assess and plan for any training and technical needs.

In closing, plans appear to be underway for JMT to review and comment on CPM Task Force recommendations or strategic plan, to finalize and adopt a SMS, to assume ACO Taskforce responsibilities and to make recommendations to DHCS and DSS on SMS and ACO requirements in order to meet the October, 2013, deadline.

Section II. Core Components

Objectives

1. *To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines family and youth engagement, service access, planning, delivery and transition into a coherent and all-inclusive approach referred to as CPM.*

2. *To address the need for subclass members with more intensive needs to receive medically necessary mental health services that include IHBS, ICC and TFC.*

3. *To develop and disseminate a Medi-Cal IHBS and ICC Services Documentation Manual and CPM Guide.*

4. *To support the development and delivery of a service structure and a fiscal system that supports the core practices and services model.*

5. *To establish a CPM Fiscal Taskforce to guide and inform implementation to the fullest extent practicable consistent with the time available, that focuses on doable, achievable and fiscally sound incentives to deliver IHBS, ICC and TFC within the Core Practice Model framework and reduce the use of group homes and other institutional placements.*

6. *To develop a CPM Guide that is easily understood by multi-agency teams and stakeholders.*

7. *To identify components of TFC services/model program that are Medi-Cal reimbursable and components that are covered by Title IV-E, and to determine all steps necessary to implement the services/model.*

8. *To foster a statewide practice model where representatives of family and youth organizations are included in opportunities to advise administrators, contribute to policy development, provide systematic feedback on agency performance, and participate in staff development and program evaluation.*

ANTICIPATED RESULTS

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

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

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

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

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

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

Phase One Timeframe: July 2012 – December 2012

A. *Produce the Documentation Manual*

1. *By August 6, 2012, DHCS will complete an initial draft of the Documentation Manual and submit to the Documentation Manual Writing Team and subgroup for review.*
2. *By September 17, 2012 the subgroup, Documentation Manual Writing Team, CDSS and DHCS will have reviewed the initial draft and submitted it to the Core Components IPT and the Negotiation Workgroup for review.*
3. *By September 30, 2012, CDSS and DHCS will review and consider the input and feedback from the Negotiation Workgroup and will post the draft for 30-day public comment.*
4. *By November 15, 2012, the Core Components IPT will submit the final draft to the Negotiation Workgroup for final review.*
5. *By November 30, 2012 DHCS/CDSS ,**Date Modified, Crt. Dkt. No. 843 to March 1, 2013,** will release the Documentation Manual and will issue an ACL/Notice to all County Mental Health Plans and County Social Services Directors that includes background information regarding the Katie A. Settlement, the Documentation Manual, the specific date for commencement of delivery and claiming of IHBS and ICC, initial training dates and information on how to access technical assistance and Web page updates. It will also be posted on the DHCS and CDSS websites.*
6. *By December 31, 2012,**Date Modified, Crt. Dkt. No. 843 to March 31, 2013,** CDSS and DHCS will have provided a basic orientation and will have released a scheduled of future webinars and regional trainings. DHCS will also be prepared to provide technical assistance to answer questions by counties, providers and stakeholders regarding the Documentation Manual.*

B. *Develop a Core Practice Model Guide and Model Adoption*

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

2. *By September 30, 2012, the CPM Guide Subgroup, CDSS and DHCS will submit the initial draft of the CPM Guide to the Negotiation Workgroup for review.*
3. *By October 30, 2012, CDSS and DHCS will release the draft CPM Guide for 30-day public comment.*
4. *By November 30, 2012, the CPM Guide Subgroup, CDSS and DHCS will have received public comment and feedback on the CPM Guide.*
5. *By December 31, 2012, the Core Component IPT will review and consider feedback received for incorporation and submit the final CPM Guide to the Negotiation Workgroup.*
6. CDSS and DHCS, in consultation with the Negotiation Workgroup, shall establish and charter the CPM Fiscal Taskforce. The Taskforce will begin meeting no later than October 31, 2012.
7. CDSS and DHCS shall establish and charter the JMT. The JMT will begin meeting no later than October 31, 2012.

Phase Two: Action Items for January 2013 and Beyond

1. *By January 31, 2013,**Date Modified, Crt. Dkt. No. 843 to March 31, 2013,** DHCS and CDSS will issue an ACL/ACIN to all County MHPs and CSS Directors which will include background information regarding the Katie A. Settlement, purpose and goals for the CPM Guide and timeline for statewide implementation and initial and ongoing expectations for its use. The ACL/ACIN will emphasize the importance of engaging families and youth in decision-making at the practice, program, and policy levels.*

2. *By January 31, **2013, Date Modified, Crt. Dkt. No. 843 to March 1, 2013**, DHCS and CDSS will release the final CPM Guide for implementation.*

3. *By January 31, 2013, **Date Modified, Crt. Dkt. No. 843 to March 1, 2013,** DHCS and CDSS will have released a schedule for basic orientation and training for the CPM Guide. CDSS will contract to provide the initial training and will also be prepared to provide technical assistance to answer questions by counties, providers and other stakeholders regarding the CPM Guide.*

4. *DHCS and CDSS will consult with the JMT on their obligation to develop and endorse practice tools, training curriculum, practice improvement protocols and quality review systems to support the shared CPM in order to support family and youth engagement and decision-making, service integration and coordination for child welfare and mental health services for subclass/class members.*

5. *By January 31, 2013, **Date Modified, Crt. Dkt. No. 843 to March 31, 2013,** develop basic orientation and adoption strategies for the CPM guide in order to promote understanding by stakeholders (State partners, Administrative Office of the Courts (AOC), counties and providers, beneficiaries and family members)*

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

6. *By January 31, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 1, 2013*** *issue an ACL/ACIN to describe IHBS and ICC services within a CPM approach.*

7. *By September 30, 2013, the CPM Fiscal Taskforce will submit a strategic plan or proposal to finance the implementation of the CPM. The recommendations shall include fiscally sound incentives to county agencies and shall be aligned with the Continuum of Care Reform efforts and recommendations to the extent possible. The recommendations must support the following desired outcomes:*

    a) *Reduction in administrative barriers;*
    b) *Statewide delivery of the CPM;*
    c) *Support training and coaching activities necessary to rollout the CPM and to support parent and youth participation in all aspects of implementation (e.g., child care, transportation and meeting attendance, etc.);*
    d) *Delivery of ICC and IHBS to subclass members within the CPM framework; and*
    e) *Reduction in the use of group homes and institutional placements.*

8. *By December 31, 2013, TFC (once determined to be a Medi-Cal covered service, but no later than December 31, 2013) will be addressed in the CPM Guide through an update or addendum.*

7. *Continuing through January 2013, the TFC Consultants will meet with DHCS, CDSS, the Special Master and plaintiffs' counsel, to provide research and information on other state models and provide a recommended model for California.*

8. *By January 31, 2013, DHCS and CDSS shall determine if any state law changes are necessary to implement TFC in California, and, if so, propose spot legislation in the regular legislative session by February 22, 2013 to enact such necessary changes.*

9. *By February 28, 2013, DHCS, CDSS and plaintiffs' counsel shall provide the model to the TFC subgroup for review.*

10. *By February 28, 2013, DHCS and CDSS shall reconvene the TFC Subgroup and the consultants to discuss the model. Continuing through May 2013, CDSS, and DHCS and plaintiffs' counsel will meet and continue to work with the consultants and the TFC Subgroup to modify and adopt a proposed TFC model to implement in California.*

11. By June 30, 2013, the following activities will be completed:

a) Identify components of TFC services/model program that are Medi-Cal reimbursable and any components that are covered by Title IV-E.

b) Identify costs of the TFC program for which Title IV-E funds may be claimed.

c) Determine all steps necessary to implement the services/model, including any necessary federal approvals (e.g. Medicaid State Plan Amendment (SPA) and Title IV-E SPA).

