County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

September 30, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003);
- Enhanced Specialized Foster Care Mental Health Services Plan (2005);
- Findings of Fact and Conclusions of Law Order (2006), issued by Federal District Court Judge Howard Matz;
- Health Management Associates Report (2007); and
- Katie A. Corrective Action Plan (2007).

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

The Strategic Plan also provides that the Departments of Children and Family Services (DCFS) and Mental Health (DMH) inform your Board regarding any revisions to the implementation of the Strategic Plan and report quarterly thereafter. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents.

Previous quarterly reports were submitted on implementation activities in June 2009, September 2009, March 2010 and July 2010. This memo serves as the fifth update to our progress in implementing the Strategic Plan.

Implementation Support Activities

- Greg Lecklitner, DMH District Chief, continues to participate as a member of the Katie A. State Negotiations Team, which is working toward a settlement of the Katie A. State Case.

- The DCFS Bureau of the Medical Director scheduled a series of four "D-Rate Town Hall" meetings for all foster parents, relative caregivers, and adoptive parents. The meetings on May 4, 2010 in Lancaster, June 8, 2010 in Glendora, and August 3, 2010 in central Los Angeles were well attended and the agenda included updates about the D-Rate Program. In addition, caregivers had many opportunities to discuss difficulties faced when meeting the needs of children for whom they are responsible, and received valuable feedback from professional staff and each other. The fourth meeting is scheduled for November 3, 2010 in Lakewood.

- On August 13, 2010, representatives from DMH, DCFS and Exodus Recovery Urgent Care Center (Exodus) met for preliminary discussions regarding a plan to provide urgent mental health care services to DCFS adolescents ages 16 through 17 years. A number of additional meetings with the departments and Exodus have occurred to develop a Memorandum of Understanding, and an expedited response protocol between DMH Psychiatric Mobile Response Team (PMRT) and DCFS. In addition, DCFS will provide "DCFS 101" training to

Exodus and PMRT staff in anticipation of the increased collaboration. DMH is also in the process of amending the Exodus contract to provide urgent mental health care services to DCFS children ages 13 and above. These services are expected to be available by January 2011, following the necessary renovations to the Exodus facility.

- DMH Wraparound Administration has begun a series of technical assistance site visits with Wraparound providers in order to improve the utilization of Early Periodic Screening Diagnosis and Treatment (EPSDT) funds associated with Wraparound programs. These site visits will be performed across all 34 Wraparound agencies over the course of the next year. DMH Child Welfare Division staff, in conjunction with DMH Service Area Administrations, has initiated a series of technical assistance site visits with Katie A. mental health providers to examine their claiming practices to improve the maximization of Katie A. contracts. These visits will begin in Service Planning Area (SPA) 3 and will continue until all 64 Katie A. providers have been visited. DMH has provided contract amendments, totaling approximately $10 million, to a set of Wraparound providers in order to enhance their capacity to perform Wraparound services. This brings the total EPSDT Wraparound allocation to over $60 million.

- DMH and DCFS staff met with three contract providers to begin negotiations to provide intensive home based services to Los Angeles County DCFS children placed in San Bernardino County. It is anticipated that contract amendments will be forthcoming for a total of approximately $1.5 million.

- Department representatives participated in a two-day meeting with the Katie A. Advisory Panel on September 15 and 16, 2010 to discuss the Core Practice Model (CPM), intensive mental health services for children in Foster Care/D-Rate homes, Quality Services Review (QSR), Multidisciplinary Assessment Team (MAT) case review and overall Strategic Plan implementation issues.

- Training for the Coordinated Services Action Team (CSAT) Redesign and revised Mental Health Screening Tool (MHST) has been completed in SPA 7 and is underway in SPA 6.

- DCFS continues to develop and maintain the Katie A. website.

- DCFS has now hired 81 of the 81 positions allocated in the Strategic Plan, and DMH has hired 38 of the 42 positions allocated.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan, are described below.

OBJECTIVE NO. 1

Mental Health Screening and Assessment

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health service needs. Below are the Screening and Assessment components of the Plan:

- *Medical Hubs (Hubs)*
- *Multidisciplinary Assessment Team (MAT)*
- *Consent/ Release of Information*
- *D-Rate*
- *Resource Management Process (RMP)*
- *Coordinated Services Action Team (CSAT)*
- *Referral Tracking System (RTS)*
- *Benefits Establishment*
- *Team Decision-Making (TDM)*
- *Specialized Foster Care (SFC)*

Medical Hubs

From July 2009 through April 2010, 82 percent of newly detained children received an initial medical examination at a Medical Hub.

DCFS continues to improve child health outcomes for DCFS children by ensuring that 100 percent of the priority populations of DCFS children are referred to and served by the Hubs. DCFS has defined the priority populations as:

- Newly detained children placed in out-of-home care;
- Children who are in need of a forensic evaluation to determine abuse and/or neglect; and,
- Children with special health care issues that need a follow-up exam, i.e., diabetes, hemophilia, developmental delay, etc.

On August 24, 2010, August 27, 2010 and September 21, 2010 the Hub Directors presented forensic evaluation and forensic interviews to newly hired Children's Social Workers (CSWs). Simultaneously, representatives of the DCFS Bureau of the Medical Director presented an overview of the Utilization of Medical Hub Procedural Guide, which included the procedures for referring children to Hubs and reinforced the use of the Hubs for consultation.

DCFS, Department of Health Services (DHS), DMH, and the Chief Executive Office (CEO) managers have met with all seven Hubs: High Desert Health System Multi-Service Ambulatory Care Center, Harbor-UCLA Medical Center Hub, Children's Hospital Los Angeles, LAC+USC Medical Center Hub, Martin Luther King Jr. Multi-Service Ambulatory Care Center, LAC+USC East San Gabriel Valley Satellite Hub, and the Olive View-UCLA Medical Center Hub. The Hub meetings are held to increase collaboration, ensure a strong understanding of Hub operations, and to plan for improved access and service delivery.

