Vignette Introduction:

Thank you for your investment of time to help us improve the system of care for our young people in foster care. Here are three vignettes, which will be used in the 10:35 agenda item, Bright Spots & Challenges within Current System, and describe the journey of a child/young person and their family in the foster care system. The goal of these vignettes is to highlight the complexities and challenges multiple systems have in meeting the needs of those we hope to help. A reminder that the purpose of our workgroup is to address the Medi-Cal system, yet the lives of those in the vignettes are touched by multiple systems. The highlighted version is Color-coded to recognize the system connected to a particular issue. Our hope is that by the highlighting of the vignettes we can better appreciate the difficulties in connecting to the most appropriate Medi-Cal services.
These vignettes will assist us in discussing the guiding questions during our breakout session. In addition, you will find an info graphic that reflects the path youth may follow in the social services system. This may be helpful when looking at the vignettes to see the points along the path where the medi-cal system intersects. We hope this exercise helps put a face to the policies we are shaping.

Vignette 1

Makayla, age three years, and Zari, age four years, are sisters brought in to child welfare by law enforcement after law enforcement was called to conduct a welfare check on the children's mother. The mother was found at the family's home in the closet hanging by a belt with her two children watching. The mother was placed on a 5150 hold and taken to obtain inpatient psychiatric care, while the two children were taken to the child welfare office. This family is African American and has no child welfare history. The sisters were placed in a foster home for several weeks, while the placement social worker identified a relative placement option. Over a period of three months, the county social worker worked with the maternal grandmother regarding placement. The grandmother was going through the process of resource family approval* (RFA), while working full time and caring for her two granddaughters. During this time, the mother was receiving mental health treatment and the grandmother received no financial support and little other resource support to care for her granddaughters. The grandmother has been trying to find a therapist through her employer's insurance for her own support and has difficulty locating a therapist that is accepting new clients and with availability that works with her tight schedule. The grandmother and biological mother requested mental health services for the girls, and the social worker submitted Screenings (Pathway) to County Mental Health Plan. The screenings identified impairment due to the girls witnessed their mother attempt to kill herself and are having nightmares, difficulty sleeping, and episodes of excessive crying, increased tantrums and difficulty being soothed. In the first three months of the case, the mental health services for the children were not in place due to the wait time for child assessments and scheduling. It was also noted by the grandmother and documented by Makayla's physician that there were some developmental delays of significance that indicated a need for further evaluation. The grandmother in this case also felt there were cultural considerations for this African American family that were not addressed. During the Child and Family Team (CFT) meetings (MH, DD, Child Welfare, Education) the family expressed that they did not feel their voice was heard by the roomful of professionals and, in fact, they felt judged.

*Resource Family Approval Program (RFA) is the family-friendly and child-centered caregiver approval process that combines elements of the current foster parent licensing, relative approval, and approvals for adoption and guardianship processes and replaces those processes.

