The Katie A. Advisory Panel
Sixth Report to the Court
March 27, 2007

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I. INTRODUCTION

The following Sixth 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. The County is now beginning work on revisions to that plan, pursuant to the Court's most recent order. This report also discusses some of the significant issues and challenges facing the County, resolution to which is critical to achieving the objectives of the settlement.

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 (in 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):

- immediately address the service and permanence needs of the five named Plaintiffs;
- 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 provisions of the settlement agreement. The Panel and plaintiffs 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. The County is now preparing that revision and has invited participation from the Panel in that process.

III. PANEL ACTIVITIES SINCE THE FIFTH REPORT

The Panel has made two visits since January in 2007, one in January and one in March. Panel members met with the County DCFS/DMH leadership team, providers, including one meeting with both providers and the County, key program managers, the Commission and conducted two visits to DCFS service area offices (SPA 2 and SPA 4).

The Panel is pleased to report that the County has been open to candidly sharing with the Panel the challenges it faces in implementing the Joint Plan and has opened the planning process to full Panel participation. This has been done through the development of seven workgroups to which Panel members have been assigned and through weekly conference calls to review plans and discuss next steps. The leadership and managers of both agencies

should be commended for approaching the planning process in this open manner.

IV. STATUS OF DCFS/DMH JOINT PLAN IMPLEMENTATION

Based on interviews and observations by the Panel and a review of the County's reports of progress, the following describes the County's current status of Plan implementation.

Creation of a Child Welfare Mental Health Services Division

The County has created a DMH Child Welfare Services Division responsible for planning and coordination, training, implementation and evaluation of specialized mental health services as well as a dedicated child welfare health hotline.

Currently, the County reports that 94 of the 113 positions allocated have been filled. Some staff expansion has been limited due to the unavailability of space to house them, specifically for directly operated programs in SA 1 and 6. The County has located additional space for two sites that will be available in April and July 2007, respectively.

Two additional barriers to filling positions have been the DMH temporary hiring freeze which will extend through March 2007 and system wide difficulties in recruiting mental health staff qualified to provide intensive, home-based mental health services.

Co-location of DCFS and DMH Staff

The co-location of DMH staff in DCFS offices has occurred. The County reports that staff have been hired as follows:

- Child Welfare Division – 11 positions filled (6 clinical / 5 administrative) and 6 positions vacant. 1 additional item has been vacated.
- Service Area 1 – 10 positions filled, (6 clinical / 4 administrative) and 5 positions vacant. In addition to the current vacant items 1 staff has vacated an item.
- Service Area 6 – 53 positions filled (42 clinical / 11 administrative) and 7 positions vacant. In addition to the current vacant items 3 additional items have been vacated.

- Service Area 7 – 20 positions filled (13 clinical / 7 administrative) and 1 position vacant. In addition to the current vacancy 4 items have been vacated and one pending.

Note: *A vacant item is a position that has been allocated for a program but the selection of the person has not occurred.*

The County reports that the revised date for the initiation of Phase 2 co-location will be dependent on the completion of the analysis of implementation being conducted by Health Management Associates (due May 31) and approval by the court of the Corrective Action/Revised Plan. The Panel has met with Health Management Associates to review their proposed methodology and to identify key issues which this evaluation could focus on. The Panel does not know when Phase 2 is likely to begin; however it has been delayed past original projections.

The Panel has encouraged the Phase 2 SPA leadership to develop clarity about the focus of the implementation and attend to pre-implementation planning. Phase 2 leadership also needs clarity about the framework for overall change and how the many different initiatives come together to support the identification and delivery of mental health service to the plaintiff class. The County has agreed to have a discussion with the Panel about the overall framework/plan and to articulate it in a manner that can be easily communicated. The County also anticipates adding additional staff to current co-location sites to address the needs of class members that are at risk of entering out-of-home care.

Additional staffing for the DMH ACCESS Hotline

One of the three projected staff has been hired. The County reports that one unfilled position is expected to be filled by transfer and a staff member has been identified to fill the third.

Creation and Staffing of DMH Mental Health Units in Each of the Eighteen DCFS Regional Offices

This section in the current County Plan refers to the co-located staff previously referenced.