12. By July 31, 2013, submit any initial requests for federal approvals necessary, which may include submission of a SPA.

13. By September 30, 2013, provide first draft of the TFC Addendum to the Documentation Manual to the subgroup and Negotiation Workgroup and review and consider incorporating input and feedback.

14. Upon securing any necessary federal approvals, and with a target date by November 30, 2013, provide the final draft of the TFC update or addendum of the Documentation Manual and the CPM Guide to the TFC Subgroup and review and consider incorporating feedback received.

15. Upon securing any necessary federal approvals, and with a target date by December 31, 2013, provide final draft to the Negotiation Workgroup for review and consider incorporating feedback received.

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

17. Contingent upon the outcome of activities 14, 15 and 16 above, TFC services will be made available statewide on January 1, 2014.

Special Master's Observation and Comments:

Issue ACL/ACIN. DSS and DHCS jointly develop All County Letters (ACLs) and All County Information Notices (ACINs). Since the March 13, 2013, status conference, the DHCS and DSS have issued five ACLs and/or ACINs. These letters formally released the CPM Guide and Documentation Manual, provided claiming instructions,

instructed counties to complete a Readiness Assessment and Service Delivery Plan and provided information to help counties successfully engage with families and youth.

Technical Assistance and Regional Orientation/Trainings. DHCS and DSS are to be commended for moving aggressively, beginning weekly technical assistance calls and scheduling regional trainings within ten days following the issuing of the Medi-Cal Manual and CPM Guide. Initially, these technical assistance calls focused on County MHP and County Child Welfare. Calls have continued weekly since March 1, 2013, and now include providers; each call has fifty to a hundred individuals on the call. Not all counties have participated in the calls. The State is aware of those counties who did not participate in the calls and will be offering additional training and technical assistance for all counties on ICC and IHBS implementation. Additionally, the results from the State's analysis of the counties' Readiness Assessment and Service Plans will provide the basis for a more focused and intentional technical assistance plan.

In general, the questions from counties and providers have been focused on billing and documentation of ICC and IHBS and less on CPM. Questions have also occurred regarding funding for implementation from county child welfare and mental health. The State has attempted to aggressively reach out and provide technical assistance to county child welfare, mental health and providers, a challenging job over the phone considering the diversity in the audience on a call. Specifically, considering the knowledge, roles and interests of the participants on the call, it has been a thought provoking task for the State to meet everyone's needs. The State is in the process of refocusing these calls to address specific technical areas. The Special Master recognizes these were early efforts and acknowledges the refinement and re-focusing that is occurring to meet the needs of the counties and providers, especially in the implementation of ICC and IHBS. In response to County requests, DHCS and DSS are currently planning three more targeted orientations.

DSS and DHCS completed eight orientation meetings (four more orientations than what is required in the Implementation Plan) in San Jose, Davis, Fresno, Redding, Pasadena, Anaheim, Sacramento and Riverside. The orientations were presented to over seven hundred people throughout the state. The orientations included background on the

Katie A. lawsuit, purpose and goals of the CPM guide and emphasis on the importance of the engaging families and youth. Families and youth were involved with each of the orientation presentations. The face to face orientations have proven to be more effective than the early technical assistance calls in transferring knowledge and engaging counties and providers in understanding ICC, IHBS and CPM, and providing a question and answer session to promote implementation.

In response to requests and questions asked during the orientations and technical calls, DHCS and DSS are developing a table to differentiate between Therapeutic Behavioral Services (TBS), Targeted Case Management (TCM) Services, Intensive Care Coordination (ICC), California Wraparound, and Intensive Home Behavioral Services (IHBS). This will be very constructive and will answer questions from the field. The end result of this effort should improve the field's understanding of what is billable and increase the delivery of ICC and IHBS. DHCS and DSS are in the process of developing responses to Frequently Asked Questions (FAQs) for posting on the State webpages and will be producing an orientation webinar accessible on their webpages. One of the FAQs will clarify claiming/billing questions for subclass members on when to provide ICC and IHBS, as medically necessary.

In summary, the state has accomplished a great deal since the March 13, 2013, Court hearing. Building on the above knowledge gained regarding core practice training needs and the results from the State's analysis of the counties' Readiness Assessment and Service Plans, the State will sharpen its focus on what is needed and identify individual and clusters of counties needing, and requesting, additional technical support and training.

TFC Coverage and Model. The Special Master is pleased to report the TFC Subgroup met with the national consultants on May 16 and June 21, 2013, to review the Draft TFC Model and make further refinements to the proposed model. DHCS/DSS, to ensure a parent perspective is included in developing the proposed TFC Model, have recruited a foster parent to join the subgroup. The TFC Subgroup continues to be missing a youth participant.

Significant progress has been made. At this time, DHCS is exploring the vehicle (State Plan Amendment or 1915(i), Home and Community Based Services State Plan Option) through which it will seek federal approval for TFC DHCS will commence preliminary communication with the Centers for Medicare and Medicaid Services (CMS) in an effort to minimize barriers and accelerate federal approval. At this time, it is thought that a TFC concept paper would be shared with CMS for feedback in advance of submitting a formal request. DHCS, by July 31, 2013, as specified in the Plan, will submit an initial written communication regarding the future request for federal approval of TFC, with a follow-up submission of a concept paper to CMS by August 31, 2013. The Parties and the State remain optimistic that a formal response from CMS can occur by January 1, 2014.

To further expedite the finalization of key implementation issues with TFC over the next weeks, a series of calls and meetings are being set with key stakeholders to address county consistency, rate setting, labor and income issues and resolving the question of a case rate (monthly rate per consumer including TFC and other mental health services) or a daily per diem rate for TFC services with other mental health services continuing to be billed separately.

Section III. Family and Youth Involvement

OBJECTIVES

1. *To ensure that family and youth involvement is prioritized and integrated at the practice, program and system levels and phases of implementation as envisioned by the CPM.*

2. *To ensure DHCS and CDSS utilize family and youth partnerships to assist with identifying the appropriate orientation, training, and other strategies needed to strengthen and/or change the State and local systems to meet the terms of the Settlement Agreement.*

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

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

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.

IMPLEMENTATION ACTIVITIES AND TIMELINES

Phase One: July 2012 – December 2012

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

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

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

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

Phase Two: Action Items for January 2013 and Beyond

1. *By January 31, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 15, 2013,*** *outreach, recruit and actively engage youth participation in all aspects of the implementation process.*

2. *By January 31, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 15, 2013,*** *draft a joint ACL/ACIN to encourage and support specific strategies for involving family and youth, which may include, but are not limited to:*

   a) *Provide specific orientation and training, as well as ongoing assistance to parents regarding administrative, budgetary, and other elements of in planning social services. Support, encourage and value parents, youth and communities agencies at meetings.*

b) Provide contract and community grant opportunities with parent and youth advocacy groups or community-based organizations that employ parents or youth to develop and direct a process that ensures sustained and thoughtful participation in planning.

c) Build collaborative working relationships by reaching out to parent and youth organizations, as well as agencies that work with parents and youth (e.g., schools, child care centers) to recommend parents and youth to participate in 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.

Special Master's Observation and Comments:

Family and Youth Involvement. Since the March 13, 2013, Court Hearing, two youth have been identified who are available to participate in a wide range of Katie A. implementation activities, including participating in the Katie A. Advisory group. The youth representatives bring the interest and perspective drawn from experiencing the foster care, mental health and educational systems. A number of parents have been identified who are available to participate in the Katie A. Advisory group. DHCS issued

the joint ACL/ACIN, as specified in the Plan, regarding family and youth involvement and engagement strategies on May 21, 2013.

Each of the eight regional orientations included two segments dedicated to hearing the youth and family voice. Youth and family members were recruited to present side-by-side with the state panel to tell their story and to describe the impact of the CPM and Client Family Teaming. Evaluations from the regional orientations indicated the inclusion of the youth and family voice in the orientations made it real and added value.