In addition, the County has taken steps to improve the continuity of care from the Hubs and has begun the development and implementation of an Enterprise Medical Hub (E-mHUB) system. The E-mHUB Project Workgroup continues to convene weekly to ensure that Saga Technology Inc. meets its deliverables.

Coordinated Services Action Team Redesign Rollout and Training Schedule

On May 1, 2009, CSAT was implemented in SPA 7 (Belvedere and Santa Fe Springs). On August 1, 2009, CSAT was implemented in SPA 6 (Compton, Wateridge, and Vermont Corridor). SPA 1 (Lancaster and Palmdale) implemented CSAT in September 2009, and SPA 3 (El Monte and Pomona) implemented CSAT on April 1, 2010.

In response to the January 19, 2010 motion from Supervisors Molina and Knabe, DCFS and DMH staff reviewed a sample of 51 children's cases from the DCFS Santa Fe Springs Regional Office for mental health screening, referral, and start of mental health services. The cases were randomly selected from newly detained children (25 cases) and newly opened non-detained children (26 cases). As a result of the case review, the Child Welfare MHST, the RTS and the CSAT Screening and Assessment Policy and related DMH policy were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs.

The MHST was revised to distinguish the acuity of a child's mental health needs and was piloted in SPAs 7, 6, 1, and 3 in May 2010. The pilot results revealed that 76 percent of the CSWs indicated that the revised MHST was easier to complete. The RTS was revised to track compliance and timelines for screening, referral, and receipt of mental health activities for newly detained children, non-detained children, and open cases.

The DCFS CSAT mental health screening and referral policy was revised to reflect the CSAT redesign process. CSAT redesign training was provided to SPA 7 in August 2010 and the revised mental health screening, referral, and service linkage

process and RTS system "trial month" phase was implemented on September 1, 2010. Formal implementation of the CSAT redesign will begin on October 1, 2010. In addition, the redesign has delayed the rollout of CSAT to DCFS offices not yet trained. Those offices already trained and implementing CSAT (SPAs 1, 6, 7, El Monte and Pomona) are being retrained and will implement the new procedures first, followed by the remaining offices.

CSAT staff and regional administration convene CSAT "pre-meets" prior to beginning training in each office. The pre-meet familiarizes regional management with the CSAT process and identifies their respective strengths and challenges, ensuring that training will be targeted to address the specific needs of each regional office. Initial pre-meets have been held in the Belvedere, Compton, Wateridge, and Vermont Corridor regional offices and the remaining pre-meet dates are to be determined.

The training rollout per office is depicted in Table 1.

Table 1: CSAT Redesign Training and Rollout Schedule

DCFS Office	*Training Month*	*Trial Month*	*CSAT Roll Out*	*Referral Tracking System Report to Board*
Belvedere, Santa Fe Springs	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct .2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster, Pomona, El Monte	Sept. – Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Pasadena, Covina Annex (Asian Pacific and American Indian Units only), Glendora	Oct. – Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
Metro North	Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011
West Los Angeles (and Deaf Services)	Dec. – Jan. 2011	Feb. 2011	Mar. 2011	May 2011
Lakewood, Torrance	Jan. – Feb. 2011	Mar. 2011	Apr. 2011	June 2011

San Fernando Valley, Santa Clarita	Feb. – Mar. 2011	Apr. 2011	May 2011	July 2011
Medical Case Management Services	Mar. – Apr. 2011	May 2011	June 2011	Aug. 2011
Emergency Response Command Post	May 2011	June 2011	July 2011	Sep. 2011

CSAT SUCCESS STORY

A 17-year-old youth came to the attention of DCFS due to his mother's history of domestic violence and the teen's aggressive behavior towards her. Due to his escalating behavior, his mother felt helpless and was willing to have the teen placed out of her home. A TDM meeting was held and it was determined that the teen required urgent linkage to mental health services.

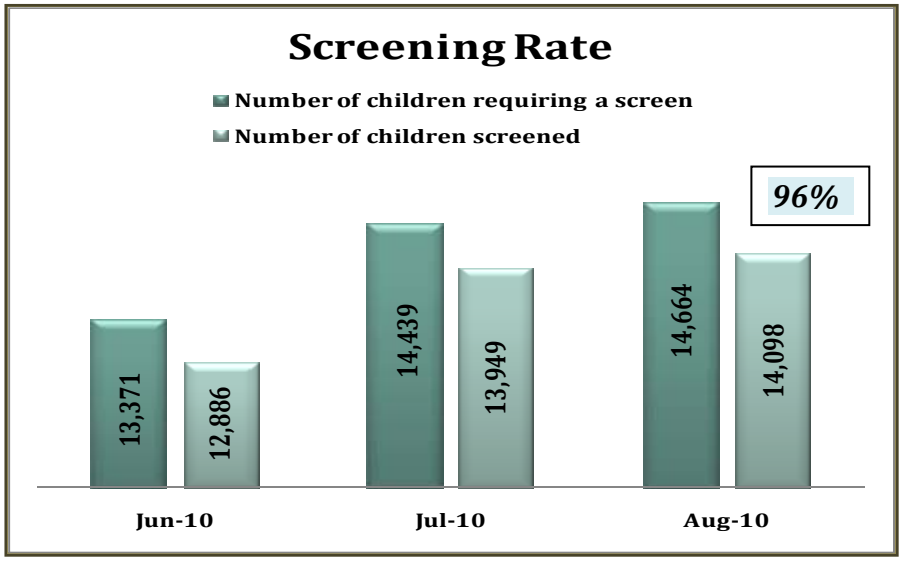
The Service Linkage Specialist (SLS) submitted the referral packet to DMH Specialized Foster Care staff, who immediately initiated a search for a mental health provider. Unfortunately, once a provider was established, the mother's Medi-Cal plan required a $500 co-payment, which she was unable to pay. With the assistance of the Department of Public Social Services (DPSS) Linkages Liaison, the teen applied for Medi-Cal benefits and was able to obtain individual benefits, thereby eliminating the $500 co-payment obligation. As a result, in-home mental health services began immediately and the teen remained in his home.

