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8
 9 UNITED STATES DISTRICT COURT
 10 CENTRAL DISTRICT OF CALIFORNIA
 11

12 **KATIE A.** by and through her next friend
 Michael Ludin; **MARY B.** by and through
 13 her next friend Robert Jacobs; **JANET C.**
 by and through her next friend Dolores
 14 Johnson; **HENRY D.** by and through his
 next friend Gillian Brown; AND **GARY E.**
 15 by and through his next friend Michael
 Ludin; individually and on behalf of others
 16 similarly situated,

17 Plaintiffs,

18 v.

19 **DIANA BONTA**, Director of California
 Department of Health Services; **LOS**
 20 **ANGELES COUNTY; LOS ANGELES**
COUNTY DEPARTMENT OF
CHILDREN AND FAMILY SERVICES;
 21 **ANITA BLOCK**, Director of the Los
 Angeles County Department of Children
 22 and Family Services; **RITA SAENZ**,
 Director of the California Department of
 23 Social Services, and **DOES 1 through**
 100, Inclusive

24 Defendants.
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 26
 27
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Case No. CV-02-05662-JAK (SHx)

**ADVISORY PANEL'S REPORT
 TO THE COURT - SECOND
 REPORTING PERIOD OF 2013,
 APRIL 25, 2014**

The Hon. John A. Kronstadt
 Courtroom: 750

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Pursuant to this Court's Order, Plaintiffs are filing the Advisory Panel's Report to the Court - Second Reporting Period of 2013, April 25, 2014. A true and correct copy of the Advisory Panel's Report to the Court is attached hereto.

DATED: June 3, 2014

Respectfully submitted,
WESTERN CENTER ON LAW AND POVERTY



By: _____
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The Katie A. Advisory Panel
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May 28, 2014

Honorable John A. Kronstadt
US District Court Judge
255 East Temple Street
Courtroom 750 - 7th Floor
Los Angeles, CA 90012-3332

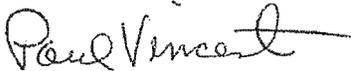
Case No. CV02-05662-AMH (SHx), KATIE A. V. DIANA BONTA

Dear Judge Kronstadt,

Attached is a copy of the Katie A. Panel's Report to the Court for the Second Reporting Period of 2013. The Panel will be following up with a bound copy for your use.

We would be happy to respond to any questions you may have about this report.

Sincerely,



Paul Vincent
Panel Chair

cc Panel Members
Phillip Browning
Kim Lewis
Ira Burnim
Antionette Dozier
Brandon Nichols
Richard Saletta

**The Katie A. Advisory Panel
Report to the Court
Second Reporting Period of 2013
April 25, 2014**

**The Katie A. Advisory Panel
c/o 428 East Jefferson Street
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Marty Beyer
Paul Vincent
Edward Walker

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Executive Summary

System Progress

The County has encountered a series of major challenges in the past 12 months. In addition to undertaking the implementation of IHBS and ICC under the State Katie A. Settlement and continuing the implementation of the County Katie A. Strategic Plan, the County has experienced a series of highly publicized cases with poor outcomes, difficulty in finding suitable initial placement settings for children and youth, insufficient numbers of foster parents, a staff work stoppage and recommendations for reforms from the Blue Ribbon Panel appointed by the Board. These circumstances have significantly strained the County's capacity to focus intensely on Katie A. implementation to the degree needed to complete implementation of the strategic plan.

However, the County has made progress in a number of important areas of strategic plan implementation, which are highlighted below.

- The Department continues to refer newly detained children for Multidisciplinary Assessments (the MAT process) at a high rate. In the past reporting period, 98.5 % of children were referred.
- Work continues on implementation of IHBS, including the promising pilot on intensive mental health services underway in five provider agencies. In addition, DMH is strengthening its capacity to provide data on services provided to the plaintiff class.
- The mental health screening of newly detained children is assessing children at a high rate. Ninety-seven percent of eligible children are screened and of those children screened positive for mental health needs, 95% are referred for mental health services.
- The County is maintaining an 85% referral rate of newly detained children to Medical Hubs.
- The County Board approved the hiring of 350 new CSWs to help reduce caseloads and workloads.

System Challenges

Many of the system challenges the County has encountered in current monitoring period remain. They include the following:

Workload

Caseloads and workloads, which are already high, have risen by 2.7 % for CSWs with generic caseloads and 1% for ER workers. The number of children in out-of-home care has increased by almost 600 children. These high caseloads are a significant impediment to successful implementation of the Core Practice Model.

Treatment Foster Care

The County has made slow progress in meeting the court's goal of creating 300 Treatment Foster Care (TFC) beds. Currently, the County is 200 beds short of that objective and in the current monitoring period, the number of available beds has declined by 15 beds. Clearly the County's strategies for TFC recruitment and retention are not being effective.

Expansion of Home Based Mental Health Services

The County reports that the Katie A. sub-class has now grown to 37%, an increase of 2,000 class members over the sub-class total for the prior year. This means that there is an increase in the number of children and youth needing more intensive mental health services. The County continues to work toward implementation of IHBS and ICC as part of its effort to expand mental health services, but the effect of these modalities is not yet apparent in the data available. Based on information from a combination of stakeholders and staff and from QSR data, the current level of availability of IHBS falls far short of meeting the needs of class members, including those within and outside of the sub-class.

Training and Coaching of DCFS and Mental Health Staff

The County is implementing processes for training and coaching of DMH and DCFS staff in Core Practice Model approaches. The current training and coaching initiative is in its early stages and has not yet begun to reflect significant improvements in practice, based on stakeholder input and the results of the Qualitative Service Review process. At the current rate of staff development, the County faces a long-period of capacity building before measurable changes in practice and outcomes become apparent. The Panel will closely observe the coaching and training initiative underway and expects to have a clearer appraisal of its efficacy over the next six months.

The Qualitative Service Review Process (QSR)

The Panel and County have been conferring about strategies that will strengthen the fidelity of County-administered Qualitative Service reviews. Like other systems at this stage of QSR implementation, the County would benefit from efforts to enhance the fidelity of reviews. The strategies agreed to by the Panel and County appear likely to result in improved fidelity and accuracy of the review process.

Family Foster Home Recruitment and Retention

The number of available family foster homes continues to lag behind the placement needs of the County. For example, the number of children in out-of-home care grew by almost 600 in the past year, but the number of additional foster homes grew by only 46. This lack of appropriate homes results in placements in poorly matched settings, multiple short-term placements, longer stays in temporary settings and additional trauma to the children placed. While the Department continues to try new recruitment strategies and is being assisted by outside technical assistance experts, at this point slight progress is being reported. The Panel considers this challenge to be among the Department's most significant barriers to meeting the needs of children and their families.

Panel Recommendations

1. Track and Report on the Placement Experience of Newly Detained Children

The County should develop the capacity to accurately report on the placement experience of newly detained children. Data should address the type of initial placement or placements, the stability of children in shelter status, placement with siblings and proximity to family.

2. Develop a Specific Plan to Increase TFC Beds to 300

The Panel recommends that the County secure the consultation of a national TFC expert to provide assistance in achieving the necessary program expansion.

3. Expansion of Intensive Home-Based Mental Health Services

The Panel has concerns about the limited capacity of mental health supports and programs to adequately serve high-need children and youth and has asked the County to participate in a joint analysis of both intensive mental health service capacity and strategies to expand that capacity. Any new Panel recommendations will follow those discussions.

4. DCFS and DMH Training and Coaching

At this point, the Panel has no new recommendations for strengthening training and coaching. It will continue to assess the new training and coaching process to determine its effect on practice performance and child and family outcomes.

5. The Qualitative Service Review Process

The Panel and County have worked together to refine the process for assuring that QSR ratings are accurate and consistent among reviewers. The following major steps will become a part of ongoing QSR operations and represent both recommendations and decisions by both entities. The County is undertaking additional fidelity steps as well.

- Reviewers will be expected to write case stories that explain their scoring reasoning for key indicators. Case stories will at a minimum address the scoring basis for:

- Safety
- Permanency
- Stability
- Emotional Well-Being
- Learning Progress
- Family Functioning
- Engagement
- Voice and Choice
- Teamwork
- Assessment
- Planning
- Long-Term View

- The Panel will be provided reviewer training curricula currently used by QA to train new reviewers.
- The Panel will provide advanced reviewer training sessions to existing reviewers. QA staff are invited to co-train as part of this process.
- Reviewers will participate in annual inter-rater reliability assessments, using written case simulations that are scored individually. The Panel will provide written case simulations and observe the rating process and discussions. These assessments may occur as part of ongoing training.
- The QSR reviewer pool will be expanded to include reviewers from external agencies, such as provider organizations, advocacy organizations and County government agencies.
- The QA unit will review the reasons families drop out of the respondent pool before reviews take place and to the extent possible, they will take steps to replace drop-outs with replacement cases.
- The Panel will be provided data about each review sample, including identification of any cases where the respondent declines to participate or the case is otherwise dropped from the sample.
- A Panel member will interview each review team about their scoring rationale prior to the scores being finalized. Preferably this will take place during the review week, however when that is not possible, the Panel may interview the team by phone.

6. Family Foster Home Recruitment

The County states that it has the capacity to offer day care to foster parents on a case-by-case basis, but does not provide it as an option for all working foster parents. The Panel believes that the cost of day care for foster parents who work, especially those who care for children who are not school age, could present a serious barrier to recruitment. Only a modest number of foster parents would be able to cease work to become a foster caregiver. The Panel recommends that the County address one of the potential barriers to recruitment of foster caregivers for young children by exploring the effect providing subsidized child care would have upon recruitment for foster parents and the potential cost of providing day care subsidies to foster parents.