The State's preliminary analysis of the Readiness Assessments and Service Delivery Plans indicates many counties are struggling with recruitment of youth and family members to participate in stakeholder functions. The state analysis is not yet complete but the DHCS and DSS are planning to recommend technical assistance, probably through a webinar, on strategies to recruit youth and family members.

Additionally, the State is aware that its own outreach to parents and youth needs to be increased, specifically in offering forums for question and answers regarding implementation and training, as they have for counties and providers, but organized specifically for parents and youth,

Section IV. Service Delivery and Rollout

OBJECTIVES

1. *To develop and guide implementation of a process or processes to identify/screen, refer and firmly link class members to services*

2. *To ensure statewide implementation of ICC and IHBS. County mental health and social services agencies will jointly develop and submit an ICC and IHBS service delivery plan to the State.*

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

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

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

6. *To ensure a forum is available to provide timely response to county and provider reports of challenges in implementing ICC and IHBS services.*

7. *To coordinate the work of the JMT, ACO and CPM Fiscal taskforces to ensure that service delivery is supported, and improved over time by governance, quality/accountability, and fiscal systems and structures that are consistent with the CPM values, goals and components.*

ANTICIPATED RESULTS

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

IMPLEMENTATION ACTIVITIES AND TIMELINES

Phase One Timeframe: July 2012 – December 2012

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

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

Phase Two: Action Items for January 2013 and Beyond

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

1. *DHCS and CDSS will provide a forum for problem resolution including, but not limited to:*
   a) *EPSDT billing or claiming barriers for MHPs and their contractors and make recommendations to DHCS and CDSS on steps to resolve.*
   b) *Addressing barriers related to sharing confidential juvenile court information with non-professionals.*
   c) *Clarifying the parameters and legal basis for counties to share child welfare and mental health data and qualitative information related to class and subclass members.*

8. *Provide consultation and guidance for counties to determine subclass members for whom IHBS and ICC (and TFC, once determined to be a Medi-Cal covered service, but no later than December 31, 2013) services are medically necessary. A Katie A. Subclass Certification Form (in the Documentation Manual) will include criteria for identifying subclass members.*

9. *By January 31, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 31, 2013,*** *DHCS and CDSS will issue an ACL/ACIN to inform counties of the criteria and selection process for designating Learning Collaborative Counties (previously referred to as Early Implementer Counties) with input from the Negotiation Workgroup, CMHDA, CWDA, and the family and youth partners.*

10. *By March 1, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 15, 2013, due back to state by May 15, 2013,*** *the MHPs and child welfare agencies will have lead responsibility for jointly completing a readiness assessment tool and developing a service delivery plan. Nothing in this requirement, or in the service delivery plan or planning process, is intended to impede timely access, or waive a child's entitlement to medically necessary Specialty Mental Health Services as required by law or the Settlement Agreement.*

    a) *Readiness Assessment Tool*
       For the readiness assessment tool, MHPs and child welfare agencies will be encouraged to seek stakeholder input, and will be encouraged to incorporate input of youth, families and parent partners. The elements of the readiness assessment tool will include, but are not limited to:
       i. *Organizational leadership*
       ii. *Systems and interagency collaboration*

iii. Systems capacity
iv. Service array
v. Children, youth and families
vi. Fiscal funding resources

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

i. A needs assessment that will describe how the county will identify members of the subclass and screen, assess or otherwise determine their needs. The needs assessment will include a subclass analysis and identify existing services provided to the subclass.
ii. An analysis of how ICC and IHBS services will be delivered in a timely manner to eligible youth.
iii. Identification of the strength of the connectivity and collaboration between child welfare and mental health to administer an array of services to support IHBS, ICC and TFC.
iv. A description of stakeholder involvement in the implementation of ICC, IHBS and TFC, specifically how youth and families will be continuously involved in implementation, policy development, practice issues and continuous quality improvement.
v. An analysis to identify gaps between the needs of the subclass and services provided, and if such a gap is identified, a plan to address it.
vi. A services capacity assessment to determine the capacity of the MHP to provide ICC and IHBS to subclass members.

c) <u>Semi-Annual Progress Reports</u>
Beginning August 1, 2013, ***Date Modified, Crt. Dkt. No. 843 to October 1, 2013,*** *county mental health and child welfare agencies will jointly prepare and submit implementation progress reports on a semi-annual basis which will include:*

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

11. DHCS and CDSS will consult with counties to ensure that each county has an ICC and IHBS service delivery plan that is capable of achieving the Objectives above. Establish and communicate guidance or standards for what is sufficient process or results for this action item.

12. By April 30, 2013, ***Date Modified, Crt. Dkt. No. 843 to August 1, 2013,*** *select Learning Collaborative Counties that will adopt the CPM and provide feedback, to identify barriers and determine potential areas for improvement to support continued rollout and promote statewide CPM adoption. The selection process for designating Learning Collaborative Counties will be based on a foundation of implementation science. The concept of implementation science allows for the appropriate grouping of peer counties based on their various levels of development/readiness, with special allowance for county size. This model allows counties to transfer "lessons learned" during the phases of implementation, how to build and deliver the services county wide and model the strong collaboration between mental health and child welfare for other counties.*

13. By June 1, 2013 ***Date Modified, Crt. Dkt. No. 843 to August 1, 2013,*** *(and by April 30, 2014 for TFC, once determined to be a Medi-Cal covered service) DHCS and CDSS will complete a statewide analysis of the information provided by the counties as described in activity D above to (1) develop and model child welfare and mental health service delivery systems based on the CPM, (2) identify opportunities for and challenges to providing full access to services for subclass members and broad, statewide application of the CPM, and (3) provide an initial framework for an ongoing process of communication, engagement, collaboration, and problem-solving with county partners and other stakeholders.*

14. By June 30, 2013, ***Date Modified, Crt. Dkt. No 843 to August 1, 2013,*** *the county-selected Implementation Teams comprised of county child welfare, mental health, youth and family support partners and providers will be required to participate as part of the learning collaborative process for implementing the CPM. The Learning Collaborative Counties will be grouped based on their level of readiness, and will be oriented to the coaching materials and receive joint training and technical assistance in exchange for providing feedback about the implementation of the CPM training, coaching and other materials developed by the MDT training subgroup.*

15. DHCS and CDSS are committed to continuously:

a) Identifying state supportive activities, resources, incentives, sanctions and guidance that may be available to increase access to ICC, IHBS and TFC.

b) Developing an ongoing state, county, provider and parent and youth problem-solving, opportunity-developing dialog/process focused on expanding service capacity at the county level.

c) Establishing program priorities and developing population-specific strategies including geographic, resource, training, and workforce challenges for increasing access to services over time.

d) Setting annual or bi-annual performance goals or targets based on appropriate localized conditions or circumstances.

e) Regularly communicating with stakeholders and developing solutions to identify challenges.

f) Borrowing/sharing resources from other successful efforts to adopt CPM or similar system of care/ wraparound methods.

g) Seeking out federal and private resources to support this effort.

h) Exploring ways to develop and/or support centers of excellence that can provide strategic, logistic, and technical support for developing and sustaining CPM systems and core elements. Such organizations could also address workforce challenges.

16. Additional training and technical assistance guidance is referenced in Section V.

17. Continue to utilize feedback from Early Implementer Counties of the CPM to determine potential areas for improvement and develop a plan to disseminate and promote statewide adoption of the CPM using lessons learned from Early Implementer Counties.

Special Master's Observation and Comments:

Service Delivery Rollout. DHCS and DSS have and will continue to dedicate an extensive amount of resources and staff time to ensure this section is successfully implemented. At this initial stage of implementing ICC, IHBS and CPM, engaging and focusing the counties and providers on the implementation requirement/activities is critical. The activities and objectives in this section require the state, in partnership with counties and providers, to develop intentionality and focus in executing the implementation of this section of the Plan. The State team is committed to this undertaking and is moving forward. The Plaintiffs, State team and the Special Master have scheduled biweekly meeting times, beginning June 28, 2013, paying particular attention to the requirements, tasks, opportunities and challenges that emerge in the implementation of this section of the Plan. Parties are committed to active communication and problem solving.

