

County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH

Summary of the Katie A. Settlement Agreement
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Background: The initial complaint for the Katie A. et al v. Diana Bonta et al was filed on December 20, 2002. It was certified as a class action suit June 18, 2003.

It was filed on behalf of children who were in foster care or imminent risk of foster care placement who have a mental illness that has been documented or would have been documented had an assessment been conducted. And, who need individualized mental health care, including but not limited to assessment, behavioral support, case management, family support, crisis support, therapeutic foster care and other medically necessary services.

Plaintiffs entered into a settlement agreement on July 16, 2003. The Director of California Department of Health Care Services is current successor of interest, as is the Director of the State Department of Social Services.

The Defendants have denied any wrongdoing alleged in the action and settled "solely for the purpose of settling and compromising the claims of the plaintiffs, in order to avoid the expense and diversion of its personnel caused by protracted litigation and to terminate the claims asserted against the defendants."

This agreement settles all claims.

The State appointed a Special Master, Rick Salleta, LCSW, on April 3, 2009 to facilitate an interest based decision making process.

State defendants agree that this agreement is binding on the California Dept. of Mental Health.

Parties acknowledge that notice of and opportunity to comment must be provided to Plaintiff Class and others affected. The parties must jointly develop a written notice to be given to plaintiff class.

Plaintiffs must now apply to the court for entry of an order in the following form:

Giving its preliminary approval of the agreement as being fair and reasonable and adequate to the members of the Class:

Approving the proposed procedures for giving notice to members of the class:

Scheduling a fairness hearing as to whether the Agreement should be finally approved as fair, reasonable and adequate to the members of the Class :

Objectives and Specific Agreements

The objectives of this agreement:

Facilitate services: coordinated, comprehensive, community based that combine access, planning, delivery and transition into a coherent, all inclusive approach.

Support the development and delivery of service structure and a fiscal system that supports a “core practices and services model”

Support an effective sustainable solution that will involve “standards and methods” to achieve quality based oversight, including training and education to support model.

Identify a subclass of members: who need more intensive services and mandate those services to be provided in their home or most homelike environment available. (Full scope Medi-Cal members with open CWS case or

Child in or being considered for Wrap, ITFC, TBS or specialized care rate due to BH need or crisis

Child is currently in, or being considered for, group home (RCL 10 or higher), psych hospital, 24 Hour Mental Health Treatment Facility or in three or more placements within 24 months due to behavioral health needs.

Objectives: Who does what?

CDMH and CDSS will: **Develop and distribute a Medi-Cal Specialty Mental Health Documentation Manual** that will inform and instruct *providers* on:

- Two arrays of service;
 - Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)
 - Therapeutic Foster Care (TFC)

CDMH, CDSS and DHCS: (with Negotiation Workgroup and other stakeholders) **will determine;**

- What parts of TFC are covered under Medicaid
- What activities are covered under State Medicaid Plan
- Whether Plan needs to be amended to cover TFC

The Documentation Manual will describe how ICC and IHBS should be provided consistent with The Core Practices Model Principles and Components using a *Child and Family Team*.

Chapters will include:

- Description of Eligible Class,
- How to refer a child to *IHBS/ICC and TFC*,
- Description of Medi-Cal reimbursable service activities,

- Authorization,
- Claiming,
- Billing Rates,
- Forms,
- Resources

CDMH and CDSS will post manual on Internet for 30 day review.

CDMH and CDSS will establish a shared management structure to:

- develop a shared mission and vision statement
- develop shared policy and program direction
- develop clear and consistent guidelines
- develop outcome and accountability measures, (consistent with the Core Practice Manual)
- develop a Core Practice Model Guide
- establish joint management task force, (members include: youth, parent partners, county and provider groups)
- report within 12 months after execution of agreement of proposed methods for doing the above.

This management structure will be established through legislation or regulation to:

Build upon existing State Agencies that serve foster youth, (Dept. of Education, Dept. of Alcohol and Drug Programs, Dept of Corrections.

Jointly develop Policies and Procedures to manage and support shared responsibility for foster youth.