**Katie A. Advisory Panel
Report to the Court
Second Reporting Period of FY 2013/2014
May 25, 2014**

I. Introduction

The following Report to the Court outlines the County's progress toward achieving the objectives of the Settlement Agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan.

II. Background

The Los Angeles County Department of Children and Family Services (DCFS) and the plaintiffs in Katie A., et al. v. Diane Bonta, et al., entered into a Settlement Agreement in May, 2003. The Agreement was described as a "novel and innovative resolution" of the claims of the plaintiff class against the County and DCFS and it was approved by the Court and became effective in July 2003.

The Agreement (Paragraph 6) imposes responsibility on DCFS for assuring that the members of the class:

- a. Promptly receive necessary, individualized mental health services in their own home, a family setting or the most homelike setting appropriate to their needs;
- b. Receive the care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
- c. Be afforded stability in their placements whenever possible, since multiple placements are harmful to children and are disruptive of family contact, mental health treatment and the provision of other services; and
- d. Receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law.

To achieve these four objectives, DCFS committed to implement a series of strategies and steps to improve the status of the plaintiff class. They include the following (Paragraph 7):

- o Immediately address the service and permanence needs of the five named plaintiffs;
- o Improve the consistency of DCFS decision making through the implementation of Structured Decision Making;

- Expand Wraparound Services;
- Implement Team Decision Making at significant decision points for a child and his/her family;
- Expand the use of Family Group Decision Making;
- Ensure that the needs of members of the class for mental health services are identified and that such services are provided to them;
- Enhance permanency planning, increase placement stability and provide more individualized, community-based emergency and other foster care services to foster children, thereby reducing dependence on MacLaren Children's Center (MCC). The County further agrees to surrender its license for MCC and to not operate MCC for the residential care of children and youth under 19 (e.g., as a transitional shelter care facility as defined by Health & Saf., Code, § 1502.3). The net County cost, which is currently appropriated to support MCC shall continue to be appropriated to the DCFS budget in order to implement all of the plans listed in this Paragraph 7.

The parties to the Settlement also agreed to the selection of an Advisory Panel to provide guidance and advice to the Department regarding strategies to achieve the objectives of the Agreement and to monitor and evaluate the implementation of its requirements. Specifically, the Settlement Agreement directs (Paragraph 15) that the Panel:

- Advise and assist the County in the development and implementation of the plans adopted pursuant to Paragraph 7;
- Determine whether the County plans are reasonably calculated to ensure that the County meets the objectives set forth in Paragraph 6;
- Determine whether the County has carried out the plans;
- Monitor the County's implementation of these plans; and
- Determine whether the County has met the objectives set forth in Paragraph 6 and implemented the plans set forth in Paragraph 7.

Additionally, the Settlement directs that:

In the event that the Advisory Panel discovers state policies or funding mechanisms that impede the County's accomplishment of the goals of the agreement, the Advisory Panel will identify those barriers and make recommendations for change.

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the objectives of the settlement agreement. The Panel and plaintiffs' attorneys

identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. That Corrective Action Plan was completed and provided to the Court. In subsequent discussions with the Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs. The County has now completed its Strategic Plan and received County Board approval for implementation.

III. Panel Activities Since the Last Report

The Panel met with County DCFS and DMH staff in September and December 2013 for discussions about the strategic plan and follow-up discussions about the overstay problems at the Welcoming Center, which the Panel visited in June. County DCFS submitted its plan of correction to the State Department of Social Services and expects to resolve the overstay problem. The County DCFS leadership has analyzed the factors contributing to overstays and concluded that reduction in the size of the pool of foster parents was the critical issue impeding timely placement with foster parents across its service system. The County believes that this limitation substantially created the placement bottleneck at the Welcome Center. The County has implemented a multifaceted foster parent recruitment strategy that it believes will grow the size of foster parent pool, which will afford timely access to foster homes across its overall service system. Discussions with County staff regarding the Welcome Center and foster parent recruitment will continue in 2014.

Panel member, Dr. Marty Beyer provided additional training sessions for mixed groups of DCFS, DMH and provider staff, including Wraparound, Multidisciplinary Assessment Team coordinators, Treatment Foster Care and Practice Model coaches in September and December 2013. Dr. Beyer provided additional consultation to coaching support groups in November and December 2013. Panel member Edward Walker participated in the Qualitative Service Review (QSR) in the Glendora office, August 5-8, 2013.

Panel member, Paul Vincent analyzed QSR reports written by the County's QSR Quality Improvement staff for fidelity to QSR protocols. Dr. Beyer performed additional analysis of the QSR Reports for identification of the child's underlying needs. In August and November 2013, Panel members discussed the analysis with the Quality Improvement leadership and made several recommendations that could strengthen the County's QSR implementation. The Panel expects to conclude discussions on the QSR recommendations in 2014. Additional details about the Panel's QSR reports analysis and discussion with County DCFS and DMH leadership will be provided in a subsequent section of the Panel's Report. The Panel will continue its focus on fidelity to the QSR protocol and overall QSR implementation in 2014.

The Panel also held extensive discussions with County DMH and DCFS regarding implementation of Intensive Home Based Services (IHBS) and Intensive Case Coordination at the September and December Panel meetings and with conference calls. County DMH selected

five provider contract agencies to initiate its implementation. Additional details of the IHBS and ICC implementation will be provided in subsequent section of the Panel's Report.

DMH Staffing

The County's plan includes the co-location of mental health staff in DCFS offices. The County has maintained the level of DMH staffing in support of Katie A. Implementation at the same overall levels reflected in the last Panel report. Current staffing levels are shown below.

LOCATION	MENTAL HEALTH POSITIONS
Child Welfare Division	51
D-Rate	12
Service Area 1	29
Service Area 2	24
Service Area 3	33
Service Area 4	17
Service Area 5	4
Service Area 6	84
Service Area 7	39
Service Area 8	23
MHSA	3
TOTAL	319

The total staffing level is unchanged from the last Panel report.

Additional staffing for the DMH ACCESS Hotline

DMH no longer sees a need to allocate the three staff originally allocated to Hotline duties and has transferred these positions to more vital Katie A. functions related to the Qualitative Service Review process and coaching. The Panel concurs with this proposed change; however the current strategic plan approved by the court remains in place. That plan sets the additional staffing for the DMH hotline as an expectation.

Selection by DMH and DCFS of Selected Performance Indicators to be tracked

There is agreement between the parties about the outcome indicators to be tracked and reported to the parties and the court. Outcome tracking and reporting occurs routinely and is reported annually by the Panel.

Development of Multidisciplinary Assessment Teams (MAT)

The County committed to implement Multidisciplinary Assessment Teams that would assess the needs of all newly detained children. The County provided the following report on implementation of the Multidisciplinary Assessment Team (MAT) process, which establishes a commitment to provide a multidisciplinary assessment of all newly detained children within 45 days of entry.

County MAT Update

At the time of the completion of the prior Panel Report, 99.5 percent of newly detained children were referred for a MAT update. During this reporting period, 98.5 percent of children were referred. From April 2013 through October 2013, there were 3727 MAT referrals and 2857 MAT assessments completed. Of those referred, approximately 23 percent were not completed, compared to 20 percent reported in the prior monitoring report. MAT referrals by SPA are listed below.

Table 1: MAT Compliance October 2013	MAT Eligible	MAT Referred	Percent
SPA 1	29	29	100%
SPA 2	78	78	100%
SPA 3	96	96	100%
SPA 4	28	28	100%
SPA 5	7	7	100%
SPA 6	128	125	98%
SPA 7	114	113	99%
SPA 8	89	89	100%
Total number of DCFS MAT referrals:	600	591	98.5%

From April 2013 through October 2013, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 46 days, about the same as reported in the prior panel report. Approximately 59 percent were completed in 45 days or less, 78 percent were completed by the 50th day and 91 percent were completed by the 60th day.

As indicated above, approximately 23 percent of children referred to MAT did not have completed assessments as of the end of October 2013. Of this 23 percent, 17 percent of children were in the process of receiving a MAT assessment, so those could not be counted as complete at the time data was collected. The remaining 6 percent were initially referred to MAT, but did not have completed assessments due to the following “MAT Cancellation Reasons:”

- Children are returned home soon after the MAT referral and are no longer MAT eligible.
- Children are referred to MAT but they have private insurance and are therefore no longer MAT eligible.
- Children who run away are not available to complete the assessment. These children are referred for mental health services when they return from AWOL but many of them do not receive the MAT assessment.
- Children who are in psychiatric hospitals or juvenile detention have billing and access issues that prevent the completion of the MAT process.

- Children move out of county or state.
- Children lose Medi-Cal eligibility after referral.

While these indicators reflect progress in MAT implementation, the Panel notes continuing challenges in MAT. During this reporting period, 41 percent of MAT assessments were not completed within 45 days or less. Delays can affect the value of the assessment to the Family Court, which issues dispositional orders within 30 days of removal. The County reports that currently the court is taking more than 50 days on average to adjudicate newly detained cases. This delay permits DCFS to submit approximately 75% of MAT Summaries of Findings to the court before disposition. The County continues to work on improving MAT performance, which is referenced in the County's update located in the Appendix. The Panel plans to review the MAT process further in subsequent reporting periods, especially the quality of identification of underlying needs and description of service needs.