Referral Tracking System

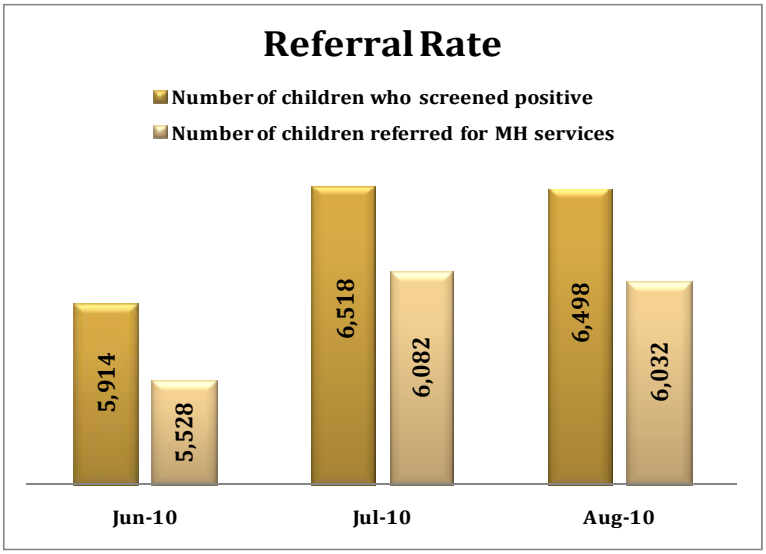
The RTS is operational in DCFS and DMH in a total of nine DCFS regional offices in SPAs 1, 3, 6, and 7. The RTS required redesign to reflect changes in the CSAT policy and procedures. The redesigned RTS will provide data on the completion of the mental health tool for screening, referral, and start of service activity for children with acute, urgent, and routine mental health needs. In addition, the RTS will track the annual re-screening of children in open cases with previous negative screens and who are not currently receiving mental health services. The RTS trial began on August 23, 2010, in preparation for the September 1, 2010 CSAT redesign trial month in SPA 7.

As of the August 31, 2010 CSAT/RTS Monthly Report, 14,098 children received mental health screens, since implementation on May 1, 2009, yielding a 96 percent screening

rate.* The mental health screening rate is tracked through the RTS for referral and mental health service linkage.



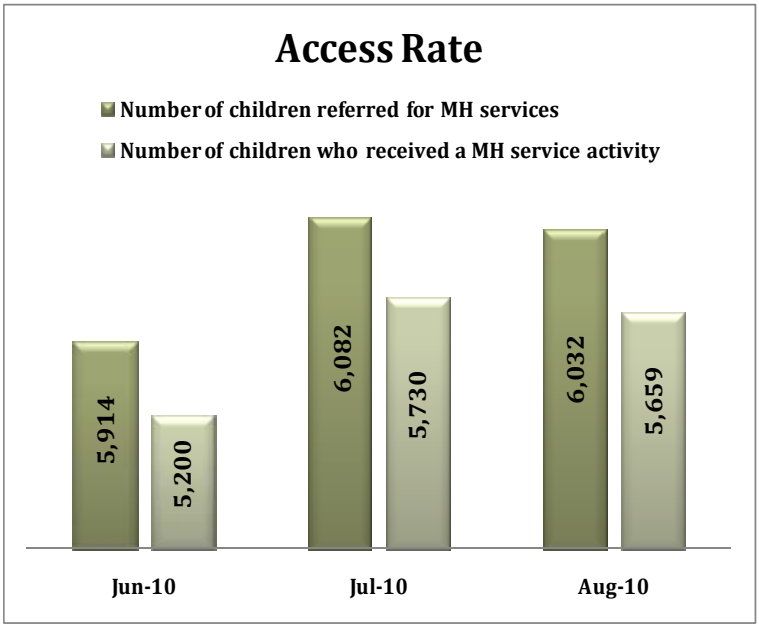
*The number of children that required screens is defined as a) the number of newly detained children (Track 1) with a case opening in the month; b) the number of newly opened non-detained children (Track 2) with a case opening in the month; c) the number of children in an existing open case (Track 3), not currently receiving mental health services, with a case plan update due or a behavioral indicator identified requiring the completion of a Child Welfare Mental Health Screening Tool (MHST) within the month. Out of the total number of children reported, the number of children requiring screens was reduced by the number of children in cases (Tracks 1, 2 and 3) that were closed during the screening, referral and service linkage process.



- As of the August 31, 2010 Monthly Report, out of the **6,498** children who screened positive, **6,032** children were referred for mental health services at a **95 percent** referral rate.**

**The rate of referral reflects the number of children who screen positive minus the number of children who are determined to be privately insured divided by the number of children referred to mental health services. The number of children referred for mental health services can be affected by the number of children with a closed case, deceased, and/or AWOL at the time of referral or still pending referral.

- As of the August 31, 2010 Monthly Report, out of **6,032** children referred for mental health services, **5,659** children received a mental health service activity within 30 days of the referral at a **94 percent** access rate.