Forum for Problem Resolution. As discussed in Section II, Core Components, of this report, the DHCS and DSS have been pro-active in providing forums for problem resolution for counties and providers around the implementation of ICC, IHBS and to a lesser degree CPM. Implementation of CPM has not been the primary concern of the counties at this time. Forums include the eight regional trainings, trainings/orientations at statewide meetings, weekly technical assistance calls and counties individually submitting questions to the state via the web. More recently, DHCS and DSS have added ICC and IHBS claiming to the weekly technical assistance calls as a standing agenda item until it appears counties and providers fully understand how to bill/claim ICC and IHBS. The state intends to continue these forums for the foreseeable future and in some cases will focus forums on specific issues.

The Special Master would like to see the State leadership engage with CMHDA and CWDA leadership to collaboratively present on the Implementation of Katie A. at key stakeholder meetings, e.g.. California Alliance of Children and Family Services, Associations Children's Committee, Beyond the Bench, Child Welfare Council, California Mental Health Advocates for Children and Youth, Annual Association Meetings. Such an undertaking would underscore the significance of Katie A. and reinforce the importance of succeeding in the statewide rollout of ICC, IHBS and CPM.

Learning Collaborative Counties. On May 29, 2013, as required by the Plan, DSS distributed an ACIN regarding the criteria and selection process for designating Learning Collaborative Counties. The State received overwhelming interest from counties in becoming Learning Collaborative Counties. Twenty or more counties expressed interest and at this time seventeen have confirmed they would like to be considered. Counties have been grouped to represent a wide diversity of levels of readiness and service capacity. The State expects to send letters confirming the seventeen counties' status as Learning Collaborative Counties no later than July 31, 2013, with expectation that the first meeting will be by conference call the week of August 12, 2013. The Special Master anticipates the first 'in person' Learning Collaborative Counties meeting will occur before October, 2013.

Readiness Assessment Tool and Service Delivery Plan. On March 15, 2013, DHCS and DSS issued an ACIN, as required by the Plan, providing instructions for completing the Readiness Assessment Tool and Service Delivery Plan. At this time, fifty-four counties have submitted both the Readiness Assessment and Service Delivery Plan and four counties submitted only the Readiness Assessment. The State is currently following up on the missing counties' Readiness Assessments and Service Plans. DHCS and DSS are in the process of collecting and finalizing information about counties' capacity to deliver ICC, IHBS and CPM, as well as other services through the Service Delivery Plan and the Readiness Assessment. The information from the Service Delivery Plan included: needs assessment, direct delivery of services, gap analysis, service capacity assessment, and stakeholder involvement. The information from the Readiness Assessment included: agency leadership, systems and interagency collaboration, systems capacity, service array, involvement of children youth and family, cultural responsiveness, outcomes and evaluation, and fiscal resources.

DHCS and DSS staff are continuing analysis of the Readiness Assessment and Service Delivery Plans and will have the initial report completed by August 1, 2013. The preliminary analysis of the counties' Readiness Assessment and Service Delivery Plan indicates it is necessary for the DHCS and DSS to provide additional technical assistance to some specific counties on identification of the subclass. The Plan specified that DHCS and DSS will consult with counties to ensure that each county has an ICC and IHBS service delivery plan that is capable of achieving the Objectives identified in Section IV, Service Delivery Rollout. In addition, the Plan calls for the State to establish and communicate guidance or standards for what is a sufficient process or results for this action item: Readiness Assessment and Service Delivery Plan. In order to accomplish the Objectives of this section of the Plan, the state may need to use the additional activities and actions, specifically activity fifteen in the Plan (see page 27 in this Report), 'Identifying state supportive activities, resources, incentives, sanctions and guidance that may be available to increase access to ICC, IHBS and TFC.' Activity fifteen provides a range of supportive and targeted strategy options to support the State in its implementation of the Plan.

Complete Statewide Analysis of Readiness Assessment and Service Delivery Plans. DHCS and DSS are actively working on completing a statewide analysis of the information provided by the counties, as the Plan requires, to (1) develop and model child welfare and mental health service delivery systems based on the CPM, (2) identify opportunities and challenges to providing full access to services for subclass members and broad, statewide application of the CPM, and (3) provide an initial framework for an ongoing process of communication, engagement, collaboration, and problem-solving with county partners and other stakeholders. The Plan called for this to be completed by August 1, 2013, but considering the complexity of the analysis of the Readiness Assessment and Service Delivery Plans, the state has indicated that the final statewide analysis will not be complete until mid-August.

Semi-Annual Progress Reports. Beginning October 1, 2013, county mental health and child welfare agencies are required to jointly prepare and submit implementation progress reports on a semi-annual basis which will include: reporting on mental health service utilization, action plans to address areas identified for improvement and specified need for technical assistance or state support. DHCS and DSS are in the process of issuing an ACL no later than August 15, 2013, to instruct counties on the content of the progress reports which are due to DHCS in October, 2013. The results from the DHCS and DSS analysis of the counties' Readiness Assessment and Service Delivery Plan is expected to inform the counties on what should be minimally included in their Semi-Annual Progress Reports.

ICC and IHBS Implementation. DHCS and DSS are preparing an FAQ to be posted on their web page emphasizing the State's expectations for counties, including the requirement that all new children entering the system receive ICC and, if medically necessary, IHBS. The Special Master anticipates the FAQ posting would occur by August 1, 2013, and also be a standing agenda item on the county and provider weekly technical assistance calls, on or before August 1, 2013. The Special Master will be recommending additional language for the FAQ, or other options, to further clarify to counties and providers when subclass members shall receive ICC and IHBS, as medically

necessary. The state has also committed to seek input on the FAQ draft from plaintiffs' counsel prior to finalizing and posting the FAQ. It is the Special Master's observations and conclusion that there is continuing confusion around this issue. This is evident by the questions being asked directly or indirectly in county and provider technical assistance calls, orientations, trainings or other less formal meetings, and is also reflected in the early analysis of the Service Delivery Plans. Clarifying this issue in the most comprehensive and timely way is essential to expedite access of subclass members to ICC and IHBS, as medically necessary.

In summary, the State and counties should be acknowledged for the significant amount of time, energy and thought that has gone into successfully fulfilling the initial requirements of Service Delivery Rollout. As discussed earlier in this section, the Special Master is impressed with commitment and focus the State team has given to fully and completely address all the service delivery specifics in the Plan. In spite of the competing demands, which probably seemed overwhelming, the State is moving ahead by:

- Finalizing its analysis of the Readiness Assessment and Service Delivery Plan;
- Preparing verbal and written responses to the counties regarding the Readiness Assessments and Service Delivery Plans;
- Drafting critical FAQs to expedite ICC and IHBS implementation;
- Maintaining and promoting forums for problem solving;
- Providing counties with expectations for submitting Semi-Annual Progress Reports;
- Launching the Learning Collaborative County strategy.

At this critical time, the Special Master and Plaintiffs are intending to work closely with the State to identify what are the key areas of the Service Delivery Plans and Readiness Assessments where additional information and/or clarification is needed.

V. Training and Technical Assistance

OBJECTIVES

1. *To develop cross-system training and coaching curriculum and educational materials for child welfare and mental health staff, youth, family support partners, providers and parents/caregivers and to include families/caregivers in the development of training.*

2 *To develop joint training and/or technical support for a child welfare and mental health leadership and workforce that is in line with the CPM to support the integration and coordination of child welfare and mental health leadership and workforces in order to deliver consistent and quality services that include families an d youth in the training process.*

3. *To clarify and provide guidance on state and federal laws as needed to implement the Settlement Agreement so that counties, providers, families and youth, and other stakeholders can understand and consistently apply them.*

4. *To develop and endorse practice tools, training and coaching curriculum, practice improvement protocols and quality control systems to support the shared CPM in order to support service integration and/or coordination for mental health services for class members.*

5. *To ensure family and youth involvement is included in all aspects of training and support development and activities.*

ANTICIPATED RESULTS

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

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

Technical assistance and training products including, but not limited to, practice tools, cross-system training/coaching curricula, practice improvement protocols, and quality control systems will support a shared Core Practice Model.

