



ENHANCING INTERAGENCY SERVICE COORDINATION AND INTERAGENCY PLACEMENT COMMITTEE TEAM FUNCTIONS

California's Children and Youth
System of Care
CFPIC
Concept Paper





Introduction & Background

Interagency Service Coordination is a broad care delivery function of nearly all helping and service systems, including Child Welfare, Education, Probation, Behavioral Health and Developmental Services. It is one of the primary interagency functional imperatives of California's Children and Youth System of Care, under AB 2083. One critical example of the many forms of service coordination is known in California as the Interagency Placement Committee (IPC). For many years, there have been expectations, rooted in WIC 4096, which have guided and informed the use of the IPC by and between county Child Welfare, Probation, and Behavioral Health partners.

IPC processes include a number of deeply interdependent functions which invite leaders to understand how critical functions like assessment, service planning, and transitioning care across the various parts of the system can be used to link and align care for youth in every local System of Care (SOC). That required alignment and coordination is made difficult by the many examples of code, statute, or practice formulary, which often actually slow or obstruct care delivery and needed interagency coordination. The field now often accepts these constructs as common practice, such as the use of exclusionary diagnoses in mental health, the absence of substantiated neglect for child welfare, school expulsions or the presence of a mental health diagnosis. All of these things can slow or even prevent access to needed services, and are but a few examples of how the system fragments itself from the fundamental intent of whole child, whole student care. *It is this fragmentation which places the function of interagency care coordination at the center of the system and which invites systems to enhance their IPC processes.*



Inherent in the SOC is the shared commitment that while the rules of care delivery may be slow to change, the relationships between teammates and organizations is the only way to mitigate these obstacles and ensure timely and effective care.

Alignment and coordination of care, and the use of the existent state required IPC are two of eleven essential functions captured in the county’s Assembly Bill (AB) 2083: Children and Youth System of Care (2018) MOU. For this reason, among others, efforts to enhance and expand the use of IPC as a mechanism, for earlier care delivery, prior to deep involvement or before youth needs have become too complex that crises are overwhelming the team.

This monograph outlines the imperative to enhance interagency service coordination and shared decision-making and seeks to inform how local partners might approach those enhancements as part of an ongoing SOC implementation under AB 2083.

Why Interagency Service Coordination and IPC Enhancement?

Research suggests that nearly every youth with complex needs was once a child with basic needs. Some functions and processes in many parts of the SOC are inherently focused on addressing only complex needs, effectively “cleaning up” aspects of the system-wide delivery of care which could have addressed a child or youth’s basic needs. It’s a fail-first system, and part of transforming that system demands that leaders look at functions which silo the care of youth. IPC is one of those functions.

IPC is part of the “glue” of the system—where difficult and challenging youth and family issues are collectively shared and where resources are mobilized toward the system’s ultimate purpose—to keep youth at home, in school, and away from involvement in juvenile corrections.

Effective IPC-like interagency functions ultimately yield fewer youth with extended inpatient stays, more youth graduating high school, fewer youth expulsions, and less entry and re-entry into foster care, among many other documented outcomes. (See: [Return on Investment in Systems of Care for Children with Behavioral Health Challenges](#).)



Intentional Purposes of an Enhanced or Expanded IPC Process



While IPC has often been seen solely as the way partners simply review current or existing care delivery or ensure appropriateness of short-term residential treatment programs (STRTPs) “fit”, there are many other potential care coordination scenarios which benefit from a well-designed and executed IPC. Properly trained IPC panel members provide effective resource and service accessibility, ensuring that youth have access to programs and supports that are far more likely to be effective.

In some counties, the IPC process (or some similar interagency care planning body) takes on additional value-added roles beyond STRTP or Wraparound approval, in order to:

- Ensure that students in the care of local Education and Regional Centers can gain access to needed services
- Divert or prevent institutional and out of home care from any part of the system
- Encourage family involvement in complex decision making
- Review the Mental Health Plan’s (MHP) Treatment Plan for youth already placed in STRTP level services
- Review recommendations for, or post-placement decisions for, inpatient hospital care
- Review the delivery of, and collaboratively coordinate, the mental health care for youth who are presumptively transferred into and out of the county, to ensure interagency coordination and timely access to care
- Collaboratively review Critical Incident Reports from providers
- Ensure local schools know which are entering and exiting their jurisdictional boundaries
- Ensure Behavioral Health partners are engaged for youth with co-morbid needs
- Better identify youth/young adults with intellectual or developmental needs