Multidisciplinary Assessment Team

In June 2010, 84 percent of all MAT eligible newly detained children Countywide were referred to MAT. From October 2009 to June 2010, there were 3,456 MAT referrals and 2,733 MAT assessments completed.

In June 2010, seven DCFS offices referred 90 to 100 percent of all MAT eligible children and eight DCFS offices referred 80 to 89 percent of all MAT eligible children. Six offices referred between 70 to 79 percent of all MAT eligible children and only one office is currently below 70 percent. Seven of the eight SPAs are referring over 70 percent of eligible children. SPA 1 referral rates lag behind due to provider capacity issues. The rate of MAT compliance is depicted in Table 2.

Table 2: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	50	23	46%
SPA 2	66	61	92%
SPA 3	71	59	83%
SPA 4	43	38	88%

SPA 5	14	13	93%
SPA 6	106	91	86%
SPA 7	60	48	80%
SPA 8	67	59	88%
Total number of DCFS MAT referrals:	**477**	**392**	**82%**

*Cumulative includes all June 2010 MAT referrals within each DCFS office and SPA.

MAT staff (DMH, DCFS and MAT agencies) meet at the SPA level on a monthly basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Operations Workgroup, comprised primarily of experienced MAT providers, DCFS, and DMH managers, is working to standardize and streamline the MAT process, improve the quality of MAT reports and overcome barriers that prevent MAT agencies from completing the Summary of Findings (SOF) Report in time to be considered by the Court for the dispositional hearing. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders of the date to the MAT agencies. In addition, DCFS MAT Coordinators work closely with the Dependency Court attorneys to ensure that children have the appropriate consents to receive needed services.

MAT staff and other stakeholders have also met to discuss the needs for timely linkage to mental health services. This meeting resulted in the creation of the MAT Linkage Workgroup. This workgroup is tasked with ensuring that children with mental health needs are adequately linked to services. The guidelines are being created, so that each MAT agency understands their new responsibility regarding timely and appropriate linkage.

DMH and DCFS have issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol, MAT checklist, and MAT CSW Interview Survey. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT program. DMH and DCFS are also convening a MAT Best Practices Workgroup to further refine the assessment process and ensure the MAT SOF Report is completed and in line with recommendations made by the Children's Services Investigation Unit. Furthermore, DMH has planned a series of trainings for MAT providers to improve their understanding of needs and strength-based assessments consistent with the CPM.

To date, DMH MAT Coordinators have completed a total of 211 MAT Quality Improvement (QI) checklists. The checklists represent their findings based upon a review of the MAT SOF. QI checklists were received from the eight SPAs. The MAT QI checklist calls for yes/no responses within eight domains. The results of the MAT QI checklists are summarized below.

Results within MAT QI domains:

- 87 percent of the SOFs reviewed showed that the assessors demonstrated reasonable efforts to engage all the stakeholders in multidisciplinary activities to support the information gathering/assessment process;
- 86 percent showed the SOF Report adequately assessed all of the MAT domains of functioning;
- 91 percent showed the SOF Report contained adequate description and information;
- 90 percent showed the SOF final report was completed within 45 days;
- 89 percent showed the strengths of the children, family, and other caregivers were adequately described;
- 91 percent showed the needs of the children, family, and other caregivers were adequately described;
- 94 percent showed the recommendations made in the report were consistent with the assessment information; and
- 97 percent showed the recommendations were specific enough to be efficiently implemented.

Overall, 91 percent of the individual domain ratings were positive.

MAT SUCCESS STORY

The MAT Coordinator in the Pomona office worked diligently to provide support to the CSW in a complex needs case. She assisted the CSW in completing the referral form to a special needs program offered by Pacific Clinics and kept the child's mother updated on the status of the referral to the program. In addition, the CSW followed up

with the child's mother regarding the child's slurred speech and engaged the Public Health Nurse to assist with identifying a neurologist. The MAT Coordinator ensured that all of the child's needs were addressed and team members were kept informed of the child's status. This is a great example of the assistance and coordination CSAT members bring to CSWs.

Consent/Release of Information

DCFS and DMH, with their respective County Counsels, developed procedures and forms to provide for the consent of mental health services for referred children, as well as the authorization to release protected health information for purposes of children's care and coordination of services. Recommendations from children's and parents' attorney groups were incorporated and the Children's Law Center (CLC), the Los Angeles Dependency Lawyers, County Counsels, and DMH and DCFS management approved the revisions. Consent forms are in the process of being revised to reflect the Court's language, and seeking approval from the DMH Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer. In addition, CLC and County Counsel agreed to write letters that provide explanation of law regarding consent and protected health information in an effort to clarify for providers what they may and may not share with DCFS and DMH staff for purposes of children's care and coordination of services. The DCFS training section will train staff from both Departments on the revised consent and release of information forms. Finally, as a result of consultation with Regional Center, DCFS, DMH, and Regional Center management are participating in a Consent Sub-Workgroup to modify the language in the consent forms and standardized court language and DCFS policy to ensure the needs of all children are appropriately addressed.

The DMH Practice Guidelines related to consultation requests involving adult mental health information is completed and being reviewed by County Counsel. The Guidelines include information on the formation of multidisciplinary teams that may allow DMH co-located staff and service providers to share adult caregiver mental health information to assist DCFS in providing protection to children and support to families. DCFS has agreed to create a comparable policy to clarify which situations merit consultation with DMH and what information can be shared within this context.

Benefits Establishment

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the Medi-Cal Eligibility Data System (MEDSlite) benefits establishment system. MEDSlite is a condensed version of the Medi-Cal Eligibility Data System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT

Coordinators that serves as an instructional guide for the use of MEDSlite, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

Although the MEDSlite system is helpful in providing a child's Medi-Cal eligibility status "at a glance", one of the limitations of the system is that it does not provide the issue date of a child's Medi-Cal card, needed most by DMH providers for mental health service billing.