Training for the Documentation Manual will be integrated with the training on the Core Practice Model Guide. CDSS and DHCS, in consultation with the Joint Management Taskforce, will endorse training products.

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

IMPLEMENTATION ACTIVITIES AND TIMELINES

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

Phase One: July 2012 – December 2012

1. *By September 2012, CDSS will initiate a request to the Statewide Training and Education Committee (STEC), which is the CDSS process for developing and coordinating all Statewide Training for county social workers. The STEC process will convene a training subgroup comprised of parent partners, providers, foster parents, mental and social work staff, clinicians, former foster youth, Court Appointed Special Advocates and other stakeholders set timelines for development of training and curriculum products.*

2. *By December 31, 2012 DHCS,* ***Did not get addressed by crt doc….*** *will instruct appropriate State and County auditors to follow the billing and documentation guidelines in order to ensure appropriate and consistent audit standards are being utilized to review provider billing claims.*

3. *Beginning December 31, 2012,* ***Date Modified, Crt. Dkt. No. 843 to March 31, 2013,*** *and ongoing, DHCS and CDSS will provide training for county MHPs and specialty mental health providers regarding the Documentation Manual and Medi-Cal coverage and billing of IHBS and ICC.*
   a) Training will coincide with the release of the Documentation Manual.
   b) Trainings will be targeted to reach MHPs and providers. Plans for where the trainings will occur, who will conduct the trainings, what materials will be used and additional pertinent information will be drafted by October 31, 2012.
   c) Presentation materials and webinars will be posted on both the DHCS and CDSS websites.
   d) Additional technical assistance needs (i.e. webinars, in-person trainings, or conference calls/meetings) will be determined following the manual release.
   e) The Documentation Guide training will be coordinated with the Core Practice Model Guide training.

Phase Two: Action Items for January 2013 and Beyond

1. *The statewide training plan for the adoption of the Documentation Manual includes the following:*
    a) *By January 16, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 31, 2013,*** *Documentation Manual training materials will be drafted.*
    b) *Starting January 16, 2013* ***Date Modified, Crt. Dkt. No. 843 to March 31, 2013,*** *DHCS will host weekly technical assistance calls to address questions, needs regarding the use of the Documentation Manual and to set time aside for CDSS to answer questions related to the core practice model following the release of the CPM Guide.*
    c) *By February 1, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 31, 2013,*** *DHCS will establish a webpage for Documentation Manual frequently asked questions and update the information on a monthly basis.*
    d) *By February 28, 2013,* ***Date Modified, Crt. Dkt. No. 843 to April 28, 2013,*** *CDSS will contract to facilitate the identification of locations for four regional trainings (Los Angeles, Bay, Sacramento and Redding). The trainings will consist of three hours of CPM training and four hours of Documentation Manual training.*
    e) *By March 31, 2013,* ***Date Modified, Crt. Dkt. No. 843 to May 31, 2013,*** *DHCS will schedule two train-the-trainers sessions (one in Sacramento and one in Los Angeles.)*
    f) *By December 31, 2013, DHCS will host two Promising Practices Webinars. County MHPs and County Child Welfare Services organizations that are identified as demonstrating strong implementation will be recruited to share their experiences.*

2. *The statewide training plan for the adoption of the CPM includes the following:* ***Date Modified, Crt. Dkt. No. 843 to April 1, 2013***
    a) *Thirty days after the issuance of the CPM Guide, the Statewide Training and Education Committee's Multi-Disciplinary Training (MDT) subgroup comprised of counties, providers, parents and youth, training academies, caregivers and other stakeholders will assemble and begin the process of developing curricula, educational materials and peer support training.*
    b) *Thirty days after the issuance of the CPM Guide, review the CPM guide and determine if existing training curricula and coaching materials can be enhanced or if new curricula and coaching materials need to be developed for use by mental health, child welfare, family and youth partners and providers and other stakeholders, including assessing the need for educational materials and/or an implementation toolkit.*
    c) *By May 1, 2013,* ***Date Modified, Crt No. Dkt 843 to June 1, 2013*** *the MDT will finalize the training curricula, coaching and educational materials and the implementation toolkit and schedule the four Regional Trainings for Trainers.*
    d) *By June 30, 2013, the county Implementation team comprised of child welfare, mental health, family and youth partners and providers will be required to participate as part of learning collaborative for implementing*

the CPM. The Learning Collaborative Counties will be grouped based on their level of readiness, and will be oriented to the coaching materials and receive joint training and technical assistance in exchange for providing feedback about the implementation of the CPM training, coaching and other materials developed by the MDT training subgroup.

e) Curricula and coaching materials will be revised by the training subgroup based on the feedback and experience of the Learning Collaborative Counties.

f) All curricula and coaching materials will be finalized and made available for all counties, other training entities and stakeholders and accessible by posting to appropriate websites.

g) Additional training for trainers and webinars will be scheduled by DHCS and CDSS leveraging the Statewide Training and Education Committee's system of coordination in addition to identifying other training opportunities from mental health entities. The learning collaborative will provide a county peer to peer learning environment that will include joint planning, common technical assistance themes, modeling for other counties and address emerging barriers, with solutions for county sites.

h) DHCS and CDSS will coordinate and stage additional rollout efforts based on counties' identified area of need for technical support based on their readiness assessment and from information on the notice of the service delivery plan that will be submitted to the State.

i) A transfer of knowledge process will be targeted to County supervisors and managers from child welfare and mental health agencies in order to further their understanding and skills about what the CPM is supposed to accomplish with their support. Materials will be developed to enhance their knowledge and skills through a variety of methods that may include but are not limited to: the use of learning agreements, curricula, online materials, webinars, technical assistance from Federal, State, contracted consultants, and coaching or mentoring support.

j) To further encourage transfer of learning, social workers and mental health staff and their supervisors will be guided on how to develop a learning plan that includes pre and post training goal setting, follow-up and assessment.

k) Advanced Training modules will be developed and made available which will assist social worker and mental health staff in delivering the CPM approach.

3. Continuous and ongoing technical assistance will include but not be limited to:

a) Assessing and evaluating coaching and mentoring needs and developing a plan to assist the counties in meeting these needs.

b) Developing policy guidance on the interrelationship between ICC, IHBS, TFC and the CPM.

c) Continuing to issue communications to describe and provide guidance regarding the expectations for and benefits of delivering services in a child/youth-centered, family-focused, community-oriented manner (e.g.,

ACL/ACIN) and participate in calls/meetings/presentations with stakeholders and associations (e.g. California Mental Health Directors Association, California Welfare Directors Association, Chief Probation Officers of California and the California Alliance of Child and Family Services).

d) Targeting specific audiences, such as: county leadership, courts, and counties that have an identified area of need for technical support based on readiness assessment.

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

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

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

Special Master's Observation and Comments:

Training and Technical Assistance. DHCS and DSS staff, as with other sections of the Plan, have been very productive in accomplishing Plan expectations and laying the foundation for next steps in implementing training and technical assistance to counties, providers, parents, youth and other stakeholders. A number of Plan activities called for in this section have been discussed earlier in this Report. The Special Master will identify the accomplishments but not describe them in detail.