Vignette 2

Emilio is 14, Latino, and grew up in Southern California. He entered a Short-Term Residential Therapeutic Program (STRTP) in Northern California two weeks ago, after having lived in 15 previous placements. The youth was most recently diagnosed with Oppositional Defiant Disorder and Attention Deficit and Hyperactivity Disorder just prior to being presumptively transferred to his new county of residence.* Emilio has a long list of other mental health diagnoses from prior episodes of treatment, including anxiety, depression, Adjustment Disorder, Reactive Attachment Disorder, and Post Traumatic Stress Disorder. The youth has received various mental health treatment over the years with several different clinicians due to the numerous placement changes that spanned across three different counties. He is currently prescribed and taking Ritalin which does not appear to be addressing the behavioral symptoms of concern. The current challenging behaviors reported include refusing to go to school at least once a week, running away to hang out with friends, not listening or following directions, and arguing with house staff. Additionally, Emilio broke windows in his last placement, and, on one occasion, had a physical altercation with peers. Although probation is not currently involved, Emilio previously had probation involvement for an incident of violent behavior when he broke out two windows at his previous group home and the police were called to remove him from the placement. Due to Emilio's six placement changes over the past 18 months, which included moves to three different counties, it has been difficult to follow up on Emilio's physical health due to changes in primary care physicians. There is a note from a physician at his last physical exam that Emilio stated that he uses marijuana approximately four to five times per week and that he feels his marijuana use helps to keep him calm. Emilio's early education experience is unclear, but it seems that he received special education services briefly while in first grade for communication-related delays and has had less formal student support plans in place to address challenging behavior in some of his school settings. Related to the frequent placement changes, Emilio has changed schools ten times. There is no known family involvement at this time. Emilio has a long history of child welfare involvement dating back to the age of two years old when he was first removed from his mother and father's care due to substantiation of physical abuse by the father and failure to protect (neglect) by the mother. Reunification services with the mother have been attempted twice over the past 12 years but reunification has not been successful. Upon entering placement there is no family placement or lower level placement identified as a transition plan. Staff from a prior placement once mentioned that Emilio shared about a positive connection with a teacher from a prior school in Southern California with whom he has lost contact.

*Placing agencies make the decisions related to presumptive transfer, and mental health plans are responsible for providing the services. NOTE: Best practice is to waive presumptive transfer when placing a youth in a STRTP.

Vignette 3

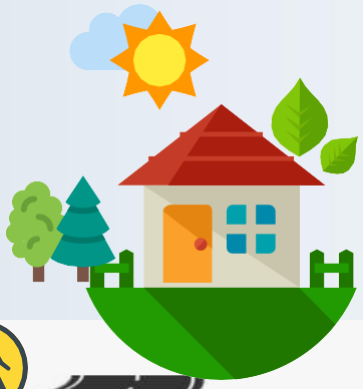
In a rural county in California, a sibling set of four, Suzy (age one year), Johnny (age two years), Lilly (age six years), and Jeffery (age eight years), entered foster care due to general neglect related to parental substance use and mental health issues. Law enforcement placed the children into temporary custody due to unsanitary conditions of the home environment as there was no edible food, animal feces/urine, and garbage found throughout the home. Law enforcement was completing a safety check at the home due to concerns reported by a neighbor. In the prior six years, the family had 15 previous child maltreatment referrals and three prior voluntary child welfare cases, which included voluntary placement. The parents are White and have a history of opioid use. Johnny was born prematurely and tested positive for opioids and THC. There are reports that the mother had limited prenatal care with the youngest two children. Jeffery was able to share with her social worker about seeing her mom and dad fight, which included yelling, hitting, and throwing and breaking items. The parents were offered reunification services for a period of 24 months. The children experienced three non-relative resource family placements in a period of four years. The movement of the siblings was in part due to the behaviors displayed by Lilly and Jeffery (tantrums, refusing directions, biting, hitting, breaking toys) that were not appropriately addressed. Due to the behaviors of the older two siblings, also not being appropriately recognized as trauma-related, the foster parents requested they be removed from the home two years after the case began. It is unknown whether the Social Worker referred the children for a mental health assessment in response to these challenges. Upon the change in placement of the older siblings, the younger children did not remain in contact. The foster parents requested to limit contact between the siblings, because of concern that the contact resulted in difficult behavior following sibling visits. Once Suzy started school, reports began regarding challenging behaviors displayed in the classroom such as difficulty sitting still, hitting peers on the playground, difficulty with peer relationships, and difficulty reading. Johnny was diagnosed with type 1 diabetes by his local doctor, who referred him to a pediatric specialist at the nearest children's hospital, three hours away, for specialized treatment. Johnny was also evaluated for developmental delays and received Early Start services and, then, later transitioned to a special education preschool setting. Lilly and Jeffery, now 11 and 13 years-old are living separately. Lilly is living in an Intensive Services Foster Care** (ISFC) home in a neighboring county and Jeffery is living in a STRTP (this is after moving to several different types of placement) in Central California. Jeffery's mental health case has been waived for presumptive transfer. Case records indicate that the parents initially reported no relative placement options and, it appears, there were no further family finding efforts to explore relative placement options for the children.