Develop models for local agencies to consider in order to work more effectively together.

CDSS and CDMH, in consultation with joint management task force, will develop:

- Cross system training tool
- Training curriculum
- Practice improvement protocols
- Quality control systems

To support The Core Practice Model.

CDSS and CDMH will develop cross system training curriculum and educational materials for child welfare and mental health staff.

- CDSS will initiate a request to Statewide Education and Training Committee
- Materials will explain the system to children and families, including toolkit for Child Family Teams.
- Develop structures for “teaming”, i.e. TDMs, Child and Family Teams, Interagency Operations and Departmental Leadership Teams.

CDSS, CDMH and DHCS will clarify and provide guidance on state and federal laws needed to implement agreement.

- Technical assistance, i.e. policy guides, manuals, training, etc.
- Ensure audit compliance.
- Encourage local policy and regulation to be consistent with Core Practice Model.

CDSS and CDMH will develop a proposal to incorporate plan to produce and post data, including claims data.

- Improve data exchanging among CDSS and CDMH and other state and local agencies.
- Develop and share clear policy on information sharing/privacy policies.
- Use existing data and benchmarks to greatest extent feasible.
- Determine what will be measured to reflect outcomes.
- Clinical status data. (How is client doing?)
- Utilization of data.
- Treatment facility data. (What is happening in placement).

A process will be developed to identify class members and link them to service.

DHCS, CDSS and CDMH will establish Data and Quality Task Force.

- Produce report with recommended actions
- Establish method to track ICC, IHBS and TFC for subclass members
- Use EQRO and CFRS requirements to plan for collection of data
- Collect data specific to class and subclass in order to evaluate utilization
- Facilitate stakeholder meeting about data that should be routinely collected

All reports to be posted on CDMH and CDSS websites.

Models:

1. Conduct statewide readiness assessment to model systems that can be successful.
2. Readiness Assessment Teams will be informed by providers, family members and youth serving organizations.
3. Readiness assessment will focus on:
 - a. The strength and connectivity between Child Welfare and Mental Health to administer services.
 - b. The ability to transfer lessons learned to other programs and counties.
 - c. Whether Counties can build a system to deliver county wide services.

At least one large county and one small county will be selected to support intensive services training and systems development for the CPM.

Model counties:

1. Will be used to test strategies,

2. Will receive training, technical assistance, and supportive incentives.
3. Will assist in facilitating the adoption of the CPM.

Implementation will address bringing plan to statewide fruition.

CDSS, CDMH and DHSC will develop Fiscal Task Force, (with stakeholders, fiscal consultants and Negotiations Workgroup.)

Fiscal Work Group will focus on fiscally sound incentives to deliver, IHBS, ICC, TFC and the CPM.

Secure alternative resources for local match for EPSDT.

Reduce reliance on out of home placements.

1. Use group homes for short term crisis stabilization.
2. Establish pilot programs for alternatives to placement.
3. Develop funding models to facilitate the transformation of existing group home beds to intensive home based services.
4. Enable transition services in community to facilitate discharges.
5. Reconfigure multi-agency mental health screening committees to access alternative services and reduce use of group homes.

(See Wraparound)

Implementation Plan:

The parties will develop Implementation Plan.

Will complete plan within six months of Court's approval of the settlement agreement.

Important Issues to Consider::

All of the provisions of the settlement identify DHCS, CDSS and CDMH as the parties affected. There is no current contracted arrangement between the State and local counties for the provision of these services.

There is very little recognition of the impact of the settlement on local government entities.

There is no report on the extent of the role that the local areas, stakeholders, contractors or county government agencies will play in the development of the plan.

There is no realistic representation of the impact of serving non Medi-Cal children who may make up a large percentage of the class, i.e. children who have reports filed, who do not have Medi-Cal.

There is no clear definition of the new services, Intensive Care Coordination and Intensive Home Based Services, or how they fit in with the existing array of services, such as TBS and Wraparound. (For example, will a child receiving TBS and Wraparound also qualify to receive each of the other services?)

Time frame of six months is exceedingly optimistic.