Expanded Criteria for IPC Referrals



One of the initial interagency steps in the enhancement of the IPC process is to consider where partners can invest in expansion of the criteria for IPC consideration and referral. Some examples might include:

- When Child and Family Team (CFT)/Teaming struggles to meet or identify needs
- When the family has asked for a new team
- When there are challenges between departments around who will fund services
- When the family shows signs of disengagement, despite the team's efforts
- When critical team members stop attending; or when CFT meetings are consistently canceled



- When critical team members, including family members, are not responsive to inquiry or communication
- When a youth experiences more than one hospital/inpatient episode for behavioral health needs
- If Student Attendance Review Board processes are not effective

Roadmap for Expansion (varies by county)



The process the Interagency Leadership Team (ILT) takes to consider expansion or enhancement of their IPC will vary and depend on local needs and dynamics. Generally, the following steps would comprise a short list of essential planning topics. The first three steps should be seen as “pre planning” in order to understand the full landscape of interagency service alignment efforts.

- 1 Inform the ILT.** Ensure the Interagency Leadership Team (ILT) and any other System of Care leaders are aware and supportive of enhanced or improved IPC process and use, and that decision makers are aligned and in agreement as to the goals and the scope of the Interagency Service Coordination function. This alignment should be captured in the AB 2083 MOU.
- 2 Complete the functional analysis of the “List of Complex Care Joint Meetings”.** While it may seem unnecessary, often in complex systems of care, partners have existing meetings with nearly identical purposes and attendees, and that landscape must be fully understood before changing the IPC process. This is often best accomplished as an ongoing and standing item on the ILT or EAC agenda, to support element 1 above, and reduce the confusion which presently exists by and between partners as to where and how care coordination occurs for youth with complex needs. [Here is a simple meeting matrix](#) which can help begin this step.
- 3 Identify and agree about enhanced purpose.** Depending on the readiness of the system and their local school partners, the IPC can serve a consultative role for youth outside of the child welfare or juvenile justice systems. Schools are not well funded for placement/residential care, and IPC serves as a potential vehicle to engage on blended or shared placement costs, and youth placed in residential care via IEP often have family support needs or reunification issues that affect or could affect other partners. In those cases, IPC must include school district representation when needing to make a Best Interest Determination decision, or when challenging, continued issues of care coordination are present.

Once these three steps are complete and the ILT or EAC clearly understands the landscape of planning meetings, the actual IPC enhancement work may begin, most often through a coordinated “IPC Workgroup” or some other ad hoc group of managers or leaders in and around the system’s partnership. These steps outlined below will require ongoing meetings and team member “homework” as well. They include:

- 1 Orient existing IPC panel members** to the vision for expansion—engage current IPC panelists to ensure they are part of and/or informed about the improvement efforts being discussed.
- 2 Evaluate key data elements**, to answer essential operational demands of a future IPC, including, “How many high needs kids are there and from which departments would the IPC referrals come?”
- 3 Establish new or expanded parameters** for referral to the IPC function, to include youth *at risk of entry* to Child Welfare and Probation. This might mean creating pathways for referral for students with complex behavioral/emotional challenges and youth with intellectual and developmental challenges. It is paramount to long-term SOC success, and to reduce the number of youth with unmet intensive service needs, to expand access to the IPC function, but referral criteria must be clearly agreed to.
- 4 Establish clear roles and commitments for local educational/school partners** to support the critical school wellness supports that are often part of an interdisciplinary IPC process. It is likely insufficient for the County Office of Education to sit on the IPC panel. Local SELPA agencies have many resources which can be mobilized, including wellness services and Community School based supports and services
- 5 Review the current IPC referral form** and packet and ensure it contains all necessary information to support the enhanced IPC utility.
- 6 Review IPC and other policies** which inform care coordination for youth with complex needs and revise the policy to support the enhanced vision.
- 7 Determine whether or not to invite or require contracted Wraparound and Therapeutic Behavioral Services (TBS) partners**, or others including: hospital discharge staff, school resource officers, or Tribal representatives, to attend and under what conditions/clinical circumstances.
- 8 Identify whether or not there exists sufficient desire to design an IPC-like process** which invites the family and youth to attend, essentially elevating a CFT-like function to the management level where a full spectrum of resources can be mobilized to support the family.