Implementation of the DMH Behavioral Health Information System (IBHIS)

The County committed to implementing a new DMH Behavioral Health Information System early in the Katie A. planning process, assuming that the State DMH development of a statewide Behavioral Health Information System would support County Katie A. needs. This system is intended to enhance tracking and reporting on the status of children served, the services they receive, and various other elements of the provision of mental health care. Frequent delays at the State level have significantly delayed the original completion date. Regarding this Panel Report, DMH reports that it has implemented an aggressive planning and testing process to design and bring up an information system that will integrate clinical, administrative and fiscal data. DMH has adjusted the target production date to December 2013. The following overview and completion projection was provided by the County.

INTEGRATED BEHAVIORAL HEALTH INFORMATION SYSTEM (IBHIS)

Description: Implement a Commercial-off-the-Shelf (COTS) behavioral health information system that provides clinical, administrative and financial functionality. The IBHIS shall include an Electronic Health Record and conform to the Mental Health Services Act Information Technology (IT) Plan Guidelines.

Status: DMH selected the Avatar system from Netsmart, Inc. (Netsmart) as the result of an RFP process. The Board of Supervisors approved an Agreement with Netsmart on October 18, 2011. Work with Vendor began in November 2011. IBHIS is now in very limited production use in preparation for 11 DMH clinic sites beginning to use it in their daily operations beginning January 27, 2014. A small group of Legal Entity (LE) and Fee-for-Service (FFS) contract providers of mental health services are expected to begin submitting their claims through IBHIS beginning February 20, 2014.

Critical Future Policy Issues: **Workforce Issues:** An electronic health record (EHR) with integrated administrative and financial functionality creates a work environment in which nearly all DMH employees will need to be computer literate. Computer literacy is not universal in DMH, but nearly so after an intensive program of Basic Computer Skills training for those who, based on a DMH-wide survey, were identified as needing the training. Workforce issues are, at this point, less of a concern than they were in the previous report.

Contract Providers: Approximately half of all DMH clients receive services delivered through contract providers of mental health services. The contract providers currently have direct access to DMH's computer system, but under IBHIS they will not. They will, instead, exchange information with DMH electronically. Initially the content of this exchange will be only slightly expanded from the current focus on behavioral health care claims, but may eventually include substantial portions of the consumer behavioral health record. This is a major change for most contract providers. The Los Angeles (LA) County DMH MHSA IT Plan includes the use of MHSA funds to facilitate this transition for contract providers. Nearly all eligible providers have initiated electronic health records projects using the MHSA funds to become EDI ready by the time they are scheduled to transition to IBHIS; many have already completed their implementation projects. DMH reached out to those who had not submitted such plans by our last report. One provider declined to submit a plan; all others have done so.

Consumer Access to Healthcare Information: The Avatar system includes a client portal. This will allow DMH clients to securely access selected portions of their behavioral healthcare record from any location in which they have access to the Internet. Setting up the client portal has been deferred until a substantial portion of DMH provider sites are using IBHIS, however, use of the Avatar client portal may not be the final choice for this functionality. The Avatar portal will provide personal behavioral health record information only for DMH clients and only about their DMH care. There are options that would allow someone to have a personal record of all of their health care consolidated in one environment. The increasing emphasis on providing integrated care across physical and mental health domains under the Affordable Care Act suggest that an integrated personal health record would be a better solution.

Key Milestones: Initial Production Use – December 23, 2013

Fiscal/ Financial Information: IBHIS contract expenses for FY 13-14 are projected at approximately \$16.19M; project salary and employee benefits expenses are another \$5.42M.

A \$57,647,430 allocation in the DMH MHSA IT Plan is being applied to IBHIS initial costs. Additional funding may come from Meaningful Use incentive payments under ACA estimated at approximately \$12M spread out

over several years. Additional funds will necessarily come from the DMH IT budget as obsolete systems to be replaced by IBHIS are finally shut down.

Stated costs do not include support for the contract providers’ transition to EDI, which is supported with \$23 million in funding through DMH MHSA IT Plan.

Completion of an Internal Qualitative Assessment of Service Provision and Client Outcomes

Consistent with its strategic plan, the County continues to conduct Qualitative Service Reviews (QSR), an interview-based evaluation of the quality of frontline practice involving a sample of cases in each office. Additional detail on current QSR review findings are provided in a subsequent section of the Panel’s report.

Service Provision to Katie A. Class Members

Provision of Necessary, Individualized Mental Health Services in Family-Based or Most Homelike Setting Appropriate to Class Member Needs

One of the stated objectives of the Katie A. Settlement is “*Provision of Necessary, Individualized Mental Health Services in Family-Based or Most Homelike Setting Appropriate to Needs*”. The Panel specifically addressed this issue in its previous report because of significant problems in finding suitable placements for newly detained children, some of whom were detained in holding rooms due to the lack of appropriate placement settings. Reports indicated that the number of children held in such settings had become large and an increase in detentions and the lack of appropriate family foster home settings was a primary cause of these unsuitable placements.

The County reports that the number of available foster homes grew by 46 during 2013.

2013	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	TOTALS
STATE-LICENSED FOSTER HOMES	545	540	543	541	546	533	534	543	549	560	575	586	+46
2014	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	TOTALS
STATE-LICENSED FOSTER HOMES	583												

The County has a number of foster home recruitment initiatives underway, including media campaigns, community events, and targeted recruitment (such as focusing on individuals who are employed in a children’s service setting) and child-specific recruitment. DCFS also received a five-year grant from the US Children’s Bureau for the diligent recruitment of families as foster caregivers.

The following table shows the monthly foster home recruitment results, by age group. The County reports that it continues to experience a significant shortage of foster caregivers for infants.

Approval Month	# of Homes	# of Bed	# of Infant Bed	# of Bed for Child 2 & Over
201203	7	11	6	11
201204	2	8	0	8
201205	9	20	4	20
201206	8	28	20	28
201207	3	8	3	8
201208	2	4	2	4
201209	9	16	4	15
201210	5	13	9	13
201211	5	17	10	15
201212	4	9	7	9
201301	9	19	10	19
201302	6	13	6	9
201303	7	12	2	12
201304	7	17	7	17
201305	6	12	6	12
201306	8	16	4	16
201307	7	16	6	15
201308	11	20	7	16
201309	14	23	18	20
201310	12	22	7	21
201311	16	23	16	18
201312	10	14	6	11
201401	10	15	6	13
201402	10	22	11	22
201403	4	6	4	4
Grand Total	191	384	181	356

Concurrently, the number of children in foster care has grown. It grew by 600 children between July 2013 and December 2013 alone. Clearly DCFS has an urgent need for additional foster homes and has made minimal progress in increasing foster home capacity.

Expansion of Home Based Mental Health Services

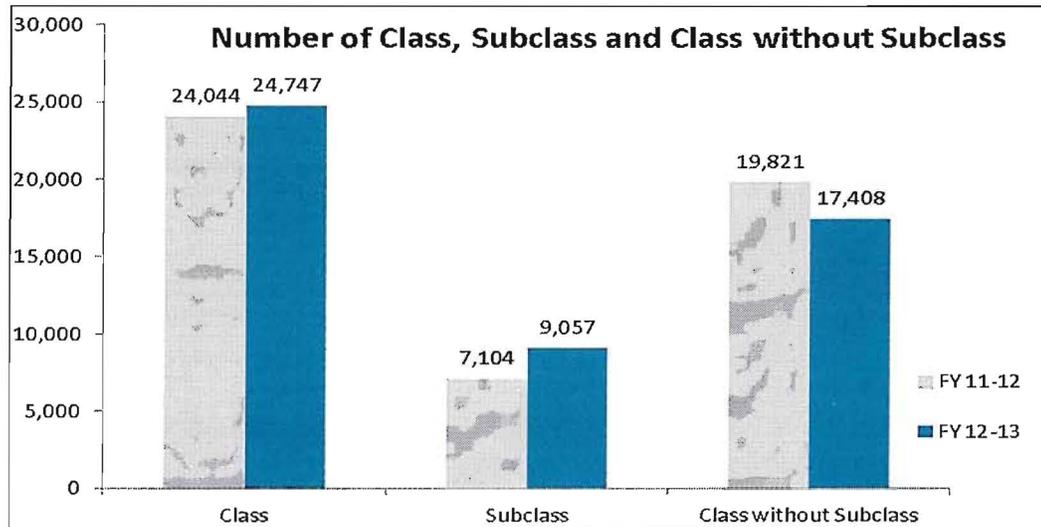
DMH provided the following report on service provision to class members.