With staff reductions at the State level, disruptions in service are occurring as it takes longer to enroll them in full-scope Medi-Cal. To further complicate the process of establishing Medi-Cal and maintaining enrollment, eligibility staff at DCFS can only access the Medi-Cal database for foster care and adoption services Medi-Cal. DCFS eligibility staffs do not have access to information regarding the type of Medi-Cal coverage for non-detained children. The inability of DCFS eligibility staff to address all Medi-Cal issues has presented challenges with enrolling children in mental health services in a timely manner.

DCFS and DPSS have built a productive partnership through the use of DPSS Linkages staff that has been very helpful. CSAT staff work very closely with Linkages staff to obtain and secure Medi-Cal services for children without Medi-Cal that are otherwise eligible.

D-Rate

In addition to the D-Rate Program's continued work to review and ensure mental health services for D-Rate children, the duties of the DCFS D-Rate Evaluators (DREs) have been expanded to include psychotropic medication monitoring for all DCFS children, psychiatric hospital discharge planning, special placement requests and approvals, and service coordination for other high-need children.

As of July 2010, there were a total of 1,477 children in DCFS care who were receiving a D-Rate, which has been gradually declining over the last several years.

Team Decision-Making/Resource Management Process

DCFS has completed 4,428 TDMs from April through June 2010. This number was almost identical from the previous three months as there were a total of 4,427 TDM's conducted from January through March 2010. Additionally, DCFS completed a total of 476 RMPs on 61 percent of youth entering a group home, 71 percent of youth replaced

and 63 percent of youth exiting a group home. This was an increase of 27 RMPs from the previous three months (January through March 2010).

Finally, DCFS continues efforts to phase in TDMs at the Emergency Response Command Post (ERCP). There were a total of 25 TDMs completed from April through June 2010. Preliminary data reflects positive outcomes: 23 (92 percent) of the ERCP TDMs resulted in children remaining home with their respective caregivers; and 16 (64 percent) of the ERCP TDMs convened had the participation of community-based agency partners.

Specialized Foster Care

The DMH SFC Care co-located staff responds to requests for consultation from DCFS CSWs, provides referral and linkages to community-based mental health providers, and participates in the CSAT process in those offices where CSAT has rolled out. Moreover, all SFC co-located staff (a total of 70 clinicians) were trained in Trauma-Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, and provide this treatment on a case-by-case basis. Currently, DMH has 178 co-located staff in 18 DCFS regional offices.

OBJECTIVE NO. 2

Mental Health Service Delivery

DMH has been working with its provider community to improve capacity and utilization of mental health services, particularly among those providers, now totaling 64, who have received a Katie A. related contract (including Wraparound, MAT, Treatment Foster Care (TFC), Comprehensive Children's Services Program, and Basic Mental Health Services). In total, these contracts now provide for over $100 million of targeted mental health services for DCFS children. In addition to these targeted contracts, DMH children's providers also use their general service contracts to provide needed services to DCFS children.

Wraparound

On May 1, 2009, the County began the implementation of Tier II Wraparound, an expansion of the existing Wraparound Program.

As of July 30, 2010, 1,088 children have been enrolled in Tier II Wraparound, which is 106 percent of our target (1,025). The feedback from the regional offices has been very positive. As a result of the recent economic downturn, many providers have not been

hiring/expanding their staff to handle the increase in referrals from the County. However, Wraparound Providers have now begun hiring again and are moving forward with expanding capacity to meet the demand.

Although Tier II is exceeding its target, as of June 2010, the Tier I enrollment has dropped from 1,059 to 1,043. The current census is expected to increase significantly with the implementation of the Residentially-Based Services (RBS) Demonstration Project slated to begin in September 2010.

Additionally, when Tier II was being developed there was discussion of how Tier II would impact Tier I. Although it is still too early to discuss a relationship, the belief is that Tier II will intervene much earlier in a family's life resulting in fewer children requiring Tier I level services.

The Wraparound Administration has also implemented a review of the Wraparound Case Rate for appropriateness and for opportunities to increase the use of EPSDT. In May 2010, a workgroup was formed that included representatives from CEO, Auditor-Controller's Office, DCFS Finance, Probation, DMH, and several Wraparound Provider agencies. The workgroup developed the methodology and the process for evaluation. On October 4, 2010, all Wraparound providers will receive instructions to provide their case rate data for review. Upon receipt, the Wraparound Administration will analyze, report findings, and discuss next steps.

Treatment Foster Care

The County's TFC Program is another intensive mental health service program, originally discussed in the Katie A. CAP. Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 TFC beds by January 2008. A proposal to develop 300 beds by December 2012 was established as the new target: 220 beds of Intensive Treatment Foster Care (ITFC) and 80 beds of Multi-dimensional Treatment Foster Care (MTFC). The Program continues to grow as placements have improved since the last report. Eight children have currently been placed compared to the three placed in the previous quarter. Each Foster Family Agency (FFA) with a vacancy has begun reviewing the list of available youth needing TFC placement. In addition, TFC outcomes continue to show a positive trend with two youth successfully transitioning to a lower level of care and none returning to a group home or psychiatric hospital since the last report.

There has been a small increase of three certified TFC homes. As seen in the last quarter, the number of potential homes has continued to rise. With the recruitment of 12 new homes, the number of upcoming homes has increased from 40 to 52. The

challenge for the TFC program remains the length of time needed to recruit, certify, and train TFC resource families. It can take between two to six months for a resource family to be fully certified, complete the adoption home-study, and receive the 40 hours of mandatory training.