** The Intensive Services Foster Care (ISFC) program was created to provide supports to children and youth who require intensive treatment, including treatment for behavioral and specialized health care needs.

Current Path to Permanency for Youth in the Foster Care System

Cross-System Planning and Coordination

High-quality, trauma sensitive, healing-focused, accessible, comprehensive, and culturally adept physical and mental health care services for children and youth in foster care must be integrated throughout the permanency planning process. Cross-system planning and coordination is the foundation of an effective model of care, so children, youth and families are healthy, whole and connected.



PERMANENCY & CONNECTION

Transition to permanent home

Ongoing Needs Assessment and Case Planning

ACEs are sometimes revealed over time, requiring ongoing trauma and mental health treatment

Successful permanency planning requires physical, mental, behavioral, and developmental health treatment plans that are responsive, comprehensive, well-coordinated, and integrated

Family Time / Visitation

Child and Family Team Meetings

Family-centered meetings focused on the needs of the youth and family

engage family and caregivers to enhance the overall well-being of the youth

Promote open and ongoing communication between parents/caregivers, youth, child welfare staff, and health care providers regarding the physical, mental, behavioral, and developmental needs of the youth and family

Change of Managed Care Plan

Development of Integrated Care Plan

Coordination and planning for physical, mental, behavioral, and developmental health services

Review of health history in order to develop a comprehensive profile of the youth and family

Referral for services and supports based on identified needs

Oversight of psychotropic medications

Placement Disruptions

Separation & Loss

Removal / Out of Home Care

Gather health information to:

- Support families and caregivers
- Identify medical, developmental, and mental health conditions that require prompt medical attention
- Identify chronic health conditions that will require ongoing treatment

Initial medical screenings including annual physical and 6-month dental

Trauma / Adverse Events

Early and Periodic Screening, Diagnostic and Treatment

Background: Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protection ensures that children and youth under age 21 receive a comprehensive array of preventive, diagnostic, and treatment services, as specified in section 1905(r) of the Social Security Act. This pediatric coverage is a comprehensive, high quality health service and helps meet children's health and developmental needs. EPSDT covers age-appropriate medical, dental, vision and hearing screening services at specified times, and when health problems arise or are suspected. In addition to screening, EPSDT covers diagnostic and treatment services described in section 1905(a) of the Act to correct or ameliorate identified conditions. The EPSDT coverage is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. Specifically, Medi-Cal beneficiaries under age 21 are entitled to EPSDT services when medically necessary and when covered by Medicaid, even if such services are not included in California's Medicaid (Medi-Cal) State Plan.

The following defines the separate components of the EPSDT coverage:

Early: Assessing and identifying problems early

Periodic: Checking children's health at periodic age-appropriate intervals

Screening: Providing physical, dental, vision, hearing, mental health, developmental and other comprehensive screening exams and tests to detect potential problems

Diagnostic: Performing diagnostic tests to follow up when a health risk is identified

Treatment: Correct, reduce or control health problems found

EPSDT also ensures assistance with scheduling appointments and arranging transportation for Medi-Cal covered appointments.

Lead Agency: DHCS

Partners: County Mental Health Plans, Medi-Cal Managed Care Plans, and providers

Problem to Solve/Opportunity: Through EPSDT protection, children's health problems should be addressed before they become advanced and treatment is more difficult and costly. There have been law suits against the state in the past based on the assertion that children are not receiving the medically necessary services they are entitled to through EPSDT. There is an opportunity to continue to educate the child-serving systems about EPSDT to ensure that children receive the comprehensive and broad array of services available to them as medically necessary.