DMH Service Provision Report

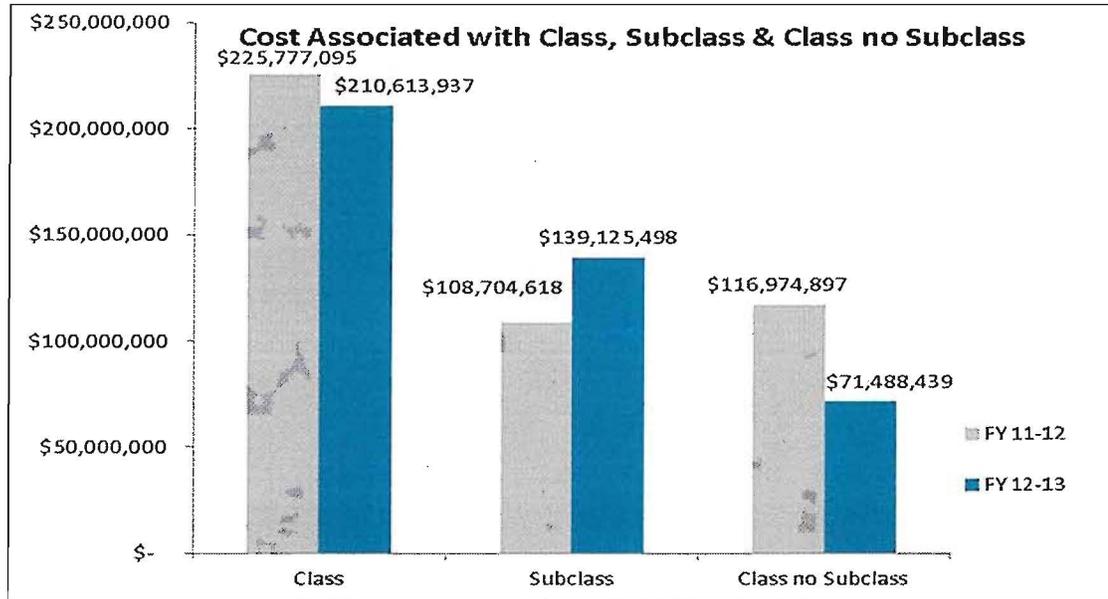
DMH conducted an updated analysis, comparing matched client data from the 2011-2012 and 2012-2013 fiscal years, to identify members of the Katie A. class and subclass and determine the levels of mental health services they were provided. The analysis used the definition of the class and subclass contained in the settlement agreement in the Katie A. State case. The data reported below is based upon the match and contains only

class and subclass members who received mental health services. The data do not contain information on children who are considered at-risk. The analysis revealed the following:

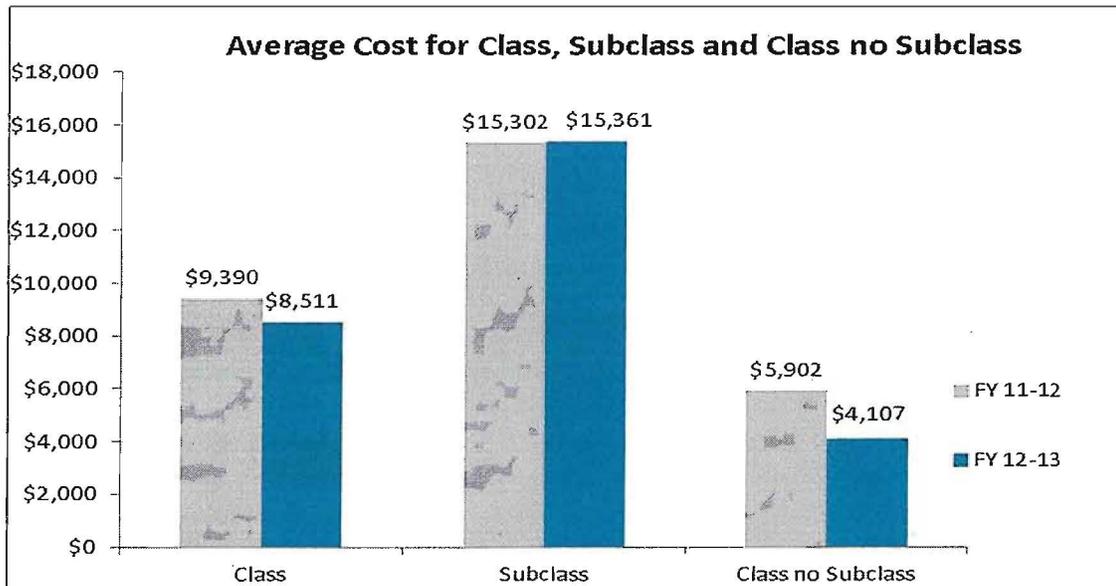
- 1) From the total amount of DCFS clients (approximately 59,000), 42% of those clients were Katie A. class members during FY 12-13, a slight increase from the previous fiscal year (41%). About 37% of the Katie A. class are subclass members and received more intensive mental health services, another increase from FY 11-12 (30%). The following graph shows the breakdown of class and subclass members, as well as a category we have identified as class members that does not include subclass members (Class w/o Subclass: FY11-12 82%; FY12-13 69%). While the subclass made up about 29% of the class during FY11-12, it made up about 37% in FY12-13. In addition, while the number of class w/o subclass members decreased by 2,400, the subclass increased by about 2,000 members. The data shows that the subclass has increased since last fiscal year, now making up a larger percentage of the Katie A. class. As a result, there are a greater number of children needing more intensive mental health services.



- 2) The cost associated with providing mental health services to the Katie A. class decreased from about \$225 million to \$210 million. In FY 11-12, while the subclass made up about 29% of the class, it made up about 48% in the total cost. During FY 12-13, while the subclass made up about 37% of the class, it made up about 66% of the total cost. The data shows that not only are more of the class meeting the subclass criteria with more intensive mental health needs, the costs associated with providing mental health services to the subclass has also increased. The mental health costs associated with providing services to this group is more than half (66%) of the total costs provided.

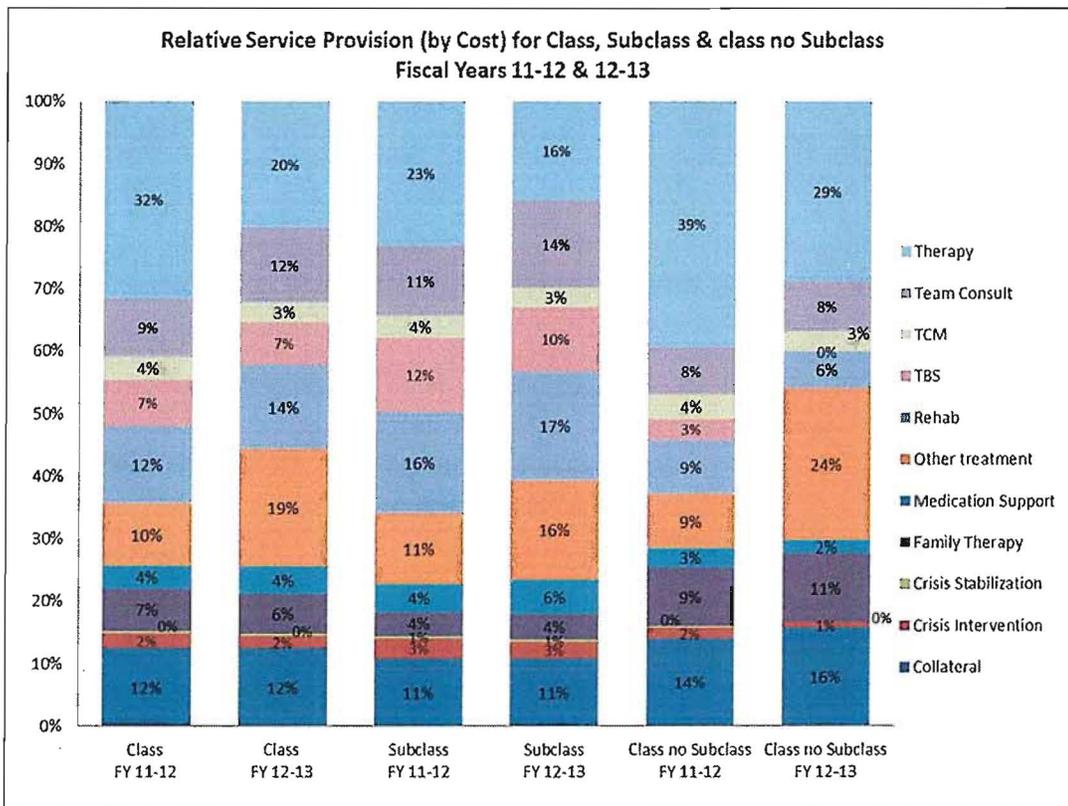


3) Upon closer look at the mental health service costs that were provided to subclass members, the FY 12-13 data shows that the average mental health costs associated with subclass members (\$15,361) is much higher than the average cost of mental health services for class members who are not part of the subclass (\$4,107). While this average cost of services for the subclass is comparable to FY 11-12 (\$15,302), the average cost for the class w/o subclass category greatly decreased since FY 11-12 (\$5,902). More specifically, subclass members are receiving more services than the average class member not belonging to the subclass.

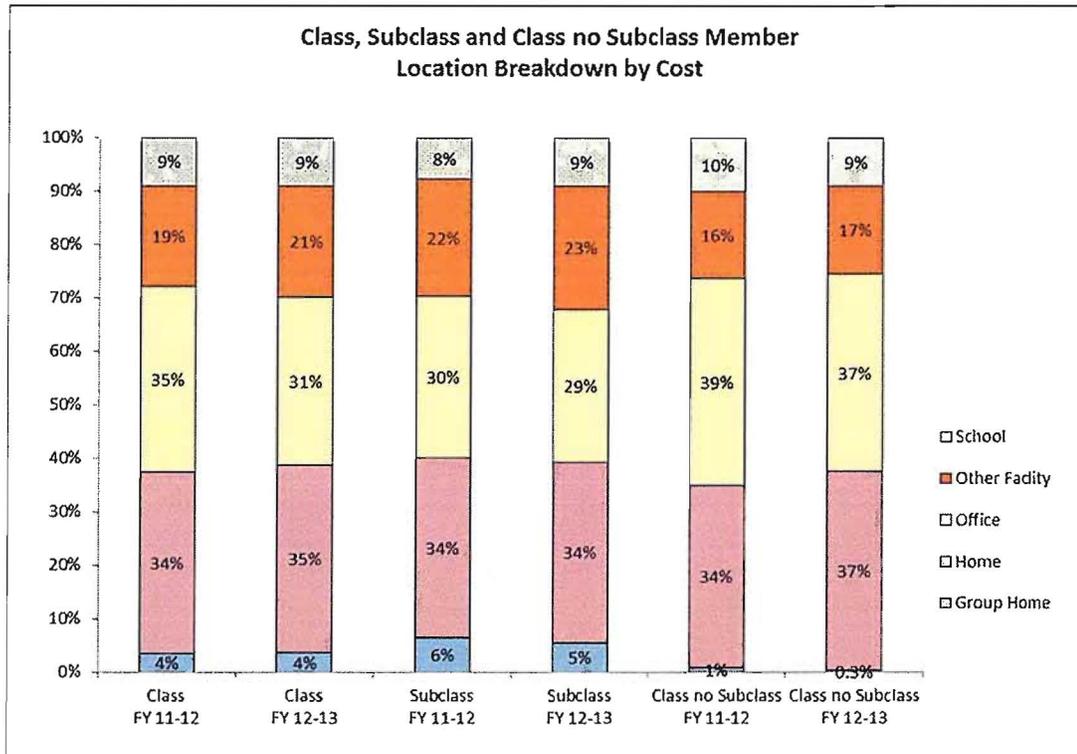


4) The mental health service array also varies slightly between class and subclass members. For FY 12-13, subclass members received less therapy (16%), more rehabilitation services including TBS (27%) and targeted case management including