Overall, TFC program development is growing. The nine FFAs that received contracts in April 2010 have begun the process of hiring and developing their treatment teams according to State regulations for intensive treatment foster care. The treatment teams consist of a case manager/program supervisor, in-home support counselor, and licensed therapist that work together to provide 24/7 intensive support services to the child and the TFC foster parent. The team members must undergo 16 to 40 hours of specialized training, depending upon their duties. With the TFC teams in place, the agencies are now tackling the time-consuming task of recruiting, certifying, and training TFC foster parents. The foster parents are also considered part of the treatment team, therefore, once recruited and certified they must also complete a mandatory 40-hours of training to work with youth with severe emotional and behavioral problems.

Table 3: TFC Placement and Capacity (as of 8/20/10)

Agency	Total No. of Placed Children	Total Certified Homes	Certified Homes Vacancies	**Inactive Homes	Upcoming Beds (cert. incomplete)
Intensive Treatment Foster Care (ITFC)					
Five Acres	10*	12*	3	1	9
ChildNet	5	8	1	2	1
Olive Crest	1	2	0	1	0
Penny Lane	0	0	0	0	11
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	0	0	0	2
The Village	2	3	1	0	4
CII	0	0	0	0	5
David and Margaret	0	0	0	0	4
Vista Del Mar	0	0	0	0	4
Hathaway-Sycamore	0	0	0	0	0
Ettie Lee	0	0	0	0	0

SUB TOTAL	18*	25*	5	4	40
Multi-dimensional Treatment Foster Care (MTFC)					
CII	5	7	2	0	0
Penny Lane	4	9	2	3	10
ChildNet	1	5	4	0	0
David and Margaret	0	0	0	0	2
SUB TOTAL	10	21	8	3	12
GRAND TOTAL	**28**	**46**	**13**	**7**	**52**

* Three children placed in one ITFC home **Per Agency request

DMH has added capacity within the MTFC program to serve children as young as six years old. In addition, DMH has also expanded MTFC capacity from two SPAs to five SPAs. TFC program staff is assisting in recruitment with more proactive outreach to existing licensed foster parents that might be interested in working with the TFC target population.

ChildSTEPs

DMH has contracted with UCLA to partner on a three-year research project which will examine the use of various evidence-based practices for children and adolescents as compared to usual or conventional treatment approaches. This project, known as ChildSTEPs, will provide substantial training, consultation and technical assistance, and tracking of outcomes for those mental health providers participating in the study and will inform future planning of children's mental health services.

To date, providers have been selected to participate in this project and the initial week of training in the model was conducted in August 2010.

DMH has also begun a large scale transformation of mental health services related to the Mental Health Services Act Prevention and Early Intervention Program. As part of this initiative, children's mental health providers are being trained in a variety of evidence-based practices, including Trauma-Focused Cognitive Behavior Therapy, Triple P (Positive Parenting Program), Child Parent Psychotherapy, Depression Treatment Quality Improvement (DTQI), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Managing and Adapting Practice (MAP), and Seeking Safety.

OBJECTIVE NO. 3

Funding of Services/Legislative Activities

Currently, we anticipate approximately $22 million in fiscal year savings from 2009-10. The savings are primarily due to vacant Wraparound slots. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings should decline in the out years.

As we have done with prior year savings, CEO has rolled the Fiscal Year (FY) 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 in support of the incremental rollout of the Strategic Plan.

The County met with the Special Master toward the end of July 2010 to discuss the Special Master's work plan for concluding negotiations between the Katie A. Plaintiffs and the State by November 1, 2010. In that July 21 meeting, the Special Master discussed plans to contract with a pool of consultants that could provide expertise in developing new approaches for the delivery of Medicaid EPSDT services to meet the needs of the plaintiff class. The County supports a detailed analysis of the various service delivery and funding models to determine the most cost-effective manner of delivering intensive mental health services to Katie A. class members. DMH is continuing to participate in the negotiations led by the Special Master and this forum remains the County's most viable opportunity to maximize revenue reimbursement to the County.

OBJECTIVE NO. 4

Training

DMH and DCFS have worked closely together to develop and implement the necessary training components related to the Strategic Plan, including:

- On May 27–30, 2010, a Coaching and Mentoring Pilot was held for five DCFS offices and selected DMH staff. Casey Family Programs sponsored the training for staff from the Pasadena, Lakewood, Compton, Wateridge, and Chatsworth offices. This core training provided staff with key skills and techniques to become office-based coaches starting with Emergency Response (ER) staff;

- An ER specific Coaching Model is being developed in partnership with California State University, Long Beach. A three-day follow-up coaching training was held

August 31–September 2, 2010. The tentative coaching roll-out for the five pilot DCFS offices is:

- o Lakewood: September 14, 2010, October 5, 2010, November 9, 2010, and December 14, 2010;
- o Compton: September 16, 2010, October 7, 2010, November 9, 2010, and December 14, 2010;
- o Wateridge: September 21, 2010, October 19, 2010, November 18, 2010, and December 16, 2010;
- o Pasadena: September 23, 2010, October 21, 2010, November 18, 2010, and December 16, 2010; and
- o Chatwsorth: September 28, 2010, October 26, 2010, November 23, 2010, and December 21, 2010.

- The Enhanced Skill-Based Training Pilots were completed on July 29, 2010. The Inter-University Consortium Trainers are incorporating feedback from the DCFS and DMH staff who attended the Pilot Trainings. This curricula is also being modified to address Katie A. Panel member feedback and was discussed at the September 2010 Panel Retreat. The office-based roll-out schedule is slated for early fall and is being drafted for the DCFS Executive Team's review and approval.