Goal(s): The goal of EPSDT is to assure that children get the health care they need when they need it – the right care to the right child at the right time at the right setting. Services for Medi-Cal beneficiaries under age 21 are available and easily accessible when medically necessary.

Activities (resources, policies, problems, etc.):

- Many Policy Letters have been sent to the Managed Care Plans and the Mental Health Plans reminding them of their affirmative obligation to make sure that Medi-Cal eligible children and their families are aware of EPSDT and have access to services.
- Regulation changes to align EPSDT definition with the federal definition.
- Beneficiary notifications.

Timeline: Ongoing

Measure(s) of Success: All children and youth receive comprehensive, high-quality services they are entitled to, at the right time, right place, by the right provider to correct or ameliorate health issues.

Children's Crisis Residential Program

Background: Children's Crisis Residential Programs (CCRPs) are Short-Term Residential Therapeutic Programs (STRTPs) where crisis residential treatment services are provided to children in crisis. CCRPs provide an alternative to psychiatric hospitalization by offering crisis residential treatment services, targeted case management, and medication support for children experiencing mental health crises. Additionally, CCRPs are community care facilities that have mental health treatment services available 24 hours a day, seven days a week, the capacity to make prompt admission determinations based on medical necessity criteria, and the ability to involve the child's family and natural support system.

Lead Agencies: California Department of Social Services (CDSS) and Department of Health Care Services (DHCS)

Partners: County Mental Health Plans, County Child Welfare Agencies, County Behavioral Health Directors Association (CBHDA), County Welfare Directors Association, (CWDA) Chief Probation Officers of California (CPOC), Department of Managed Health Care (DMHC), Advocates, Providers, Youth, and Parents

Problem to Solve/Opportunity: STRTP, which are residential facilities licensed by CDSS and operated by any public agency or private organization that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term, 24-hour care and supervision to children, presented an opportunity to create a new licensing category for mental health crisis residential care for children and youth who are beneficiaries of both public and private health care plans. AB 501 authorized CDSS to license an STRTP to operate as a CCRP, and required a CCRP to obtain and have in good standing a mental health program approval issued by DHCS or a county MHP to which DHCS has delegated authority.

Goal(s): Provide Crisis Residential Treatment Services for children and youth experiencing mental health crises in the least restrictive environment, as an alternative to psychiatric hospitalization. CCRPs are a level of care for the treatment of children and youth with a serious behavioral health disorder in a mental health crisis. CCRPs provide crisis residential treatment services, targeted case management, and medication support to children experiencing mental health crises.

Activities (resources, policies, problems, etc.): Many additional activities to the below.

- DHCS in consultation with CDSS, CBHDA, CWDA, CPOC, DMHC and other stakeholders, established CCRP standards and procedures for oversight, enforcement, and issuance of children's crisis residential mental health program approvals.
- CDSS issued CCRP interim licensing standards.
- While the authorities exist and the structure was implemented to administer CCRPs, CDSS and DHCS have not yet received any applications.
- Potential issue: Reimbursement for Room and Board in CCRPs. (Federal funding cannot be used.)

Timeline: Effective January 1, 2019. No CCRPs to date.

Measure(s) of Success: Children and youth experiencing mental health crises can be appropriately served in a CCRP as an alternative to psychiatric hospitalization. CCRPs should have the ability to involve the child's family and natural support system. There are sufficient CCRP facilities regionally to accommodate the need for children and youth to receive crisis residential treatment services.

Presumptive Transfer

Background: Assembly Bill (AB) 1299 (Ridely-Thomas, Chapter 603, Statutes of 2016) added section 14717.1 to the Welfare and Institutions Code and established presumptive transfers that the responsibility for the provision of, or arranging and payment for, Specialty Mental Health Services (SMHS) will promptly transfer from the county of original jurisdiction to the county in which the foster child resides when a foster child/youth is placed outside of their county of original jurisdiction. Presumptive transfer is intended to ensure that counties are clear on their responsibility for provision and payment for SMHS for provide children /youth in foster care who are placed outside their counties of original jurisdiction.