team consultation (17%) as compared to what class members who are not part of the subclass received for therapy (29%), rehabilitation services (6%) and targeted case management (11%). In addition, from FY 11-12 to FY 12-13, the amount of individual therapy decreased (23% to 16%), the amount of rehabilitation services including TBS stayed fairly consistent (28% to 27%), and targeted case management slightly increased (15% to 17%) for subclass members. The mental health service array for subclass members is more in line with the intensive services we would expect subclass members to receive and hypothesize that this type of service array would be more equivalent to ICC and IHBS and thus contribute to higher success rates for this population. For FY 13-14, we expect the amount of rehabilitation services and targeted case management to increase with the implementation of ICC and IHBS.



5) Currently, the location of services differs slightly when comparing class and subclass members. The graph below shows that 37% of the mental health service costs provided to class members who were not part of the subclass were provided in the office while only 29% of the mental health service costs for subclass members were provided in the office. This is also more in line with ICC and IHBS, as these services are expected to be more accessible and thus, primarily be provided in the home or most home-like setting. While we expected to see subclass members receiving more services in the home during FY 12-13 (34%) as compared to FY 11-12 (34%), there was no change noted.

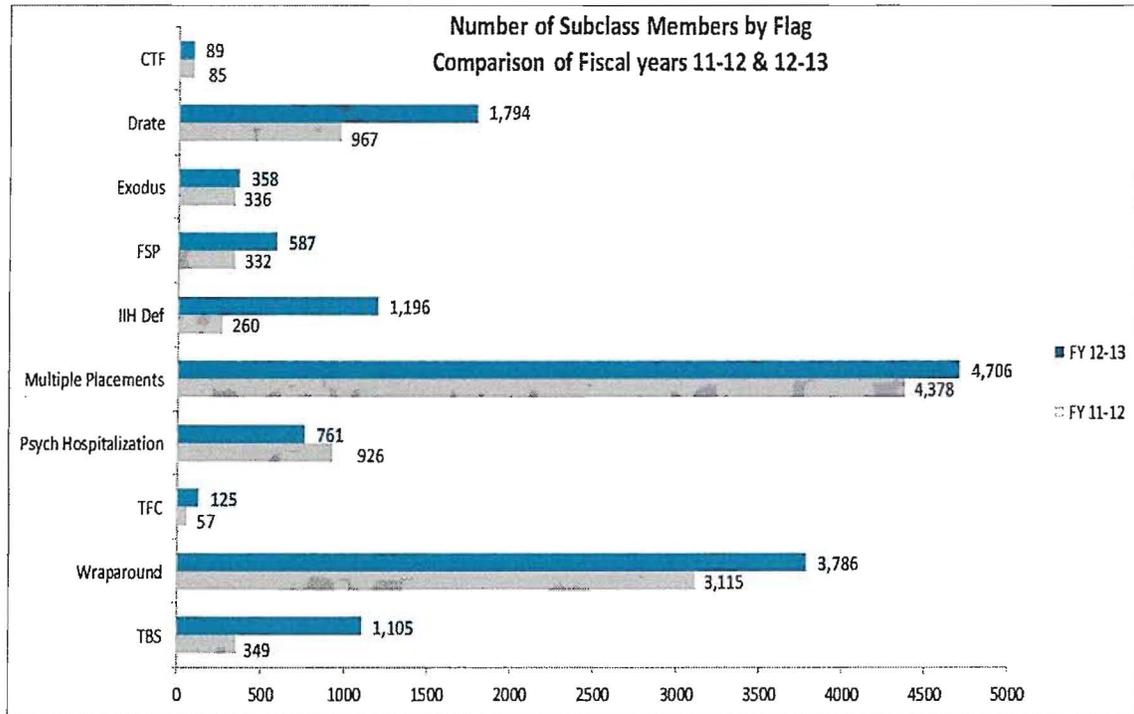


Using both fiscal years 2011-2012 and 2012-2013 data, we identified some of the mental health services that were provided to subclass members that we identified as being similar to services provided within ICC and IHBS.

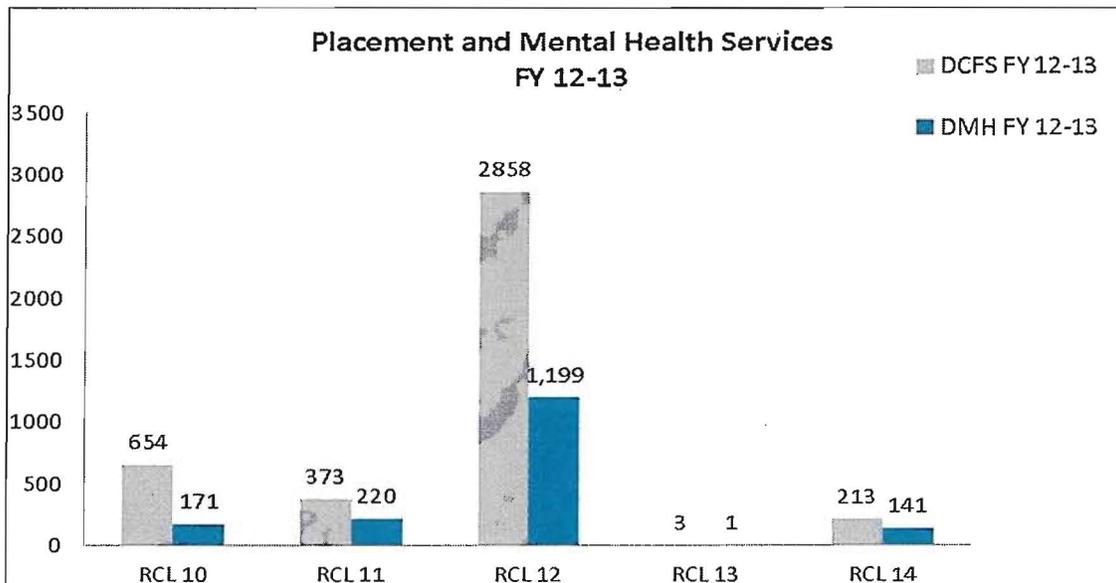
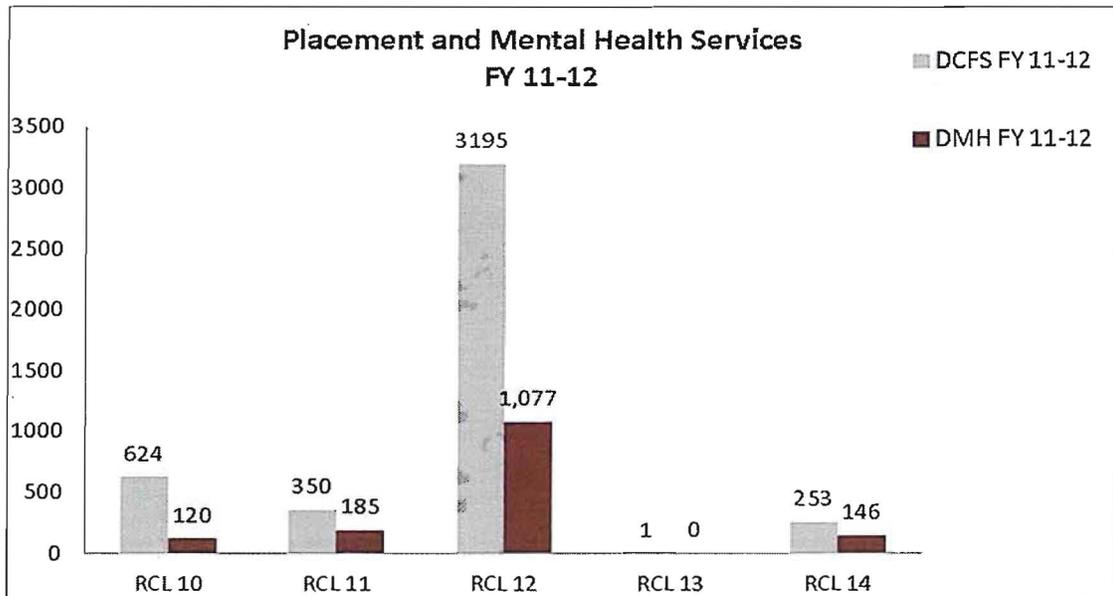
1) Subclass members are receiving a variety of services to meet their mental health needs. We have identified these services and programs as providing a high intensity of service, frequency of services and services more often provided in the youth's home or most home-like setting. Based on the subclass definition, we have developed a chart below of the criteria or programs youth were in that contributed to them being in the subclass. In FY 12-13, the majority of youth had three or more placements (4,706), Wraparound (3,786) or were placed in a D-Rate home (1,794). During FY 11-12, the majority of youth had three or more placements (4,378), Wraparound (3,115) or were placed in a RCL 12 (1,077). It is important to note that many of our youth fell into multiple categories below.