- 9 Conduct outreach and social messaging** to case carrying staff across the SOC partnership. Leadership communication about the expanded IPC use and its criteria must be messaged to not only Child Welfare and Probation, but to other partners as well, depending on the criteria selected in Step 1.
- 10 Identify a new meeting name** for the interagency service planning process. IPC implies a focus on placement approval, which often inadvertently reinforces the team's mindset that the meeting is about only approving STRTP or out of home placement. Some examples of naming from counties in California include Family Resource Community Collaborative; Family Resource Consortia, Interagency Resource Collaborative, and Placement Prevention Team.
- 11 Ensure consistent panel membership.** Some counties rotate IPC members so often that trust, consistency of information and the planning process itself are undermined, essentially disempowering the IPC process entirely. Each SOC partner agency (or others as identified by contract/agreement) should have consistent panel members and designated back ups. It cannot be assumed that any supervisor or manager, for instance, can adequately represent in a high stress teaming environment.
- 12 Identify and mobilize administration and operational support of IPC by:**
- Scheduling standing meetings
 - Preparing and disseminating referral information to panelists in advance and at IPC events
 - Capturing IPC meeting commitments
 - Creating and maintaining a Shared Drive where key documents and the IPC Policy are retained and updated
 - Communicating with the IPC panel members in the days and weeks that follow, to ensure that the specific youth/family commitments of the IPC team are followed through on in a timely manner
- 13 Address privacy/confidentiality issues.** There is great variance in local understanding about whether IPC members may or may not share information without an Authorization for Disclosure or Release of Information (ROI). The quickest solution is to simply establish that all referrals for IPC will have an ROI included, after the holder of rights (youth/caregiver) are appropriately oriented to the purpose and intent of the IPC. It's rare that a youth or caregiver would not consent to authorizing the sharing of information when it means possibly getting access to more/better care or supports or diverting future crises.

- 14 **Consider a “pilot” of a smaller cohort.** In some local systems, it may be prudent to expand in a limited manner, to test out the new processes and procedures. One example might be to open IPC to just one large school district or to youth placed in Foster Family Agency (FFA) homes. The learning from the pilot can then be expanded in future system improvement.
- 15 **Report back to the ILT or EAC teams.** Finally, and importantly, the work group's products and processes must be consistently held to accountability via the EAC's or ILT's oversight. This will ensure that shared policy and practice will be anchored within the SOC's collective pursuits, and the MOU which captures the system's intent.

IPC Best Practices

Whether or not a local system chooses to fully expand or enhance the IPC process, this best practices section offers ideas that may help improve IPC-related outcomes. To ensure success, high functioning and impactful teams:

- Call referring staff ahead of time to prepare them.
- Invite Tribal partners when applicable.
- Hold meetings in person when possible for stronger collaboration
- Include Qualified Individuals (QIs) under FFPSA Part IV when appropriate. Inclusion of the QI should not be duplicative to the existing “assessment” for SMHS.
- Prepare and welcome families if they attend.
- Use name tents and mix seating to avoid agency silos.
- Train IPC panelists regularly on policy, process, and available services.
- Involve trusted CBOs in care planning.
- Report outcomes (e.g., number of youth reviewed, kept in the home, placed in an STRTP, etc) to the ILT/EAC regularly.



Special Considerations



Opening a pathway for referrals to IPC from school partners is critical. The IPC can serve both a consultative role and, in some cases, a decision-making role, depending on the jurisdictional (300 or 600) or Special Education status of the youth. Schools are not well funded for placement/residential care, and IPC serves as a potential vehicle to engage on blended or shared placement costs, and youth placed in residential care via IEP, often have family support needs or reunification issues that affect or will affect other partners.

In other cases, the IPC will be an authoritative and decision-making entity authorizing the actions of the system/department in support of their family-centered decision making; decisions by the IPC Committee will become the recommendations of Child Welfare or Probation to inform the court. The IPC should include school district representation when needing to make a best interest determination decision, or when challenging, continued issues of care coordination are present.