Lead Agencies: Department of Health Care Services (DHCS) and California Department of Social Services (CDSS).

Partners: County Welfare Directors Association (CWDA), County Behavioral Health Directors Association (CBHDA), Chief Probation Officers of California, Providers, Child Welfare Agencies, County Mental Health Plans, County Probation Agencies, and the author of AB 1299.

Problem to Solve/Opportunity: Continue to improve local processes so that foster children/youth placed out of their counties of original jurisdiction to receive medically necessary SMHS in a timely manner.

Goal(s): The primary goal of presumptive transfer is to ensure that counties are clear on their responsibility for foster children/youth placed out of their counties of original jurisdiction so that disputes amongst counties will not inhibit the timely receipt of medically necessary SMHS. County Mental Health Plans and County Child Welfare Services Agencies have a shared responsibility to meet that goal and need to work in close collaboration and communication to appropriately serve these foster children and youth.

Activities (resources, policies, problems, etc.): Too many activities to list all.

- DHCS and CDSS released two joint ACLs/INs providing initial and ongoing presumptive transfer policy guidance (ACL 17-77/IN 17-032 and ACL 18-60/IN 18-027).
- DHCS and CDSS in consultation with CWDA and CBHDA provided technical assistance and guidance that specifically addressed issues with presumptive transfer for children and youth placed in Short-Term Residential Therapeutic Program.
- DHCS, California Institute for Behavioral Health Solutions and CDSS provided regional convenings for counties and providers to discuss children's policy issues, including presumptive transfer.
- DHCS and CDSS conducted several webinars for counties and providers on implementation of presumptive transfer.
- DHCS and CDSS provided counties technical assistance and issue resolution at both a system level and case specific level.
- DHCS and CDSS continue to work collaboratively to monitor implementation of presumptive transfer.

Timeline: Presumptive transfer was effective July 1, 2017.

Measure(s) of Success: Children and youth are receiving timely and effective SMHS regardless whether they reside in their county of original jurisdiction or are placed in another county. All determinations regarding presumptive transfer are made in consultation with the child, child's Child and Family Team members, and other professionals who serve the child. Close collaboration and ongoing communication between the counties and systems serving the child or youth.

Pathways to Well-being (Formerly Katie A.)

Background: Katie A. was a class action lawsuit filed in 2002 against the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) on behalf of California children in foster care, or at imminent risk of foster care placement, with behavioral, emotional or psychiatric impairments in need of mental health services. The lawsuit was settled in December 2011 with the help of a "negotiation team."

Lead Agencies: CDSS and DHCS

Partners: County Mental Health Plans, County Child Welfare Agencies, County Behavioral Health Directors Association, County Welfare Directors Association, Advocates, Providers, Youth, and Parents

Problem to Solve/Opportunity: Continue to improve infrastructures and service delivery systems to ensure children receive appropriate Specialty Mental Health Services, as medically necessary. Services are guided by a "Core Practice Model" (CPM) involving the provision of coordinated, community-based services, including the use of Child and Family Teams.

Goal(s): Child welfare and mental health systems work together to meet the mental health needs of children and youth involved with both systems. The mental health needs of children are met through the use of the CPM and provision of Intensive Care Coordination (an intensive form of Targeted Case Management that facilitates assessment of, care planning for, and coordination of services for children and youth. This service is intended for children who are involved in multiple child-serving systems, have more intensive needs, and/or whose treatment requires cross-agency collaboration) , Intensive Home Based Services ((IHBS) individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's or youth's functioning), and Therapeutic Foster Care ((TFC) short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs). ICC, IHBS, and TFC are services that resulted from the Katie A. settlement. Ensure services are delivered in a coordinated, comprehensive, community-based way. Allow children and youth to receive medically necessary services in their own home, a family setting, or the most home-like setting appropriate to their needs, in order to facilitate reunification and to meet their needs for safety, permanence and well-being.