Using this same data set, we also identified some of the mental health services that were provided to subclass members.

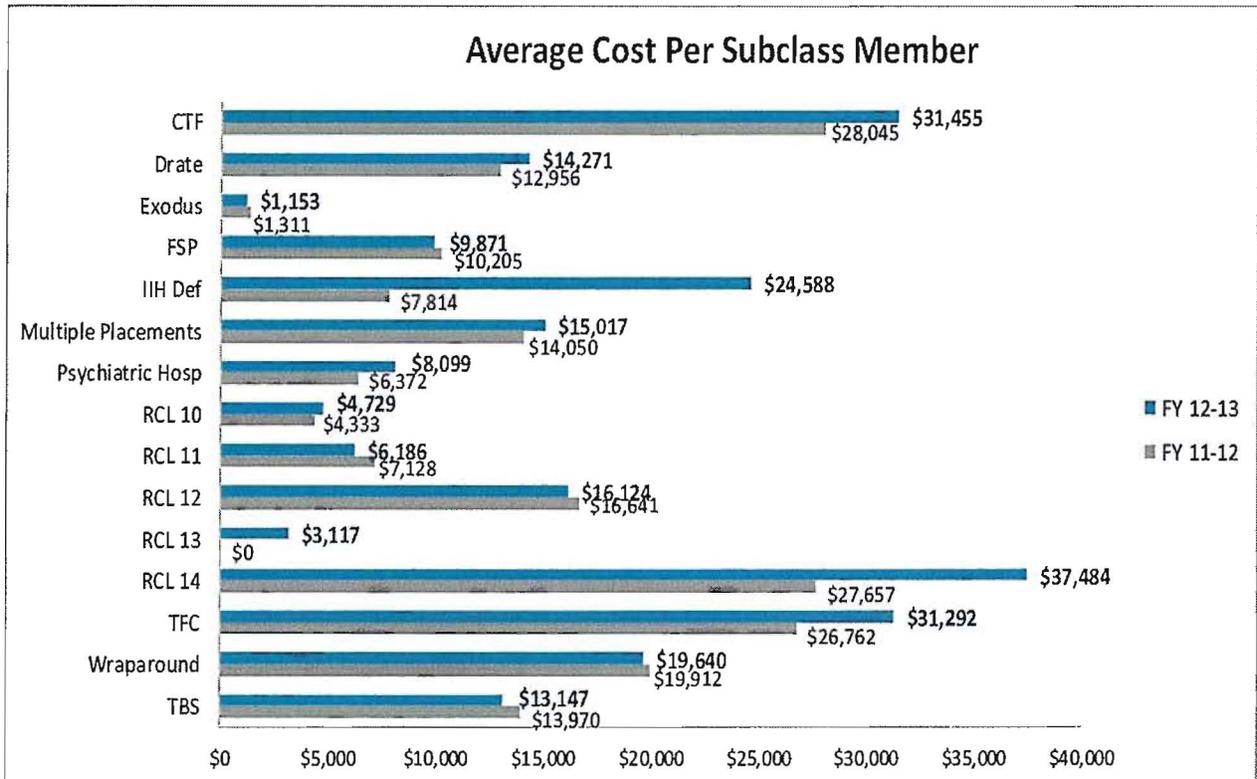
- 2) Subclass members received a variety of services to meet their mental health needs. We have identified these services and programs as providing a high intensity of service, frequency of services and services more often provided in the youth’s home or most home-like setting. Based on the subclass definition, we have developed a chart below of the criteria or programs youth were in that contributed to them meeting subclass criteria. Based on the chart below, from FY 11-12 to FY 12-13, more youth were enrolled in D-Rate homes (967 to 1,794), Wraparound (3,115 to 3,786), TFC (57 to 125), FSP (332 to 587), TBS (349 to 1,105) and received IIH (260 to 1,196). There was a decrease in the amount of youth that were hospitalized (926 to 761). Again, it is important to note that during this timeframe, many of our youth fell into multiple categories below. *[The subclass criteria below include Full Service Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placements), Treatment Foster Care (TFC), Intensive In-Home Definition (IIH – youth that within a 30 day period, received at least eight face-to-face contacts, at least two occurrences of Targeted Case Management and at least two occurrences of Team Consultation), Community Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10 -14 (RCL 10 – 14), Psychiatric Hospitalization (Psychiatric), Wraparound, Exodus, and/or Therapeutic Behavioral Services (TBS)].*



3) The Rate Classification Level (RCL) figures for FY 12-13 demonstrate an overall slight increase when compared to FY 11-12, except for RCL 14 which slightly decreased from 146 to 141 clients. In the data provided below, DCFS' fiscal year placement numbers were compared to DMH's clients that received a mental health service while in placement. There is a noticeable disparity in RCLs 10 and 12 figures. It is important to note that many of the children placed in the RCLs may in fact be receiving mental health services from the group homes' staff members and/or Fee for Service Providers which is not reported to our mental health database. Additionally, some of these children may be placed in facilities located outside of the County and/or State; therefore, in these instances, their mental health information would not be reported to DMH because of their technical "unmatched" label. DMH and DCFS will continue to explore possible reasons why some of the children in these placements did not reportedly receive any mental health services.



4) The average cost associated with the identified criteria or programs varies greatly, with costs associated with Rate Classification Level 14 (\$37,484), Community Treatment Facilities (\$31,455) and Treatment Foster Care (\$31,292) being the programs with the highest costs for subclass members in FY 12-13. In FY 11-12, Treatment Foster Care (\$26,700), Community Treatment Facilities (\$28,000), Rate Classification Level 14 (\$27,700) and Wraparound (\$20,000) were programs associated with the highest costs for subclass members (see chart below).



Utilization of Evidence-Based and Promising Practices for Class Members

Evidence-Based and Promising Practices

Using fiscal year 2012-2013 data, DMH identified the Evidenced-Based and Promising Practices that were delivered to class members. DMH reports below the number of class members that received these services and the number of legal entities in Los Angeles County that provided these services to class members. The chart also breaks out the number of Birth to Five class members that were served by these services.

Evidence Based and Promising Practices	Number of Clients Served FY 11-12 (All Ages)	Number of Clients Served FY 12-13 (All Ages)	Number of Legal Entities FY 11-12 (All Ages)	Number of Legal Entities FY 12-13 (All Ages)	Number of Client Served FY 11-12 (0-5)	Number of Client Served FY 12-13 (0-5)	Number of Legal Entities FY 11-12 (0-5)	Number of Legal Entities FY 12-13 (0-5)
Multisystemic Therapy (MST)	39	31	13	14	5	7	4	2
Functional Family Therapy (FFT)	334	272	14	15	15	11	8	4
Brief Strategic Therapy	42	54	9	11	7	17	2	6
Child Parent Psychotherapy (CPP)	773	1,124	37	43	711	1,189	35	40
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	47	36	9	6	4	3	2	2
Incredible Years (IY)	263	324	16	16	104	165	14	12
Parent-Child Interaction Therapy (PCIT)	220	194	15	12	159	160	13	10
Strengthening Families	43	53	6	5	3	1	2	1
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	4153	4,274	79	83	549	690	56	60
Triple P Positive Parenting Program	658	548	37	38	210	205	25	25
UCLA Ties Transition Model	39	37	2	2	28	33	2	2
Aggression Replacement Training (ART)	606	524	26	23	17	25	5	6
Alternatives for Families – Cognitive Behavioral Therapy (AF - CBT)	52	133	4	7	6	19	3	5
Managing and Adapting Practice (MAP)	2476	2,859	76	79	301	395	52	53
Seeking Safety	1433	1,233	56	56	17	28	8	8

The County reports that for FY 12-13 almost 10,000 DCFS involved children received treatment using an evidence-based or promising practice at a service cost of \$43 million compared to FY 11-12 where 9,000 DCFS involved children received treatment at a cost of \$40 million. Compared to FY 11-12, the County is spending more on providing evidence-based and promising practices to DCFS involved children.

Intensive Home-Based Services and Intensive Care Coordination

The County developed a phased approach to implementation expansion in which Los Angeles County began providing ICC and IHBS at the end of FY 12-13. IFCCS was Phase One of the ICC and IHBS rollout and began June 2013. Wraparound and Treatment Foster Care (TFC) began implementing ICC and IHBS in August 2013 (Phase Two). As of January 2014, DMH expanded the ICC and IHBS to the Full Service Partnership program as Phase Three of the implementation effort. DMH is considering expansion of ICC and IHBS to the Group Homes later this year.