Sample Language from System of Care MOUs

The AB 2083 System of Care MOU is a key sustainability tool for interagency service coordination and care delivery. The MOU, per state guidance, must include IPC related content. Most often, this will be in at least two places:

- In the roles and responsibilities of the ILT or EAC, there should be reference to the leadership team overseeing the IPC process and its success and sustainability.
- In the IPC section, the details about how system partners use IPC to support shared decision making that helps the system partners keep youth at home, in school, and away from youth corrections. On the following pages are a few examples taken from System of Care MOUs that may help inform or inspire.

Tuolumne County Excerpt

Interagency Resource Collaborative (IRC)



“Interagency care coordination and service planning are hallmarks of a System of Care. SOC partners collaborate to review and inform child and family decision making in many ways, including early intervention. When necessitated by partner and/or client need, system partners hold IRC meetings. Committee members, including Child Welfare, Behavioral Health, Probation, Foster Youth Services Coordinating Program, Regional Center staff, Public Health, and Tuolumne Band of Me-Wuk and Chicken Ranch Rancheria Tribal partners, and Managed Care Foster Liaisons, as case-indicated, and other appropriate partner agencies, meet to discuss the needs of children, youth and families.

The purpose of these meetings is to identify, develop, coordinate and monitor the care of at-risk children, youth and families across programs and within the county. The IRC will also serve as the county’s Integrated Placement Committee (IPC), and Intensive Care Coordination (ICC) process, and will include school district representation when needing to make a best interest determination decision.

The IRC will be comprised of experienced managers, deputies or other leaders, who will meet to consider and inform or support care planning to address any of the following needs:

- Community pathway for at-risk families to access resources, such as Wraparound services, community-based home visiting services, and navigation services as outlined in Tuolumne County’s FFPSA Comprehensive Prevention Plan.
- Mobilize resources and align services from any partner agency on behalf of youth and family in care.

- Review and consider recommendations from the CFT for youth to be placed into Short Term Residential Treatment Programs (STRTPs), out of state residential care (educational placements only), and Therapeutic Foster Care. (per WIC 4096 and ACL17-122)
- Ensure that determinations of need, from the county's Qualified Individual, are in alignment with the System of Care's team based decision making commitment.
- Review, every ninety days, the MHP's Treatment Plan or Treatment Plans and Services for youth already placed in STRTP level services.
- Review, every six months, the Case Plans or Treatment Plans and Services for youth already placed in STRTP level services.
- Review recommendations for, and service needs for youth with multiple inpatient hospital episodes. Review the delivery of and collaboratively coordinate the Mental Health care for youth who are presumptively transferred into and out of Tuolumne County, to assure care coordination and timely access to educational, developmental and health care services.

The IRC serves both a consultative role and, in some cases, a decision-making role. Depending on the jurisdictional (300 or 600) or Special Education status of the youth, this process may serve solely as an expanded teaming and consultation process in support of court mandated or educational required procedures. These events are purely intended to advise the planning process, and do not obligate providers, schools or decision-makers. In other cases, the IRC will be an authoritative and decision making entity which authorizes the actions of the system/department in support of their family-centered decision-making, and decisions by the IRC Committee will become the recommendations of the Child Welfare Division or Probation department.”

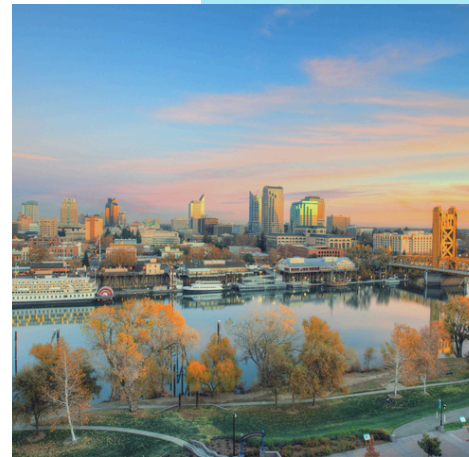
Sacramento County Excerpt

“Building on the teaming processes outlined above in this OA, CYFSOC members agree to support children and Non-Minor Dependents (NMD) who have significant behavioral, substance abuse, emotional, medical, and/or developmental needs via the state mandated IPC process.

The Sacramento County IPC ensures that interagency resources are available, accessible, and it provides a venue for teams to collaborate on circumstances for which intensive services are necessary for both residential and therapeutic needs, with the intent to identify the strengths and functioning of the child and family, prevent reoffending, enhance safety and achieve permanency.