DHCS and DSS completed eight orientation meetings presenting to over seven hundred people throughout the state. Orientations provided background information on Katie A. lawsuit, how to use the Medi-Cal Manuals and purpose and goals of the CPM guide. The State team continues to host on-going weekly technical assistance conference calls. After four months of calls, the State has observed that counties are at varying stages of implementation and levels of technical understanding of Katie A. requirements. The Plan also called for two train-the-trainer sessions to be scheduled by May 31, 2013, one in Sacramento and one in Redding. These sessions were cancelled after DHCS and DSS reassessed current training and orientation needs and responded with four additional orientations in Riverside, Pasadena, Orange, and Fresno Counties. The Special Master concurs with the State team's strategy.

Katie A. Trainings to Counties and Key Stakeholders. DSS and DHCS staff have provided a number of specific and general trainings since the March 13, 2013, Court Hearing. DSS and DHCS Trainings include:

- A joint presentation on Katie A. implementation at the Senate Human Services Committee Hearing on the Commercial Sexual Exploitation of Minors on May 14, 2013;
- A joint presentation on Katie A. Implementation to the Indian Child Welfare Act Workgroup on May 14, 2013;
- DHCS Participation in a Katie A. implementation panel presentation at the 33rd Annual California Mental Health Advocates for Children and Youth on May 8, 2013;
- Opportunistic trainings by DHCS on Katie A. implementation with counties during various CMHDA committee meetings (e.g., Children's Systems of Care, Medi-Cal Policy, Information Technology, Financial Services and Executive Board), and by DSS regularly during monthly meetings with CWDA Children's Operations and Executive Committees, as well as CWDA Board of Directors.

DSS will reach out to the Judicial Council Beyond the Bench Conference in 2014 planning committee to explore the use of that forum for orienting judges and court officers.

Counties and organizations have contacted DHCS and DSS, inviting the participation of the Departments in various conferences, trainings and meetings. DHCS and DSS are responding to requests from counties and other stakeholder organizations for orientation information and presentations.

Training and Education Development, Curriculum and Funding. The State Training and Education Committee (STEC) Multi-disciplinary Training Subgroup (comprised of counties, providers, parents and youth, training academies, caregivers and other stakeholders) has met and completed recommendations for training and has collected

potential curricula resources. STEC continues to integrate concepts from the CPM in their work on the Common Core curriculum revision for all child welfare social workers, so that the values and principles will be institutionalized in the statewide training system. The Zellerbach foundation provides funding for subject matter mental health consultants that are involved at the STEC Katie A. subcommittee to facilitate the continued linkage and collaboration between mental health and child welfare systems in the areas of training and curricula development.

Specific training and technical assistance activities:

- University California, Davis, Resource Center for Family Focused Practice has prioritized providing support to promote the adoption of CPM Resources for fiscal year 13/14. Fifteen training days have been identified for integrated planning which can be used to support counties.
- The Wraparound Institute funded at $150,000 will be repurposed to focus on promoting the CPM and bridge the collaborative work between mental health, child welfare and other stakeholders. The Institute will be held in June 2014;
- All Regional Training Academies received funding in each CWDA region to support Katie A. activities.
- DSS has received $250,000 for the Fiscal Forums beginning in October which will focus on fiscal strategies for adoption of the CPM. Information taken from the Readiness Assessment will inform the planning process. The first planning meeting was held on July 16, 2013.

DSS State Local Assistance Funds and Federal IVE Foster Care and Adoption Funds underwrite all of the above activities.

California Social Worker Education Committee (CalSWEC) has a curricula specialist tasked with aligning the MSW curriculum with Katie A. values and practices and ensuring the mental health linkage with child welfare.

The California Family and Policy Institute was funded by CWDA and the Casey Foundation in collaboration with the CalSWEC, to facilitate and support a two day

meeting (July 11-12, 2013) for County Directors and Deputies, to address the best process for the integration of CPM practice activities.

The Chadwick Center at Rady's Children Hospital, in partnership with DSS was funded ($1.2M) by the Administration for Children and Families to develop and pilot new approaches in the child welfare and mental health systems of San Diego, Mariposa and Tulare Counties. The Grant includes two phases over five years, starting in 2013, to promote integrated and coherent approaches to screening and assessment process. The scope included resources to support Katie A. implementation and provide subject matter expertise.

The Special Master is impressed with the gathering of resources from multiple sources and interests to promote Katie A. and in particular the CPM. Moving forward and melding, collaborating and integrating these resources into a cohesive plan will be challenging, but necessary. The Special Master understands that an effort is underway with STEC to accomplish that task. The State team should be commended in their effort. It is striking that so little reference is made to funding by DHCS and/or California Mental Health Directors Association (CMHDA) to support counties in the implementation of Katie A. The Special Master understands discussions are underway to identify funds by DHCS to support the implementation of an overarching training plan.

Section VI. Data and Quality Assurance

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

<u>OBJECTIVES</u>

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

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

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

4. *To collect existing data specific to the class (and subclass) in order to evaluate utilization (patterns, type, frequency, intensity of services) and timely access to appropriate care, including informal services and natural linkages..*

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

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

7. *To engage youth and families in all aspects of data and quality assurance planning, design, decision-making and implementation.*

8. *To measure the success of the processes to identify/screen, refer and firmly link class members to services and to adapt and modify Implementation Plan strategies to resolve problems or eliminate barriers that may arise and impede access to IHBS, ICC, TFC, or the application and use of the CPM.*

9. *Using the ACO and/or JMT taskforces, identify monitoring, measuring, evaluating, reporting and adapting mechanisms that will be used to assure that local efforts meet Section V, Objective 1 and 2 as appropriate.*

ANTICIPATED RESULTS

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

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

The State will have and share publicly the necessary information to determine whether implementation of IHBS, ICC and the CPM is successful, and if not, what measures need

to be taken to achieve success. Data and oversight systems will continue to be used to improve performance and quality over time.

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

IMPLEMENTATION ACTIVITIES AND TIMELINES

Phase One: July 2012 – December 2012

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

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

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

Phase Two: Action Items for January 2013 and Beyond

1. *By January 1, 2013,* ***Date Modified, Crt. Dkt. No. 843 to January 31, 2013,*** *DHCS will implement new procedure codes in the SD/MC II system.*

2. *By January 31, 2013,* ***Date Modified, Crt. Dkt. No. 843 to March 21, 2013,*** *DHCS and CDSS will establish and convene an ACO Mapping Group to inventory and report on the current array of ongoing state and county data efforts by CDSS, DHCS and others.*

3. *By February 28, 2013,* ***Date Modified, Crt. Dkt. No. 843 to June 1, 2013,*** *the ACO Taskforce will begin convening monthly meetings. The ACO Taskforce will support service integration and/or coordination for mental health services for class members by improving methods and adequacy of data collection, matching and sharing to support the CPM at the State, county and provider levels. The taskforce will provide recommendations to DHCS and CDSS to inform the design, development and support of the SMS.*

4. *By April 1, 2013,* ***Date Modified, Crt. Dkt. No. 843 to September 30, 2013,*** *DHCS and CDSS will analyze and evaluate utilization (patterns, types, frequency and intensity of services) and timely access to care based on data elements in both departments' data systems specific to the class and subclass.*

5. *By April 30, 2013,* ***Date Modified, Crt. Dkt. No. 843 to July 15, 2013,*** *the ACO Taskforce will convene and facilitate a stakeholder meeting to solicit ideas from youth and families, providers, advocates, counties, and other stakeholders about what data concerning the class DHCS and CDSS should routinely produce and post on both department's websites.*

6. *By June 30, 2013,* ***Date Modified, Crt. Dkt. No. 843 to October 31, 2013,*** *data and subsequent analysis and evaluation of utilization (as described in item A above) will be shared publicly with counties, providers and all stakeholders through postings on both departments' websites, every six months through December 31, 2014.*

7. *By September 1, 2013,* ***Date Modified, Crt. Dkt. No. 843 to October 31, 2013,*** *the ACO Taskforce will produce a report with recommended actions and timelines related to identifying, devising and collecting:*

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

<u>Special Master's Observation and Comments:</u>

Implementation of New Billing/Claiming Procedure Codes for ICC and IHBS.