- The refinement and adaptation of the DCFS/DMH CPM into a desk guide that aligns both departments policies and procedures. The CPM desk guide will articulate how staff will integrate the key competencies of engaging and teaming, while using a strengths-based approach into daily practice.

- On August 17, 2010, DMH and DCFS provided a joint training to Wraparound and SFC staff on the Child Assessment Needs and Strengths (CANS) tool. In addition, needs-strength based mental health assessment training will resume for MAT Providers and DMH co-located staff.

OBJECTIVE NO. 5

Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,680 (January 2010) to 15,375 (July 2010).

Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

As of January 2010, individual CSW generic caseload sizes were reduced from an average of 26 to 22.48. An increase in this average in July 2010 brought the average caseload to 25.47 children per social worker.

As of January 2010, the ER caseload was reduced from an average of 24 to 19.25. This service component showed a significant decrease through July 2010, bringing the current referral average to 15.19. The escalating trend in caseload averages is due to the increased number of ERCP referrals received within the past six months, associated workload tied to heightened safety measures in emergency response activities and investigations, and the need to address an increasing backlog of emergency response investigations.

OBJECTIVE NO. 6

Data and Tracking of Indicators

The departments, with approval from County Counsel, implemented a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The SAS Dataflux system is being used for matching DMH and DCFS client data. This software has undergone extensive parallel testing, with the assistance of the Internal Services Department, to improve the validity of client matches. The SAS Dataflux system is now in full production, whereby matches can be conducted more frequently and the departments have agreed to conduct weekly matches of client information.

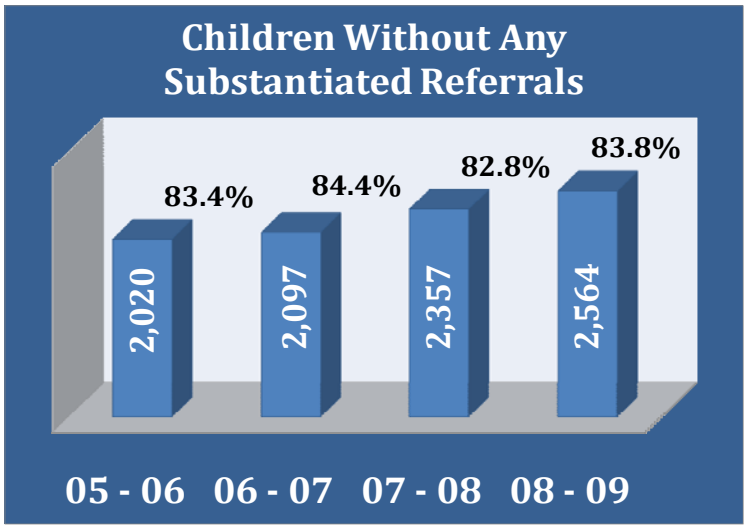
The Katie A. Advisory Panel informed the Court of our agreement on the Safety and Permanency Exit Indicators in their August 18, 2010 Report for Court. Discussions on the mental health screening, assessment, and service delivery exit indicators continue. Should the Court agree with the County and Panel's recommendations on the Safety and Permanency Exit Indicators and targets, the first step in identifying measurable exit

criteria by which to evaluate the County's progress in complying with the Katie A. lawsuit would be accomplished.

DATA OUTCOMES

SAFETY	***PERMANENCY/ REDUCED OUT-OF-HOME CARE***

The intensified collaboration of the departments to advance the objectives of the Strategic Plan simultaneously impacts DCFS key goals to: 1) improve child safety; 2) decrease timelines to permanency and reduce reliance on out-of-home care; and 3) improve child well-being. A sample of Katie A. Safety and Permanency Exit Indicators for class members (those receiving mental health services) are depicted below.



Safety Indicator 1:

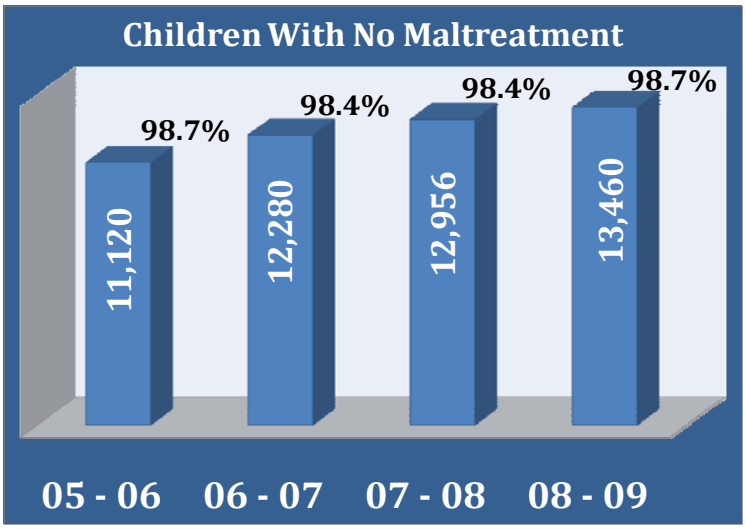
Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

This indicator has remained fairly stable over the last few years at roughly 83 percent and demonstrates that the majority of children are remaining safely at home.

Safety Indicator 2:

Of all children served in foster care in the fiscal year receiving mental health services, how many did not experience maltreatment by their foster care providers?

Again, this indicator has remained stable at 98 percent indicating that the majority of children in foster home settings experienced no substantiated foster parent maltreatment.