Activities (resources, policies, problems, etc.): Too many to list them all.

- Shared management structure supporting joint program and policy development, as well as continued collaboration and coordination at the state and local levels;
- Data sharing between CDSS and DHCS for the purpose of oversight, coordination, monitoring and evaluation of mental health services for children and youth who are entitled to them.

Timeline: Settled December 2011; Court jurisdiction ended December 2014; Implementation ongoing.

Measure(s) of Success: All children and youth receive screening, appropriate referrals, and medically necessary specialty mental health services to stabilize current placement and reduce reliance on residential care.

Fact Sheet:
The Family First Prevention Services Act

Project:
The Federal Family First Prevention Services Act (FFPSA) was signed into law as part of the Bipartisan Budget Act on February 9, 2018. This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system. The bill aims to prevent children from entering foster care by allowing federal reimbursement as a payer of last resort for mental health services, substance use treatment, and in-home parenting skill training.

Lead Agency and Partners:
The California Department of Social Services (CDSS) leads the cross-system partnership between California Department of Health Care Services (DHCS) and California Department of Developmental Services. Local partnerships in the effort are to include the county child welfare agency, probation department, behavioral health plan, county office of education (in partnership with local education agencies and special education local plan areas), regional center, Child Welfare Directors Association (CWDA), Chief Probation Officers of California (CPOC), County Behavioral Health Directors Association (CBHDA), advocacy agencies, and consultation with local land based federally recognized tribes.

Problem to Solve:
FFPSA modifies funding under Title IV-E of the Social Security Act to be: (a) available to specified prevention services to candidates for foster care, or a pregnant or parenting foster youth, and the allowable costs for the proper and efficient administration of the program; and (b) to reduce the use of congregate care in the foster care system.

FFPSA Part I – Prevention Activities under Title IV-E:
FFPSA allows states and tribes the option to provide and receive Title IV-E funding, as a payer of last resort, for pre-approved preventive services provided to candidates for foster care, pregnant or parenting foster youth, and their parents or kin caregivers. Services that may be funded include evidence-based and trauma-informed mental health, substance use, and in-home parenting skill-based services for up to a 12-month period at 50% Federal Financial Participation to eligible candidates. FFPSA also allows for states to develop a licensed family-based substance use disorder residential treatment facility able to receive FCMPs for up to 12 months.

These services must be evaluated at specified evidence-based practice (EBP) levels and approved by ACF's Prevention Services Clearinghouse (the Clearinghouse). States may also conduct their own systematic review of a program or service pending a determination by the Clearinghouse.

FFPSA Part IV – Ensuring the Necessity of a Placement not in a Foster Family Home:
FFPSA restructures claiming of Title IV-E Foster Care Maintenance Payments (IV-E FCMPs) for children and youth placed in congregate care settings by limiting the ability to claim IV-E FCMPs beyond two weeks only to four specified settings: settings deemed to be Qualified Residential Treatment Programs (QRTPs), specialized settings for pregnant and parenting youth; independent living settings for those aged 18 or older; and specialized settings for children who are at-risk or victims of sex trafficking.

FFPSA establishes requirements for QRTPs including:

- Operation of a trauma-informed treatment model and organizational framework able to meet the clinical needs of children with serious emotional or behavioral disorders or disturbances.
- Have a licensed or registered nurse, not necessarily a direct employee of the facility, and other licensed clinical staff, provides care in accordance with state law, are on-site per the treatment model, and available 24 hour/seven days a week.
- Facilitates participation of family members in child's treatment plan, facilitates outreach to the family members of the child, including siblings, and documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained.
- Provides discharge planning and family-based after-care supports for at least six months post-discharge.

