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Chief Executive Officer

December 21, 2011

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
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Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

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EMERGENCY RESPONSE COMMAND POST AND EMERGENCY SHELTER SERVICES – SECOND QUARTERLY UPDATE

On July 12, 2011, your Board approved a recommendation to extend Emergency Shelter Care contracts with 13 contractors and to increase the capacity of three. In addition, your Board directed: 1) the Auditor-Controller to conduct an independent review of the Department of Children and Family Services (DCFS) Emergency Response Command Post (ERCP) operations since 2005; and 2) the Acting Director of the DCFS and the Chief Executive Officer (CEO), in conjunction with the Director of the Department of Mental Health (DMH), to report back in 30 days and quarterly thereafter, with a comprehensive analysis of Countywide need and placement capacity; and recommendations to better integrate and blend funding and services between the two departments. The first quarterly report was issued on September 20, 2011 to the second directive, and this report provides a second quarterly update. The Auditor-Controller is conducting an independent review of the ERCP operations since 2005 and will report back to your Board separately.

In the first report, representatives from the DCFS, DMH, and the CEO noted the characteristics of children who are more difficult to place and identified barriers to describe need. Furthermore, we showed the capacity of each placement type in all County contracted facilities. In this report, the workgroup updates the Board on five recommendations to improve placement capacity and inform of our planning efforts to integrate services and increase the number of children placed who receive timely and stable placement.

"To Enrich Lives Through Effective And Caring Service"

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Recommendations to Enhance Placement Capacity

When placement is needed during evenings or after business hours, weekends, and holidays, children are brought to the ERCP. Staff take children to the ERCP when they are initially taken into protective custody, or are referred to the ERCP by regional staff. Information from managers and staff suggest that the following groups are more difficult to place: younger children (0-5 years of age); teenage youth; and youth with behavioral/emotional issues. The workgroup's goal is to identify solutions to limit wait time at the ERCP and find the most stable placements for children in a timely manner.

From emergency shelter care in the short-term to longer-term, permanent placement, the workgroup presents five initial recommendations to better meet the placement needs of all children, and we will continue to explore the feasibility of integrating services and blending funding in order to implement these strategies:

Recommendations

- ① Expand Emergency Shelter Care at licensed foster homes and Group Homes for young children and older youth with behavioral/emotional issues.
- ② Expand Treatment Foster Care by enhancing support for foster parents to provide care and stable placement for youth with mental health needs.
- ③ Recruit foster parents for younger children, teenagers, and target populations in need of placement.
- ④ Advance intensive care coordination for youth 12 years and older with urgent mental health needs.
- ⑤ Strengthen data management to better track placement capacity and find more placements in less than four hours.

1. Expand Emergency Shelter Care (ESC) at licensed foster homes and Group Homes (GHs) for young children and older youth with behavioral issues.

Rationale – When a child is referred to the ERCP and placements are not readily available, the child may be placed in ESC foster homes for up to 14 days and ESC GHs for up to 30 days, until a suitable permanent placement is found. ESC can be especially helpful for more difficult to place populations such as younger children, teenagers as well as teen mothers and their young children. Having more than the existing 40 ESC beds would decrease waiting time at the ERCP and provide

additional time to search for the most suitable placement. The following strategies outline efforts to increase ESC at licensed foster homes and GHs.

Strategies

- ESC expansion at licensed foster homes – The DCFS Out-of-Home Care Management Division (OHCMD) is releasing an ESC contract for licensed foster homes that will become effective October 1, 2012 through September 30, 2017. The Request for Statement of Qualifications was released on November 21, 2011, and a Statement of Qualification may be submitted through February 28, 2017. The DCFS Contracts Administration Division processed a mass mailing to all active State-licensed foster parents, released newspapers advertisements in four languages during November, and held a series of conferences in December to answer questions and assist ESC Services applicants.
- ESC expansion at GHs – The OHCMD also approached GHs to ask whether they would be interested in increasing capacity to provide ESC services. In May 2011, 15 GH contractors responded with interest to provide ESC services, and 13 GH providers met qualifications to increase program capacity. Of these 13 providers, five have chose to continue with the process. The providers are working on program statements to specify what and how they would operate the ESC services, and their statements will be reviewed for approval by DCFS and Community Care Licensing. Upon approval, DCFS will write a letter to the State to request an increase in GH capacity in order to make an exception to the current moratorium. A total of nine new ESC GH sites are being proposed, which would provide an additional 58 ESC GH beds. The targeted start time is expected in April 2012.

2. Enhance supports and services for foster parents who provide care and stable placement for youth with mental health needs who meet D-rate criteria.