Permanency Indicator 1:

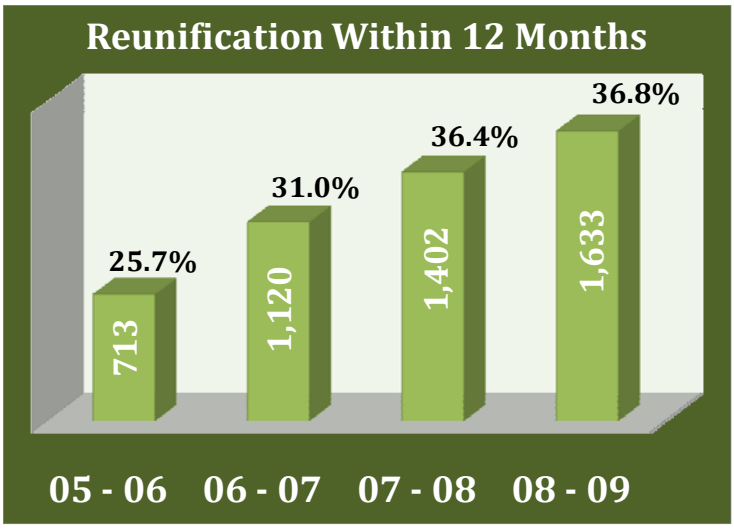
Median length of stay for children in foster care receiving mental health services.

This indicator reflects meaningful improvement – a 23 percent decline – in median days in foster care from FY 2005-06 to FY 2008-09.

Permanency Indicator 2:

Reunification within 12 months for children receiving mental health services.

Dramatic improvements in reunification are evident – over 100 percent increase from FY 2005-06 to FY 2008-09.



OBJECTIVE NO. 7

Exit Criteria and Formal Monitoring Plan

The Strategic Plan identifies three formal exit criteria, including the: (1) successful adoption by your Board and the Federal District Court of the Strategic Plan; (2) acceptable progress on a discrete set of agreed upon data indicators; and (3) a passing score on the QSR.

The conceptual framework of the Katie A. five-year Strategic Plan has been approved by your Board, the Advisory Panel, and Plaintiffs' attorneys, and, as previously noted, the Strategic Plan was approved by the Federal District Court on July 22, 2009. This notes the first time since the inception of the lawsuit that a County developed plan for Katie A. has been approved by the Court, which is a significant achievement in itself for the County and identifies a practical timeline with objective criteria for exiting the lawsuit.

Quality Services Review

QSR is an in-depth, case-based quality review process focused on integrated child welfare and mental health practices involving dependency and concurrency for children in care. Review findings will be used by the departments to stimulate and support efforts to improve practice for children, youth, and families receiving child welfare and children's mental health services in Los Angeles County. Review findings identify

current strengths and accomplishments, practice challenges, and limiting conditions, as well as opportunities for advancing practice and improving local conditions for better outcomes.

The QSR process will take place in three phases. Phase I activities, which have included the development of a tailored QSR instrument, the identification of staff responsible for the development of the protocol, the identification of training resources, the identification of and training of lead reviewers, and the development of a QSR implementation plan have been completed as projected by July 2010.

In the Belvedere QSR Pilot completed in July 2010, a sample of 14 randomly selected cases was reviewed and an average of 8.5 children, youth, caregivers, family members, service providers, and other professionals were interviewed per case. Overall, the children in the cases reviewed were found to be safe, healthy, and well cared for. On the Child and Family Status Indicators, which include Safety, Well-Being, and Stability/Permanency, 85 percent of the cases had favorable outcomes, with over 98 percent of the children identified as being safe. The Practice Performance Indicators identified areas for improvement, including Engagement, Teaming, and Long-Term View. Other factors that were found to have an impact on outcomes included the positive correlation between case outcomes and continuity of the CSW; the utilization of trauma informed evidenced based treatments; the completion of early assessments that address the underlying needs of the child and family; implementing a team approach to treatment; and developing a shared vision with clear goals to be achieved for safe case closure. A technical review of the pilot test version of the protocol was performed. On August 5 and 6, 2010, the second set of 12 selected DCFS and DMH staff received QSR protocol training. Furthermore, the first "rollout" of the QSR was successfully accomplished on August 9-13, 2010 in the DCFS Santa Fe Springs Office.

QSR Phase II activities, which are to be completed by December 2012 have begun, including the commencement of the administration of the QSR across the 18 DCFS regional offices. Phase III activities, to be completed by December 2013, shall consist of any follow-up reviews that may be necessary to achieve passing scores. Advance preparations are also underway to implement the third set of trainings and the second "rollout" of the QSR from October 18-22, 2010 within the DCFS Compton Office. This is the last QSR review scheduled for the 2010 calendar year. The initial sequence of offices to undergo reviews in 2011 has been identified and "rollout" is expected to generally follow the order of the CSAT implementation and Enhanced Skill-Based Training.

The review provides an opportunity to understand what works well and where there is opportunity for growth. The departments have been developing a shared CPM, Enhanced Skill Based Training, and Coaching and Mentoring Program, so there is a

consistent method of practice in working with children and families. In addition to these change strategies, the departments will implement regional based improvement plans to strengthen practice and ensure quality services.

Summary Highlights

During the last three months, the County has continued to demonstrate significant progress toward meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Significant highlights from the last report include:

- DMH has initiated contract amendments with Wraparound Providers that will expand the County's capacity to provide Wraparound services for DCFS-involved children and youth by an additional 817 slots;

- DMH has begun a series of technical assistance site visits to work with Wraparound providers and other Katie A. funded mental health programs to improve utilization and reporting of Katie A. related funds; and

- DMH and DCFS have worked together to improve coordination and responsiveness to children and youth with urgent and acute needs for mental health services, including revisions to the mental health screening tool, policy and practice changes. Coordination has been enhanced between DCFS and DMH for the PMRT, Child Welfare, and DMH co-located staff, and initiation of and a contract is under development with an urgent care center to provide mental health crisis intervention services to DCFS involved children and youth.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Assistant Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:KH
LB:AM:mh

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