Sacramento County IPC is an interagency placement committee as prescribed by Welfare and Institutions Code Section 4096 for placements initiated by the county or funded through the Aid to Families with Dependent Children-Foster Care Program. Sacramento County IPC-specific practices are contained in its own separate MOU with DCFAS, Probation, DHS, ACRC, and SCOE, and form a critical component of the Children’s System of Care (Welfare and Institutions Code § 18986.40).

The agencies and individual representatives of the IPC are committed to the principle of making recommendations that are in the best interests of the child, the family, and the community. Although some of the children and families that the Sacramento County IPC serves have been or are involved with the court process, the IPC makes no determination of the actual or perceived legal culpability of any individual it serves. In cases where such legal responsibility is potentially an issue affecting the Committee’s recommendation, the IPC either delays making a recommendation until a judicial determination is made, or makes its recommendation in the alternative, based on the various possible outcomes to the legal issues. “



Alpine County Excerpt

“ILT members will...

A. Participate in or assign someone to the IPC, ensuring that the IPC has the experience, depth, and wisdom to make decisions and recommendations in keeping with the purpose of this agreement.

B. INTERAGENCY PLACEMENT COMMITTEE (IPC):

The parties to this MOU will comprise the IPC with other staff attending as needed. The System Partners will jointly convene and administer an IPC, as required by state mandates. The IPC will meet as needed to conduct the following activities in pursuit of the shared goals of this MOU:

- Use the assessment and teaming processes described in Sections C and D to determine the least restrictive placement for the child
- Review Challenging Youth and Family Service Plans
- Review Requests for STRTP and/or Out-of-State Placement
- Review Cases in which a youth has been in STRTP or other Congregate Care Setting longer than six months and every six months, thereafter.
- The IPC will defer to the Tribe in cases involving tribal children and families.

Decisions and recommendations by the IPC will become the recommendations of the responsible department, division, or unit of the System Partner that referred the youth. Any involved staff member associated with the youth’s care who disagrees with the IPC recommended action may raise an objection to the recommended action or may advocate for a different action within the IPC meeting or at the earliest opportunity.”



Mendocino County Excerpt

“B. INTERAGENCY PLACEMENT COMMITTEE (IPC):

The Interagency Placement Committee, locally referred to as the Multi-Disciplinary Team (MDT) is established, as defined in California Welfare and Institutions Code Section 4096, to support coordinated decision making and approval for specialized services and placements for children/youth in foster care. The MDT is a multi-agency, multi-disciplinary team that supports children and youth, including Non-Minor Dependents (NMD), with significant behavioral, emotional, medical and/or developmental needs through a collaborative review process whereby a child/youth's treatment and placement needs are determined. The MDT review process includes consideration of available assessments/evaluations, treatment information, and other relevant information regarding the child/youth/NMD's history and current services and needs.

The MDT may also include other participants such as the Social Worker or Probation Officer from the placement agency, Indian Child Welfare Advocate, Public Health Foster Care Nursing staff, FCS Placement staff, Wraparound Supervisor, representatives from the Child and Family Team, representatives of service provider agencies, Court Appointed Special Advocate (CASA) representative, RCRC staff and Educational/ Developmental rights holder when a referral has been made to RCRC based on suspicion of a developmental disability, but no determination has yet been made.

The FCS Sr. Program Manager, JPD Supervisor/Manager, RQMC designee, BHRS designee, and MCOE designee are hereby designated as Co-Leaders of the MDT. In order to reach a shared agreement, the MDT shall utilize a shared decision-making process and consensus based on the results of the assessment and guidelines. If the MDT is unable to reach consensus or needs additional input, the MDT Coordinator will refer the matter to the ILT Chair for either an urgent review or review during the next regularly scheduled ILT meeting.