On January 1, 2013, DHCS implemented new procedure codes for ICC and IHBS in the SD/MC II system. The ACIN was issued May 3, 2013, outlining claiming and billing procedures, reminding the counties that claims have been possible since January, 2013, and encouraging counties to claim services provided immediately. Although counties were informed by DHCS in the ACIN on how to claim, multiple complications arose between the counties and their information technology (IT) vendors on what needed to be added or changed in the IT system and who was responsible to pay for it. As a result,

there has been a delay in the electronic processing of claims to the state. DHCS indicated counties are negotiating their contracts with their IT vendors. Vendors are in the process of making changes to their systems and testing those changes. According to DHCS, CMHDA anticipates all vendors will be able to process ICC and IHBS claims no later than November 1, 2013. DHCS' ACIN on claiming was also delayed in being issued. The Special Master was under the impression the ACIN was going to be issued on or about at the same time the Manuals were issued.

One of the complications surrounding claiming ICC and IHBS is how the counties are going to use the Demonstration Project Identifier (DPI), the indicator that has been added to the Short Doyle Medi-Cal system. Counties are indicating confusion on how and when this indicator should be used. In response to this challenge, DHCS has planned the following next steps:

-Develop FAQs that put forth clear directions to counties regarding these issues.

-Provide targeted technical assistance to counties that continue to indicate equivalency issues based on the Service Delivery Plans.

-Communicate with vendors on current claiming abilities and plans on making claiming systems compliant.

DHCS is taking the technical issues that have arisen in counties claiming ICC and IHBS very seriously and the Special Master expects the issue to be resolved quickly. This is another delay in data being collected on ICC and IHBS implementation. The Plan specified that DHCS and DSS will analyze and evaluate utilization data and timely access to care by September 30, 2013, and share publicly with stakeholder the results from its data analysis and evaluations regarding utilization and access to services by October 31, 2013. The impacts of these technical problems are likely to effect the quality of data available September 30, 2013.

ACO Mapping Taskgroup and Taskforce Implementation. A number of Plan activities called for in this section have been discussed earlier in this Report. The Special Master will identify the accomplishments but not describe them in detail. The ACO Mapping is on track to complete its tasks as outlined in the ACO Mapping Charter by

August 1, 1013. The ACO Task Force, which will be subsumed as part of the JMT, August, 2013, is expected to complete the ACO Taskforce charge, as specified in its Charter, by October, 2013. The JMT Taskforce appears to also be on track to produce the recommendations as specified in the ACO Charter.

Conclusion: Special Master's Overall Summary Comments and Findings:

In summary, since the March 13, 2013, Court Hearing, the initial implementation of the Plan by DHCS and DSS through an intense interdepartmental collaboration has primarily focused on:

-Issuing ACL/ACIN as specified in the Plan.

-Providing initial and basic Regional Orientations and Technical Assistance Calls on ICC, IHBS and CPM.

-Convening the Statewide Training and Education Committee (STEC) to develop recommendations for CPM training and the identification of potential curricula resources.

-Developing and preparing to distribute FAQ's for counties, provider, parents and youth that will increase access statewide for subclass members to ICC and IHBS, as medically necessary.

-Convening ACO Mapping Taskgroup.

-Completing Initial analysis of counties' Readiness Assessment and Service Delivery Plan.

- Utilizing the result from the above analysis, identifying each county's capacity to meet the Objectives of Section IV, Service Delivery Rollout, and establishing a process of communicating guidance or standards to the counties regarding the 'sufficiency of the Readiness Assessment and Service Delivery Plan'.

-Preparing to use the results of the analysis and 'sufficiency' review will become part of the County Semi-Annual Progress Report.

-Finalizing a draft framework for a Shared Management Structure for the JMT Task Force to review and finalize into an operational recommendation to DHCS and DSS for adoption as the State Shared Management Structure.

-Developing draft recommendations for CPM Fiscal Task Force.

-Seeking endorsement of a proposed TFC Model and coverage by the Subgroup and preparing to communicate concepts to Centers for Medicaid and Medicare Services for discussion.

-Developing a more regular and prescribed process with the Special Master and the Parties that ensures essential and constructive communication and feedback will take place regarding the Implementation Plan.

-Developing an initial Charter for the Katie A. Implementation Advisory Group, establishing membership and deferring its first meeting until a later stage of implementation.

The Special Master views this initial implementation effort having been successful on four fronts. First, a vast amount of information and guidance has been provided, distributed and discussed across the state with counties, providers, parents and youth, thus launching Katie A. at the county level. Second, the State has gained insights into possible problem areas or confusion amongst counties, provider and parents, some of which need to be addressed immediately to secure a successful and timely implementation. Third, by completing their Readiness Assessment and Service Delivery Rollout Plan, counties are likely to be more informed on what is needed in their county to install CPM and for a timely implementation of ICC and IHBS. Fourth, the State is better informed on the counties' readiness and capacity to install CPM and to expedite statewide implementation of ICC and IHBS.

In addition, the State is preparing to provide counties with information on the 'sufficiency' of their Readiness Assessment and Service Delivery Rollout Plan in meeting the established objectives in Section IV, Service Delivery and Rollout, of the Plan, and offer technical assistance, training and additional collaborative support. The State's response and standards and guidance will become part of the Counties' Semi-Annual Progress Reports.

The Special Master wants to acknowledge the extensive interdepartmental collaboration underway between DSS and DHCS. The Special Master, in thirty-five years of experience in California working in the child welfare and mental health field, has never observed such a collaborative enterprise between the state departments to be so

successfully undertaken. In the past, at best, it was just an aspiration to work together and share resources on behalf of California's most vulnerable children and their families. Without their full set of needs being addressed, the costs to the children and youth, their families and society are well documented. The Departments' shared accomplishments to date are commendable and serve as a model for California; but there will be challenges to sustain it, and it is vital to keep up the effort.

The Special Master recognizes that it is early in the implementation of the Plan and is encouraged by the State's recognition that during this initial phase there are essential activities specified in the Plan that need special attention. The Special Master finds that if the following activities are not addressed by the State over the next three months the overall success of the Plan is in jeopardy:

-Subclass Members receive ICC and IHBS, as Medically Necessary

DHCS clearly instruct county MHPs on how to identify subclass members;

-County CPM Readiness and ICC and IHBS Service Delivery Plans

DHCS and DSS take the necessary steps, once analysis of the counties' Readiness and Service Plans is complete, to provide counties direct feedback on their Readiness and Service Plans. Provide counties, as necessary, clear guidance and/or standards that results in capacity to ICC and IHBS being made available in every county in a timely manner and CPM in being implemented or the capacity is being put into place that will lead to the installation of CPM;

-TFC

DHCS will submit an initial written communication regarding the future request for federal approval of TFC with a follow-up submission of a concept paper to CMS;

-Claiming ICC and IHBS

DHCS ensure all county vendors have made the necessary changes to county claim/billing systems;

-ICC and IHBS Utilization

DHCS/DSS complete initial data/utilization analysis;

-Collaborative County Meetings

DHCS and DSS convene Regional Learning Collaborative County meetings.

Although not specifically a three-month action item, the Special Master has encouraged DHCS to support CMHDA in expanding its engagement and outreach efforts at the county level over the next eighteen months, taking a more active and visible statewide role promoting the implementation of Katie A. in multiple public and association forums. The Special Master recognizes that since the March 13, 2103, Court Hearing, DHCS and CMHDA leadership have worked together to address important claiming and related Short-Doyle II coding issues for data collection on ICC and IHBS and to identify fiscal incentives/strategies for CPM and TFC implementation.

County Welfare Directors Association of California (CWDA) continues to be engaged with the DSS and is actively and visibly supporting the implementation of Katie A. statewide. In this initial implementation phase, DHCS and CMHDA are taking the lead in implementing ICC and IHBS. Over the next eighteen months is will be important that DSS in partnership with CWDA expand on their current efforts in promoting the implementation of Katie A. in multiple public and association forums.