Rationale – For children with mental health needs, therapeutic services by trained professionals are important for healing. A D-rate is a funding category for foster care providers who have received specific training to provide care for children with special needs due to a mental health diagnosis. D-rate foster homes are primarily licensed foster homes, relative homes or relatives/foster parents who have obtained legal guardianship of D-rate children. In an effort to expand mental health support for resource families serving youth who meet criteria for the D-rate, DCFS and DMH propose a pilot study. The pilot will focus on children currently placed in D-rate foster homes with relatives and non-relatives who also receive Wraparound services. With innovative treatment levels that rely on teams comprised of cross-trained professionals, foster parents, school representatives, and families,

D-rate foster homes could build capacity to effectively escalate the level of care that their children receive. Enhancing services, improving quality of training to staff and families, and developing additional supports will lead to increased identification of youth's needs and creative ways to meet those needs without placement disruption.

Strategy

- Addition of an intensive tier to the basic D-rate system with the support of Wraparound to develop a pool of professional D-rate caregivers (Table 1).

Table 1: Pilot for Children in D-rate Foster Homes

Component	Description
Training and support	<ul style="list-style-type: none"> • Providing foster parents with additional training and support would empower them to be more active participants on the team, enhance the quality and intensity of service provision, and improve placement stability for the children.
Training components	<ul style="list-style-type: none"> • Foster parent training would consist of: 1) a trauma-informed approach to service delivery; 2) pro-social skills development with behavior management strategies; and 3) in-home coaching supports.
Best practices	<ul style="list-style-type: none"> • Treatment and support services would focus on best practice standards offered from both the Intensive Treatment Foster Care (ITFC) and Multidimensional Treatment Foster Care (MTFC) programs.
Cross-training	<ul style="list-style-type: none"> • The pilot proposes to collaboratively cross-train TFC and Wraparound staff, as well as D-rate Foster Parents. This approach to cross-train staff in various service modalities along with caregivers is a best practice model used effectively in the County of San Luis Obispo.
Potential payment options	<ul style="list-style-type: none"> • DCFS and DMH are exploring three potential payment options for FFAs that offer TFC: 1) develop a legislative remedy to legalize a different payment structure so that TFC may be offered through licensed foster parents; 2) offer a patch rate to pay net County cost to provider to enable payment for certified foster parents at a higher level; and 3) work with the State to receive more flexibility through CDSS.

As a result of these preliminary discussions, the team has identified the need for a program evaluation including a qualitative review of services and a closer

examination of which type of foster parents are best fit to meet the needs of the children served.

3. Recruit foster parents for younger children, teenagers, and target populations in need of placement.

Rationale – In addition to general recruitment through faith-based organizations, the media (radio/TV/print ads), and community colleges, the DCFS Adoption and Recruitment Division recruits foster parents for infants, sibling groups, teenagers and other groups that are more challenging to place. For example, a recent targeted recruitment effort that focused on foster parents for infants involved distribution of flyers to local businesses. Additional recruitment strategies are highlighted.

Strategies

- Ambassador program – The Adoption and Permanency Resources Division created the Ambassador program where existing resource parents recruit and mentor new families as they go through the approval process.
- TFC recruitment strategies – DCFS and DMH are partnering to recruit for TFC for children and youth with behavioral/emotional issues as shown in Table 2.

Table 2: Recruitment Strategies for Treatment Foster Care

TFC Recruitment	Description
Needs assessment	<ul style="list-style-type: none"> • With existing foster parents and Parent Advocates, DMH and DCFS identify strategies to enhance targeted recruitment efforts. This review yielded a list of possible incentives, and a more refined approach to training and support that until now have been deterrents from working with FFAs.
Outreach	<ul style="list-style-type: none"> • Through Foster Parent Associations and Parent Advocacy support groups, DCFS and DMH began to market the programs and recruit for foster parent participants.
Support workgroup	<ul style="list-style-type: none"> • To address recruitment, training, and foster parent support with TFC providers in an effort to consolidate resources and collaborate on best practices, the workgroup is coordinating a foster parent training, support, and recruitment fair on February 17, 2012.
Screening level system	<ul style="list-style-type: none"> • The system incorporates a likert scale to evaluate the level of need for the client and to determine the appropriateness of this program to meet the client's needs and ensure enrollment.

4. Expand intensive care coordination for youth 12 years and older with urgent mental health needs.

Rationale – Youth age 12 years and older with urgent mental health needs can access the Exodus Recovery Urgent Care Center for 23 hours on a voluntary basis. Such youth often exhibit intensive mental health needs and require specific placements/services to achieve stability. Currently, a relatively high number of DCFS children admitted to Exodus overstay and/or return to Exodus at a later date due to the complexities of their needs and the lack of services and/or placement to truly meet their needs. A workgroup represented by DCFS, DMH, and Exodus is working on care coordination planning to decrease lag time in linking youth at Exodus with Wraparound and other mental health services.