The MDT meets weekly and as necessary to carry out its functions. The functions include, but are not limited to, the following:

- Supporting coordinated decision-making approval for placement and specialized services to wards and dependents of the court jointly identified by FCS, JPD, RQMC, MCOE and placement agency staff based on review of child/youth/NMD's history, assessments, evaluations conducted by agency partners and others, and review current services and needs and recommendations) of the Child and Family Team (CFT).
- Reviewing and approving initial and continued treatment of youth in a Short Term Residential Therapeutic Program (STRTP) or Community Treatment Facility (CTF) consistent with state law to support transition upon completion of treatment in an STRTP or CTF. The MDT shall confirm whether the child/youth/NMD meets medical necessity criteria for MediCal specialty mental health services and/or their individual behavior or treatment needs can only be met by the level of care provided in a STRTP or CTF, and not in a family-based setting.
- Identifying the most appropriate level of services and whenever possible, the least restrictive placements, for other high-risk children and youth. These levels of services or placements may include but are not limited to Intensive Services Foster Care (ISFC), Therapeutic Foster Care (TFC) and Wraparound services.
- Reviewing community children/youth with complex needs with a referral for review from local education agencies, community partners working with families or RCRC, with parental/legal guardian consent and signed Releases of Information, to help coordinate preventative services.

The MDT will provide reports as requested to the ILT on placements, improvements in services, systems, need for new or redesigned service delivery, areas of improvement and status of observed Integrated Core Practice Model implementation.”

San Diego County Excerpt

“The ILT will review and discuss Interagency Placement Committee data and trends at regular scheduled meetings and monitor outcomes. The ILT will communicate with the IPC department leads for supplemental information, presentations, and updates as necessary.

The IPC provides all System Partners an opportunity to coordinate and align care to the extent possible and leverage combined service and fiscal resources to meet the unique needs of youth.

California Welfare and Institutions Code 16521.6 provides for confidential information and data sharing among members of the Interagency Placement Committee (IPC), as defined in Section 4096, child abuse multidisciplinary personnel team, as defined in Section 18961.7, or child and family team, as defined in paragraph (4) of subdivision (a) of Section 16501.

System Partners are included in Multidisciplinary Team (MDT) meetings, Child and Family Team (CFT) meetings, Interagency Placement Committee (IPC) meetings, and other platforms of case consultations to ensure interagency collaboration and sharing of necessary and relevant information related to youth and their families. System Partners begin to recommend, coordinate, and align services and care within IPC meetings to leverage combined services and fiscal resources.

The IPC meets at a minimum of three times per week and is composed of representatives from CWS, BHS, Probation, and FYSCP. SDRC is notified and invited to participate when the youth is an identified SDRC consumer or in the process of determining service eligibility. The diverse multi-disciplinary team includes but is not limited to Pathways to Well-Being staff, Public Health Nurse, permanency support staff, CWS staff psychologist, and tribal representation, when applicable.



BHS is responsible for notifying and inviting the youth's treating mental health clinician to the IPC meeting to provide input on the youth's current diagnosis, mental health services provided and impact of those services, the current treatment plan and progress toward goals, and ideas or strategies to meet the child/youth's mental health needs. Input given by the mental health clinician contributes to the decision-making process, confirms medical necessity, and appropriateness of less restrictive levels of treatment to meet the youth's needs. CWS, BHS, and Probation ensure the IPC is fully inclusive of multiple System Partners as applicable.

The IPC is responsible for determining eligibility for Medi-Cal specialty mental health services and treatment in a STRTP through group consensus.

CWS and Probation are responsible for establishing and sending IPC agendas weekly to committee members. Forms of communication among IPC members include but are not limited to written, electronic, telephonic, and virtual communication.

In support of the ICPM and teaming process, the IPC considers recommendations from the CFT and through this collaboration, all relevant information about a youth is gathered and considered for the committee to make an informed decision on whether a youth meets medical necessity criteria for Medi-Cal specialty mental health services, and for initial placement or continued placement and treatment in an STRTP, where behavior or treatment needs can only be met. The IPC engages in cross-system discussions and provides all partner agencies the opportunity to coordinate care and optimize availability and appropriateness of services and supports to safely maintain a youth in the least restrictive home-based family setting, other appropriate alternative settings, and to support a youth step down and transition to a lower level of care.

The IPC is a standing agenda item at ILT meetings. This provides a platform and space to share IPC trends, address service and placement gaps, identify systemic barriers preventing timely placement and services, develop and strengthen collaborative authority, and highlight cross system success.”

Resources for Continued Learning



[CFPIC IPC Enhancements Webinar](#)

[CFPIC System of Care Coordination Tool](#)

[Example Template Functional Analysis](#)

[AB 2083: Toward Effective Children and Youth System of Care](#)