DHCS and DSS, in partnership with CMHDA and CWDA, will need to work closely together to advance the statewide implementation of the Core Practice Model (CPM), Treatment Foster Care (TFC), a Shared Management Structure, Training and Technical Assistance, Family and Youth Involvement and the Accountability, Communication and Oversight framework.

In closing, the Special Master will make additional comments and observations in this section. By no means are these comments and observations intended to diminish the State's effort and accomplishments to date. Things are moving forward. The bottom line is that they are just moving forward slower than the Agreement contemplated and, in some cases, the Plan specified and/or the Special Master expected.

The Special Master remains concerned that the State Departments see themselves as limited or uncertain in their authority to enforce the implementation of the Plan with the counties. As discussed and or identified in the March 13, 2013, Special Master's Report, Crt. Dkt. #839, pages 15-18, the ongoing sorting out of the state and county policy, fiscal and oversight relationships under Realignment, the consolidation of the State Department of Mental Health with DHCS, the impact of the passage of Proposition 30 in November, 2013, and the Affordable Care Act implementation in January, 2014, continues to

complicate discussions and decision making. The Special Master's comments are not intended to be critical or find fault in the State team's efforts to implement the Plan. The above structural and fiscal changes in how the State and counties do business have had significant impact on meeting the timelines and results that should be expected during the Court Jurisdiction.

The Special Master has specifically highlighted the following Plan deliverables for the Court's information; this is not intended to be an exhaustive or prioritized list of deliverables nor is it to take the place of the requirements specified in the Plan. While not suggesting the Court take any action at this time, the Special Master is becoming increasingly concerned that there may be inadequate time between today's date and December 1, 2014, to determine:

-If ICC and IHBS are available and being provided, as medically necessary, statewide to the Sub-Class members and to what extent are these and other mental health services being delivered consistent with CPM;

-If every county child welfare and mental health agency has developed policies /protocols for screening, assessing and linking class and subclass members to mental health services;

-The number of county Mental Health and Child Welfare agencies and their providers who have implemented CPM and the strategies underway to promote and sustain the statewide of implementation of CPM after December 1, 2014;

-What resources have been identified and utilized for CPM coaching and mentoring of county and provider staff;

-If, and to what extent, are DHCS, DSS and California Mental Health Director's Association/CiMH/CalMHSA and County Welfare Directors Association of California/Child and Family Institute of California, resources committed to statewide implementation of CPM training/coaching/mentoring;

-That TFC coverage and model is available statewide, has been or is planned to be implemented in a number of counties and the necessary steps are underway to sustain its implementation statewide. TFC is added to the Medi-Cal menu and in the county MHP contracts and funded - (a) SPA or Waiver submitted and approved by CMS, (b) contracts negotiated with CMHDA/MHPs, (c) documentation manual

supplemented with expectations for the service and billing codes, (d) ACL with obligation to have it available, as medically necessary, statewide and (e) DSS has addressed all necessary licensing, rates, waivers, regulations that support the implementation of TFC;

-That a Shared Management Structure has been established between DHCS and DSS and is operational, and to what extent is it aligned with the JMT Charter;

-The number of counties that have adopted a Shared Management Structure or are in the process of developing such a structure;

-If, and to what extent, are the recommendations from the CPM Fiscal Task Force implemented as a result of actions taken by DHCS and DSS Shared Management Structure and to what extent it is aligned with the CPM Fiscal Charter;

- If there is a shared and transparent quality assurance and accountability system in place between child welfare and mental health, at the state and county level, as a result of actions taken by DHCS and DSS Shared Management Structure. (Do the state and county systems, minimally, have the capacity to track class members getting mental heath services, sub-class members getting ICC, IHBS, and TFC, including a uniform statewide accountability process of the quality of the services consistent with CPM and to what extent it is aligned with the ACO Charter?)

In California's current environment it is necessary and reasonable that the counties and State need additional time, beyond what might have been required prior to realignment, consolidation of DMH with DHCS, the recent passage of Proposition 30, and the Affordable Care Act, to get answers, develop a plan, problem solve and to move things forward. Essentially, the state departments and county associations need time to sort out/negotiate issues of responsibility, accountability, authority, and funding in this new environment.

PART THREE

SPECIAL MASTER'S RECOMMENDATIONS TO THE COURT

Consistent with Court's May 29, 2013, Order to report on the progress in the case, including with respect to those matters described in the Letter and in its five-page exhibit and dates for future status conferences, the Special Master makes the following recommendations:

Recommendation 1 *Subclass members receive ICC and IHBS, as medically necessary*: DHCS and DSS shall instruct and guide the county Mental Health Plans (MHPs), by no later than August 31, 2013, as follows:

a. All children and youth in the subclass who are newly identified to the County MHPs shall be provided ICC and IHBS, as medically necessary.

b. All subclass members currently receiving Specialty Mental Health Services shall be provided ICC and shall receive IHBS, when medically necessary or, unless as noted in c. below, are receiving intensive mental health services in one of these programs during this transition period.

c. All subclass members who are currently receiving wraparound services (including Welfare & Institution Code Section 18250, et seq.) or Full Service Partnership (FSP) Services, pursuant to Mental Health Services Act, (Section 3620, Title 9, Div. 1., Chapter 14, Mental Health Service Act) that provide a Child & Family Team, consistent with the Core Practice Model, should be provided and claimed as ICC and IHBS, as medically necessary. MHPs and its providers may elect, during this temporary/transition changeover period, to continue claiming these mental health services as they do now and are required to document in the Short Doyle II data system (or other approved method of documentation) that fact of receiving such wraparound and Full Service Partnership services and shall report all such subclass members to the State on a quarterly basis. This is intended to be a temporary transition period, which will no longer be necessary when all subclass members are receiving ICC and IHBS, as medically necessary.

d. DHCS shall instruct county MHPs (and DSS/DHCS notice child welfare agencies of this action) that MHPs shall be providing services to all 3 groups above, by no later than November 1, 2013.

Recommendation 2 *Claiming ICC and IHBS to DHCS*: DHCS will ensure all County Mental Health Plans' (MHPs') information technology (IT) systems can submit ICC and IHBS claims to DHCS on or before November 1, 2013. DHCS will advise the Parties and Special Master when this is accomplished.

Recommendation 3 *Therapeutic Foster Care Coverage and Model*: By July 31, 2013, DHCS will submit an initial written communication regarding the future request for federal approval of TFC with a follow-up submission of a concept paper to CMS by August 31, 2013.

Recommendation 4 *Schedule Status Conference to Review Progress:* Set a status conference for the week of November 8, 2013, to review implementation progress on the following:

a. Katie A. Subclass statewide access to ICC and IHBS. DHCS and DSS prepare, to the extent data is available, an analysis and evaluation of data and timely access to ICC and IHBS.

b. Final Results from DHCS and DSS analysis of the counties' Readiness Assessments and Services Delivery Plan and how it has informed the State's expectations/requirements for the County Semi-Annual Progress Reports.

c. DHCS and DSS analysis of County Semi-Annual Progress Reports due to the State on October 1, 2013.

d. Implementation of Therapeutic Foster Care coverage and model for California.

e. Development of a statewide training plan and activities for installing the Core Practice Model (CPM).

f. Joint trainings provided by DHCS and/or DSS and California Mental Health Directors Association and/or County Welfare Directors Association of California promoting the immediate roll out of Katie A. and the overall expectations and results from its implementation.

g. Other activities and progress in implementing the Plan.

In closing, as Special Master I would like to thank the Court for affording me the privilege of serving as Special Master for the Katie A. case. I am very proud of the remarkable accomplishments made by the parties as reflected in the progress made implementing the Plan, and I look forward to the opportunity to continue to work with the parties and the Court in advancing the successful implementation of the Katie A. Agreement.

Dated: May 26, 2013

Respectfully Submitted

Richard Saletta, LCSW
Special Master