Other documentation and assessment requirements include:

- Qualified Individuals (QIs) must determine appropriateness placement based on an approved functional assessment tool.
- Development of a Family and Permanency Team to assist the QI during the appropriate placement determination process.
- Case plan documentation.
- Sixty-day court determination within the start of each placement where a family or juvenile court or another court of competent jurisdiction, or an administrative body appointed or approved by the court shall approve or disapprove of the placement.

Goals:

FFPSA Part I – Prevention Activities under Title IV-E:

Prevent candidates at imminent risk for entry into foster care from entering the system by providing trauma-informed, evidence-based mental health, substance use, and in-home parenting skills interventions to children and their parents or kin caregivers.

FFPSA Part IV – Ensuring the Necessity of a Placement that is not in a Foster Family Home:

- Reduction in the use of congregate care through increased oversight of individual placements and restrictions on placement determinations.
- Improving outcomes and services for children through better assessment and trauma informed care, provision of aftercare, and on-site nursing availability.

Activities, Timelines and Measures of Success:

FFPSA Part I – Prevention Activities under Title IV-E:

Currently, California is aiming to opt into the prevention services component of FFPSA with a target date of October 2021. The Department is consulting with counties, Tribes, stakeholders, partner departments, and peer resources across the country to develop the best approach to implement FFPSA and to draft California's Five-Year Prevention Plan. The Department will submit FFPSA Prevention Services Plan by Fall 2020; begin offering prevention services by October 1, 2021.

The Department will measure success through approval of the Five-Year Prevention Services Plan by ACF and diversion of imminent risk population from foster care as measured in outcome measures reported to ACF.

Fact Sheet:
AB 2083 – Trauma-Informed System of Care for Children and Youth in Foster Care

Project:
Assembly Bill 2083, was passed in 2018 and builds upon the current Continuum of Care Reform implementation effort by developing a coordinated, timely, and trauma-informed System of Care approach for children and youth in foster care who have experienced severe trauma and are most often served within multiple systems.

The bill requires each county to develop and implement a memorandum of understanding (MOU), establishing the roles and responsibilities of agencies and other entities that serve children and youth in foster care who have experienced severe trauma.

The MOU should represent the aligned and shared roles and responsibilities of the local agencies serving children and youth in foster care. The specified roles and responsibilities and provisions addressed in the MOU are referred to as the System of Care. The local execution of an MOU is a critical step in implementing a coordinated System of Care.

While AB 2083 focuses on children and youth in foster care who have experienced severe trauma, it reflects a priority to build a locally-governed interagency or interdepartmental model on behalf of all children and youth across California that have similar needs, that interact with and are served by multiple agencies.

Lead Agency and Partners:
California Health and Human Services Agency (CHHSA) leads the cross-systems partnership between California Department of Social Services (CDSS), California Department of Health Care Services (DHCS), California Department of Developmental Services (DDS), California Department of Education (CDE), County Welfare Directors Association (CWDA), and County Behavioral Health Directors Association (CBHDA). Local partnerships include the county child welfare agency, probation department, behavioral health plan, county office of education (in partnership with local education agencies and special education local plan areas), regional center, and consultation with local land based federally recognized tribes.

Problem to Solve:
AB 2083 seeks to better serve children and youth in foster care who have experienced severe trauma and are most often served by multiple public programs by developing a coordinated, timely, and trauma-informed System of Care approach. Improve system collaboration and coordination by having the child serving systems understanding each other's' programs and services in order to best address the needs of the children and youth. We must come together to break down silos and build a culture that is focused on delivering services that are person-centered and not program-centered.

Goals:
AB 2083 System of Care work brings together state, county, local partners, and other stakeholders to better serve children and youth who are receiving services from multiple public programs. **Our goal is simple: our programs must meet the needs of the children and youth we serve.** These are our collective children, and they all deserve the very best.