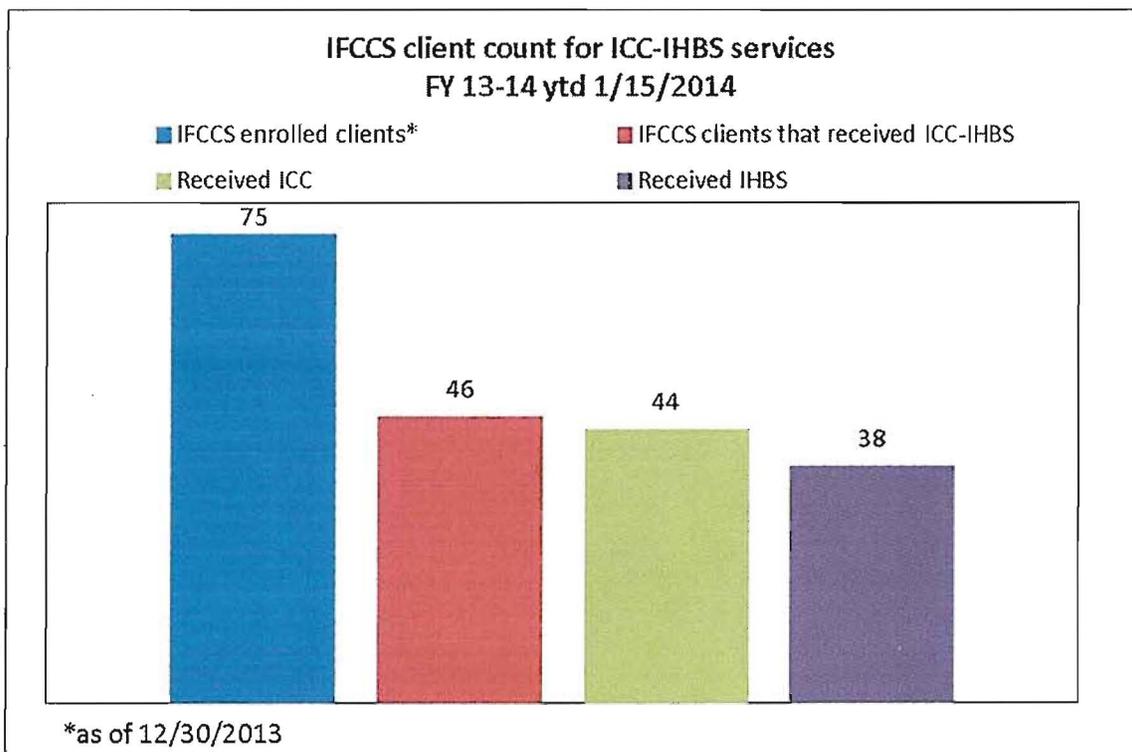
	Name	Start	Finish
	Phase One - Intensive Field Capable Clinical Services	05/01/13	Ongoing
1	Identify Resources	10/01/12	12/30/12
2	Conduct Solicitation of Eligibility and Interest	01/28/13	01/28/13
3	Select Providers	02/20/13	02/20/13
4	Amend Contracts	04/30/13	04/30/13
5	Provide ICC/IHBS Claiming Ability in the DMH IS	06/24/13	06/24/13
6	Orientation for Referral Sources	04/10/13	04/30/13
7	Develop Program Policies and Procedures	03/01/13	04/15/13
8	Training of IFCCS Providers	04/17/13	04/17/13
9	Install LATC Coaching Support	11/05/13	01/31/14
10	Tracking of Service Delivery and Outcomes	06/01/13	On-Going
	Phase Two - Wraparound	08/01/13	Ongoing
1	Develop Training Materials (providers)	06/03/13	07/11/13
2	Develop Training Materials (family outreach)	06/03/13	06/11/13
3	Amend Program Policies and Procedures	TBD	TBD
4	Conduct Trainings (Spa based - Learning Labs) Spa 1 (12/6/13); Spa 4&5 (12/18/13); Spa2 &8 (January 2014)	12/06/13	On-Going
5	Community Presentations	11/15/13	On-Going
6	Install LATC Coaching Support	01/01/14	TBD
7	Tracking of Service Delivery and Outcomes	12/02/12	On-Going
	Phase Two - Treatment Foster Care (TFC)	08/01/13	Ongoing
1	Develop Training Materials	06/03/13	07/11/13
2	Develop Program Policies and Procedures	06/03/13	07/11/13
3	Conduct Trainings	08/27/13	08/27/13
4	Install LATC Coaching Support	11/14/13	01/31/14

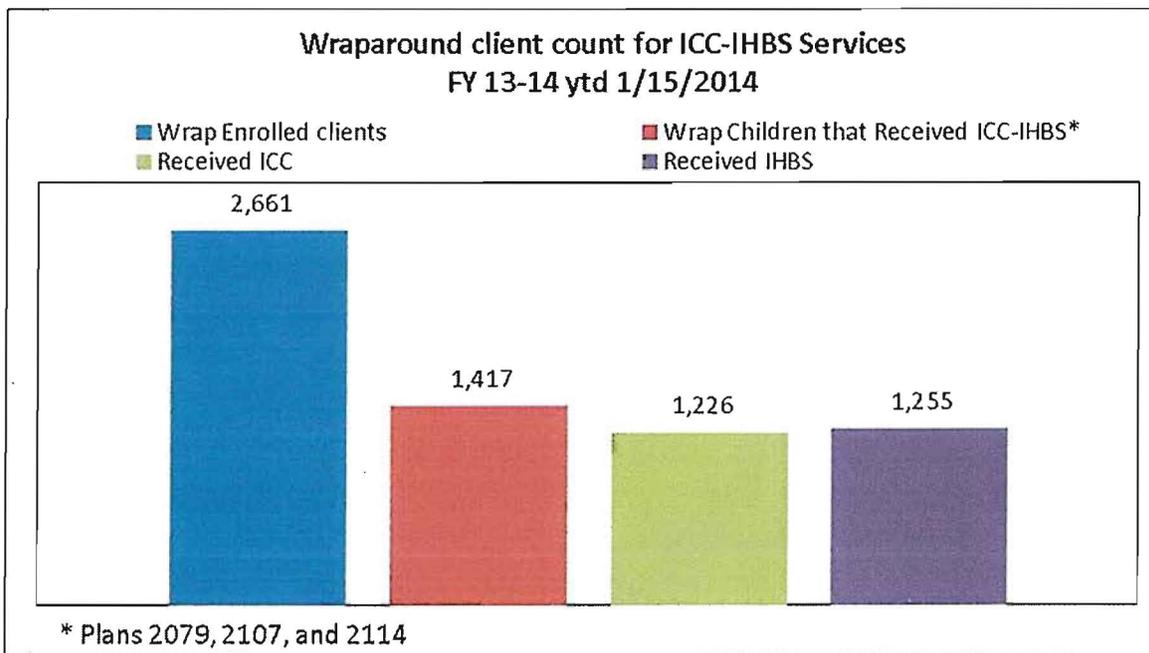
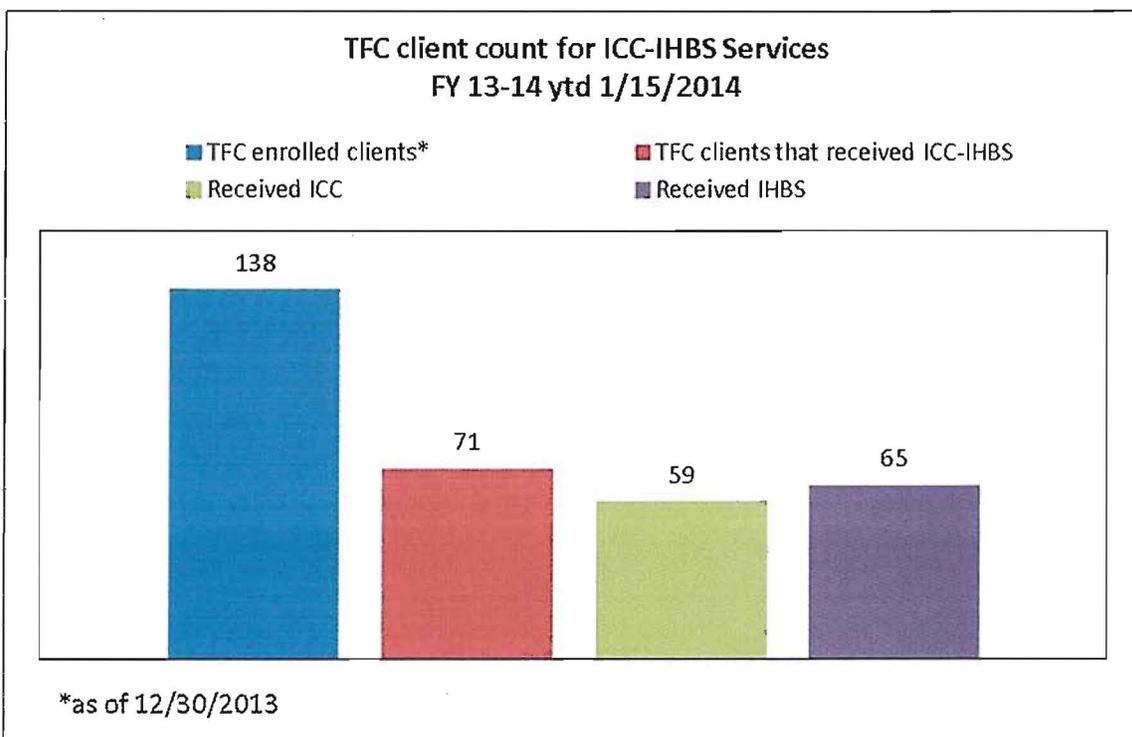
	Name	Start	Finish
5	Tracking of Service Delivery and Outcomes	10/10/13	On-going
6	Consultation with Tim Penrod (IHBS Implementation)	TBS	TBD
Phase Three - Child Full Service Partnership (FSP)		11/1/2013	Ongoing
1	Form Implementation Team	11/1/2013	11/1/2013
2	Prepare PFARs (ICC/IHBS Claiming Ability in the DMH IS)	Ongoing	Ongoing
3	Crosswalk /Companion Guide	1/31/2014	1/31/2014
4	Gather current TCM/Rehab Data	12/1/2013	12/1/2013
5	Develop Program Policies and Procedures (form)	Ongoing	Ongoing
6	Training of Providers	Ongoing	Ongoing
7	Phased rollout for providers	Ongoing	Ongoing
8	Install Coaching Support	Ongoing	Ongoing
9	Tracking of Service Delivery and Outcomes	Ongoing	Ongoing
Phase Four - Group Homes			
1	Form Implementation Team	TBD	TBD
2	Prepare PFARs	TBD	TBD
3	Identify Resources	TBD	TBD
4	Conduct Solicitation of Eligibility and Interest	TBD	TBD
5	Select Providers	TBD	TBD
6	Amend Contracts	TBD	TBD
7	Provide ICC/IHBS Claiming Ability in the DMH IS	TBD	TBD
8	Orientation for Referral Sources	TBD	TBD
9	Develop Program Policies and Procedures	TBD	TBD
10	Training of IFCCS Providers	TBD	TBD
11	Install LATC Coaching Support	TBD	TBD
12	Tracking of Service Delivery and Outcomes	TBD	TBD