Strategies

- Linkages to mental health services – Exodus staff was provided with brochures for the Wraparound program which included referral criteria. It was agreed that if a youth was identified as needing Wraparound services, Exodus staff could contact Wraparound staff and request that they contact the CSW about initiating a referral. They were also provided a list of Wraparound staff in each DCFS office.
- Expedited connections – Exodus was provided a list of the on-call numbers of each Wraparound provider in the event that a youth currently enrolled in Wraparound is admitted to Exodus. It was emphasized that Wraparound is a 24/7 program and the youth's Wraparound team should be engaged as soon as possible.
- Discharge planning – DCFS discussed the possibility of assigning a TDM facilitator to Exodus to assist with facilitating discharge planning meetings for youth leaving Exodus. The intent is to pull key members of the youth's team together to develop a comprehensive discharge plan.
- Placement search assistance – DCFS also discussed the possibility of assigning RUM staff to Exodus to assist with finding placement for youth once discharged. DCFS agreed to pilot the assignment of staff to determine if it is fruitful.
- Resources for linkages to mental health services – DMH provided an overview of the Specialized Foster Care Co-Located programs and indicated that co-located staff could be utilized as a resource for linking youth to mental health services.

- 5. Improve data management to better track placement capacity and find more placements in less than four hours.** DCFS has redesigned its process to track placements made by the ERCP. In January, DCFS will implement a new automated system to track the number of hours children wait at the ERCP, barriers to placement, and final placement information. In the next quarterly report, the workgroup plans to review recent data collected by ERCP staff in order to identify:
- 1) characteristics of children who wait longer than four hours to be placed; and
 - 2) barriers to placement for these children.

A new template and process was issued in December 2011 to ensure tracking of all placements and standardize definitions of 14 barriers. More than one of the 14 barriers may be selected on the template:

- Age
- Behavior
- Criminal history
- Gender
- Mental health
- Sexual identify issues
- Sibling set
- Substance abuse
- Teen with child
- Other
- Medical issues
- Education barriers
- Youth refuses placement
- Medications/prescription

Tracking of Placement Capacity

DCFS tracks capacity of five types of out-of-home care providers: 1) State licensed foster homes, 2) foster family agency placements (FFA homes), 3) group homes and residentially based services (RBS), 4) emergency shelter, and 5) treatment foster care. Table 3 shows a total capacity of 12,151 beds and a vacancy of 1,946 as reported for five types of out-of-home care providers during October 2011. In comparison to June, vacancy increased from 1,459 by 35 percent. The table includes all County of Los Angeles contracted facilities.

The OHCMD is working with the Business Information Systems (BIS) Division to implement the FFA update tool to ensure FFA agencies have capability to update bed vacancy for FFA-certified homes. The BIS has also created and implemented a placement resources tool for the OHCMD staff. The tool allows staff to view licensed placement homes with facility information and children served.

Table 3: Out-of-Home Care Placement Capacity – October 2011					
OHC Type	Description	Homes	Capacity	Placed	Vacancy
1) Licensed Foster Homes	Homes collectively serve children of all ages	843	2,192	1,225	933 ¹
2) FFA Homes	Homes collectively serve children of all age	3,047	8,118	4,950	828 ¹
3) Group Homes (GH)²	Children 6-18, GH level of service and supervision varies by RCL	12	88	74	14
RCL 7,8,9					
RCL 10,11,12	Intense supervision	49	1,431	1,294	137
RCL 14	Very intense supervision	4	84	62	22
Community Treatment Facility (CTF)	Youth with serious emotional and behavioral disorders; locked setting	2	64	59	5
RBS RCL 12	Pilot helping higher-risk transition to permanency	3	57	49	8
4) Emergency Care	30-day beds; teenage males and females	2	14	14	-
GH Emergency Shelter Care					
Emergency Shelter Care Foster Homes ³	14-day beds; males 13-17; and females 0-17	12	26	49	4
5) Treatment Foster Care	Therapeutic foster homes, less restrictive, intensive treatment for children ages 6-17; not for emergencies	52	52	45	7
Intensive Treatment Foster Care					
Multidimensional Treatment Foster Care	Mental health service included with DMH	25	25	19	6
TOTAL		4,051	12,151	7,840	1,946

The workgroup consisting of DCFS, DMH, and CEO staff will continue to provide quarterly updates on the analysis of Countywide need and placement capacity related to the ERCP. We will further define strategies that better integrate services and blend funding between DCFS and DMH to offer more support for a significant number of children.

¹ Only a subset of these beds are actually available at any given time due to home study determinations. Therefore, the vacancy rate may overstate the number of beds actually available at any given time.

² Group home rate classification level (RCL) includes four levels rated by services and supervision.

³ Capacity increased in September 2011.

Each Supervisor
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Please let me know if you have any questions regarding the information contained in this report, or your staff may contact David Seidenfeld, Acting Manager, at (213) 974-1457, or via e-mail at dseidenfeld@ceo.lacounty.gov.

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VD:ljp

Attachment

c: Executive Office, Board of Supervisors
Auditor-Controller
County Counsel
Children and Family Services
Mental Health

ERCP December 2011.bm