Activities, Timelines and Measures of Success:
The legislation calls for the establishment of a joint interagency resolution team to provide guidance, support, and technical assistance to counties with regard to trauma-informed care to foster children and youth. The mission of the joint resolution team is established to be:

1. Promote collaboration and communication across systems to meet the needs of children, youth and families.
2. Support timely access to trauma-informed services for children and youth.
3. Resolve technical assistance requests by counties and partner agencies, as requested, to meet the needs of children and youth.

In addition to the establishment of the joint interagency resolution team, the legislation calls for the following AB 2083 deliverables:

MOU Guidance:
The joint interagency resolution team is responsible for development of guidance for counties, county offices of education, and regional centers (local partners) regarding development and implementation of the required MOU. The joint interagency resolution team is also responsible to provide technical assistance to counties and local partners to identify and secure the appropriate level of services to meet the needs of children and youth in foster care who have experienced severe trauma.

Process to request Technical Assistance from Joint Interagency Resolution Team: A process will be developed for counties and partner agencies that are parties to the MOU to request interdepartmental technical assistance from the joint interagency resolution team.

Identify Gaps in Placement Types, Services, or Other Issues:
By January 1, 2020, the joint interagency resolution team, in consultation with county agencies, service providers, and advocates for children and resource families, will review the placement and service options available to county child welfare agencies and county probation departments for children and youth in foster care who have experienced severe trauma and shall develop and submit recommendations to the Legislature addressing any identified gaps in placement types or availability, needed services to resource families, or other identified issues.

Develop a Multiyear Plan for Increasing Capacity:
By June 1, 2020, the joint interagency resolution team, in consultation with county agencies, service providers, behavioral health professionals, schools of social work, and advocates for children and resource families, will develop a multiyear plan for increasing the capacity and delivery of trauma-informed care to children and youth in foster care served by short-term residential therapeutic programs and other foster care and behavioral health providers.

Fact Sheet
Family Urgent Response System (FURS)

Project	Establishes a statewide 24 hour/7 day a week hotline, paired with a regional, and county-level in-person mobile response service to support families during situations of instability or family distress, for purposes of preserving the relationship of the caregiver and the child or youth by providing conflict management and resolution skills, and connecting the caregiver and child or youth to the existing array of local services.
Lead Agency	CDSS
Partners	DHCS, CWDA, CPOC, CBHDA, County Child Welfare & Probation Agencies, Children Now, Casey Family Programs
Problem to Solve	California's Continuum of Care for foster care does not provide youth currently or formerly in foster care and their caregivers with **immediate, trauma-informed support** in times of family distress**. This lack of support results in** calls to 911 and law enforcement, and frequently results in psychiatric hospitalizations and placement disruption which creates further trauma.
Goal(s):	• Reduce placement disruptions and **preserve the relationship** between the child or youth and their caregiver. • **Reduce** the need for a 911 call or **law enforcement involvement** and the needless criminalization of traumatized youth. • **Reduce psychiatric hospitalization** and placement into **congregate care.** • **Connect** children and families to existing services in their communities. • **Decrease trauma** experienced by the child/youth and family by addressing the mental health needs of the child within a reasonable timeframe of the triggering event or episode. • **Promote healing** as a family.
Activities (resources, policies, problems, etc.)	In order to engage stakeholders in the development and implementation of the FURS program, the Department of Social Services is coordinating four work groups to address the key components of FURS: (1) Statewide Hotline (2) Mobile Response Teams (3) Data and Outcomes (4) Communications and Outreach
Timeline	January 1, 2021 for implementation of the Statewide Hotline and County Mobile Response systems.
Measure(s) of success	Number of youth and caregivers served, type of response received, and services provided measured against known child welfare outcomes. We would expect to see improvements such as: • Increases in placement stability. • Retention of Resource Families. • Reduced psychiatric hospitalizations. • Decreases in the reentries into foster care. • Decreases in the movement from Child Welfare to Juvenile Justice. • Improved timeliness to permanency.