In regard to implementation of ICC and IHBS, the County reports the following:

DMH has begun to examine the number of subclass members that are receiving ICC and IHBS. As of October 2013, 51 youth received ICC and 23 received IHBS. As of January 2014, this number greatly increased to 772 subclass members receiving ICC (653) and IHBS (669). The graphs below show the number of clients within Intensive Field Capable Clinical Services (IFCCS), Treatment Foster Care (TFC), and Wraparound (WRAP) that have received ICC and IHBS during FY 13-14. Out of the 75 children that were served in IFCCS, 46 (61%) received ICC or IHBS. Out of the 138 children that were served within Treatment Foster Care, 51% received ICC or IHBS. It is important to note that we expect these numbers to be actually higher than reported, as many of the Integrated System (IS) claims have not been submitted at this time. Out of the current 2,661 enrolled Wraparound clients 1,417 children (53%) received ICC or IHBS.

The County believes that it is beginning to make progress toward ensuring that subclass members are getting these services within some of our more intensive programs and expect this number to steadily increase as it continues to move forward with its implementation plan.





Intensive Field Capable Clinical Services (IFCCS)

According to the County, “IFCCS are an array of services intended to expedite access to Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). Specifically, IFCCS are targeted to youth who are discharging from the Exodus Recovery Urgent Care Centers (UCCs), discharging from Psychiatric Hospitalizations, awaiting placement at the DCFS Emergency Response Command Post or Children’s Welcome Center, or the subject of a joint response from the DMH Field Response Operations Team without a psychiatric hospitalization. Exodus UCCs are crisis stabilization centers, where youth 12 and older can stay for a maximum of 23 hours.”

IFCCS is intended to ensure that children and families who have historically been more difficult to link to appropriate resources are engaged effectively as a part of a Child and Family Team consistent with Los Angeles County’s Shared Core Practice Model.

The County now has a capacity of 59 slots. Because the program is new, the County reports that it does not yet have an estimate of average costs. In the initial Program Improvement review, the County recommended improvements in assessment, better clarity about the clinician role, maximizing the benefits of teaming and focusing on the ultimate goals for the child and family. Current barriers to IFCCS effectiveness are shortage of foster homes to stabilize youth and the inability of providers to maintain service intensity when children are not placed in close proximity to the agency. The growth of the program is displayed in the tables below.

Referral Type for Active Cases	As of 9/30/2013	As of 11/26/2013	As of 1/10/2014
ERCPC/CWC	14	13	8
Exodus	2	4	5
PMRT/FRO	2	4	4
Psychiatric Hosp. Discharge	24	33	31
Total Enrolled	42	54	48
Total Available Slots	48	59	59

Referral Type for Served Cases	As of 11/26/2013	As of 1/10/2014
ERCP/CWC	33	33
Exodus	7	11
PMRT/FRO	4	5
Psychiatric Hosp. Discharge	57	62
Total Enrolled	105	111

As the mental health data summarized above reflects, DMH has an improving capacity to collect and analyze data that strengthens its ability to assess implementation performance and strengthen system management. Data will become more useful when additional detail is available addressing the specific type of mental health service provided, the setting in which it was provided (home and community-based compared with office-based) and the intensity/duration of the service

Treatment Foster Care (TFC)

As a result of slow progress in the County’s efforts to expand therapeutic foster care, the County was directed by the court in its Corrective Action Plan order to expand therapeutic foster care to 300 beds.

The following table displays growth and exit outcomes over time and reflects the continuing slow progress in complying with the court’s order.

	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14 (July-Dec)
New Intakes	26	30	68	62	85	23
Youth Exiting TFC	14	27	36	49	63	26
Exit to Higher Level of Care (GH, Hosp)	9 (64%)	12 (44%)	17 (47%)	14 (29%)	23 (37%)	8 (31%)
Exit to a Lower Level of Care (HOP, LG)	5 (36%)	15 (55%)	19 (53%)	35 (71%)	40 (63%)	18 (69%)
Youth Receiving TFC Services in FY	30	41	81	95	107	111

In the period covered by the previous monitoring report the County had developed 107 certified TFC beds with 91 children receiving TFC services. In the current monitoring period, the number of beds had declined to 92 beds, serving 85 children.

The County has consistently hoped that implementation of the State Katie A. Settlement would assist in the development of TFC beds. While there may be programmatic gains as a result of implementation, the Panel believes that other factors may be affecting the County’s problems with recruitment and retention. The County needs to develop new strategies for improving recruitment

and retention if it is to achieve the target in the Corrective Action Plan. The Panel recommends that the County enlist the technical assistance of a national expert in TFC to determine how to expand TFC resources.

Expansion of Funding for Katie A. Implementation

The County reports the following related to mental health service expansion.

During this fiscal year, DMH has allocated 3.3 million dollars of Mental Health Services Act (MHSA) funding to support the implementation of IFCCS. IFCCS is Phase 1 implementation for ICC and IHBS within the County. DMH has also augmented the EPSDT contracts of several Wraparound providers by a total of \$2.1 million dollars for fiscal year 2013-2014. This will bring the total EPSDT allocation for Wraparound to \$53.6 million dollars countywide. The Exodus UCC contract has been augmented by \$96,000 to expand services for DCFS involved children and youth.

In January of this year, DMH expanded the TFC contract for The Village to provide funding for an additional 15 slots, raising the total TFC funded slots to 314 countywide. The Village has been the most successful TFC program in terms of the recruitment of TFC foster parents and needed these additional dollars to expand their program.

As a result of SB82, DMH will be expanding its crisis stabilization and urgent care center capacity. With respect to children involved with DCFS, DMH will be contracting with a set of mental health providers to operate Youth Placement Stabilization Teams (YPSTs). These teams will provide countywide coverage and rapid response to children who are experiencing placement challenges as a result of their mental health condition. The teams will operate within the framework of the Core Practice Model and provide ICC and IHBS as well as other medically necessary mental health services, similar to the work currently being done by the providers of IFCCS.

In total, this project will provide an additional \$1.415 million dollars of mental health services to this target population. DMH hopes to have these services available at the beginning of FY 14-15.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

In its strategic plan, the County committed to providing a comprehensive medical examination for all newly detained children. These assessments are delivered by a series of Medical Hubs, located in hospital settings.

Currently, the County reports that for the period of January 2013 to December 2013 and as of December 29, 2013, 85.5 percent of newly detained children were referred to a Medical Hub for an Initial Medical Examination (IME). In the prior reporting period, the Panel reported that 86 percent of children had been referred. The County's goal for referrals is 100 percent of newly detained children. The County reports the following steps are being taken to increase referrals:

- With permanent funding now solidified, DCFS implemented a partnership with DHS and Children's Hospital Los Angeles (private sector Hub) to outstation CSWs and PHNs at the Medical Hubs on a full time basis, including after hours at the 24/7 LAC+USC Medical Center Hub. The out-stationed CSWs, as reported previously, continue to significantly contribute to the efficiency of DCFS making referrals to the Hubs and to the work flow/operations of the Hubs. The out-stationed PHNs are contributing to case management and care coordination to children served by the Medical Hubs.
- In addition, the tracking tool, "Medical Hub Exam Results Entered into CWS/CMS" that was previously reported to the Panel, continues to be maintained and utilized to identify the status of the results of the IMEs received from the Medical Hubs through DHS' E-mHub System, being entered into CWS/CMS.
- Further, DCFS and DHS continue to address enhancements to the DHS E-mHub System, a web based medical health information system on children under DCFS' care and supervision who are served by the Medical Hubs, towards strengthening the notifications between DCFS and the DHS Medical Hubs such that the service delivery system in regard to the IME can be more efficient/timely.

The County appears to have reached a plateau of performance in its efforts to achieve its goal of 100 percent referrals.

Expansion of Team Decision-Making (TDM) Capacity Sufficient to Meet the Needs of the Plaintiff Class

In its initial strategic plan the County committed Team Decision-Making as a means to meet the needs of children and families. The County's implementation of TDMs utilized the facilitated process at key decision points (initial removal, re-placement and re-unification) and also to address the needs of special populations and or children/youth with specialized needs. The number of TDM facilitators has not increased and has been downsized in part due to the need for supervisory coverage of line units. The County reports that 42 TDM facilitators are being given new roles as coaches for staff learning the child and family teaming process, which will ultimately increase the number of team meetings being held.