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

The Panel and the County have reached agreement on nineteen indicators that will be tracked on an interim basis until the new DMH information system (IBHIS) is completed in June 2008. The County reports that it has produced a draft of the data report on the proxy class for internal review and with refinement, may be able to track areas such as psychotropic medication and psychiatric hospitalization. Potential confidentiality barriers have delayed this information, an issue which will be addressed later in this report. Unless confidentiality barriers prevent matching the data from DCFS and DMH, the County expects to share the first reports with the Panel by April 15, 2007.

Development of the DMH Children's System of Care Assessment Application

The County reports that this Application is a comprehensive functional application tool to provide age category information regarding client outcomes. Providers have been trained on the tool and have begun to generate baseline information on those children receiving mental health services.

Development of Multidisciplinary Assessment Teams (MAT)

The County reports that the Multidisciplinary Assessment Teams are operating in SA 3 and 6 and that 823 referrals have been made with 484 completed. The County reports that it plans to implement the MAT in Service Area 1 by June 30, 2007 and in Service Area 7 during the next fiscal year. The County does not have a formalized implementation plan for MAT and this concerns the Panel as the MAT is considered the vehicle articulated in the Countywide Enhanced Specialized Mental Health Services Joint Plan for the assessment, linkage, and implementation of mental health services for children with positive mental health screens. Since February 2007 the County and the Panel have held productive discussions about the barriers to MAT implementation and the County has chosen to include MAT issues in the Joint Plan.

Progress has been slowed in part as a result of barriers in billing Medicaid for some elements of the assessment process. There has been a perception by providers that they would not be fully compensated for completing an assessment. The County asked the Panel to examine this as a potential State barrier to meeting the settlement agreement. The Panel reviewed CDMH

ACL 06-05 and California Code of Regulations, Title 9. Rehabilitative and Developmental Services Division 1, Department of Mental Health regulations for Medi-Cal Specialty Mental Health Services and found no substantial reason for the perceived limitation in billing. See the February 11, 2007 letter to Dr. Charles Sophy, presented as an Attachment, for a description of the specific issues and remedy. The Panel later met with County DMH and DCFS Clinical and Quality leadership about the billing barriers. While there is general agreement with Panel that billing can greatly expand, there continues to be hesitance expressed by DMH and DMH staff because of the restrictive California Department of Mental Health Audit Environment designed to recoup significant saving in EPSDT expenditures. In reviewing reasons for recoupment there does appear to be a discrepancy between what appears to be allowable by the State and the restrictiveness of the State's own audit approach. At present, this has diminished provider reluctance to participate in MAT. To mitigate this somewhat in the near term DCFS has dedicated one million dollars of the MacLaren money to make up the shortfall for providers. This represents a significant acknowledgement by the County of the importance of the MAT in achieving the aims of the settlement agreement. The Panel made seven specific recommendations to the joint County leadership team to increase provider readiness for billing and to attempt to address the perceived State audit barrier. These included:

1. Developing a series of documentation vignettes that would provide greater levels of practical guidance to the providers.
2. Create a single mental health assessment and treatment plan document that would meet the needs of both DMH and DCFS. The maintenance of two separate sets of documents (even though significantly similar) perpetuates an arbitrary distinction between what is a social welfare activity versus a mental health activity. In addition, the maintenance of separate documentation results in significant wasted time, inefficiency, and redundancy of effort.
3. LA County should mobilize the Children's Commission and other child advocacy groups to attend the State hearings on the mental health audit process and bring the discrepancy noted above to light and its impact on children needing mental health services.
4. Other counties have gotten around some of the problems in billing early during the assessment process by establishing an interim/initial treatment/service plan that allows providers to begin providing mental health services while assessment is being conducted. There is an incorrect assumption by the County and providers that that no service is billable while assessment is ongoing. The Panel suggests training providers to document

early intervention as an assessment technique to examine the child's adaptability, coping, and response to intervention strategy. This is billable if documented appropriately.

5. Explore carving out MATs from the basic mental health plan and establish DCFS as a certified mental health provider. In this way the MAT activities would most likely fall outside the CDMH audit process and, rather, be held to DCFS audit processes which are more flexible.
6. Billing difficulties seem to be age group specific. The Panel recommends conducting a demographic analysis of MAT assessment and then tailor documentation standards and vignettes to the unique needs of the sub-group for example, children ages 0-5.
7. Conduct a IV-E activity analysis and clearly identify IV-E eligible MAT activities and ensure that under the IV-E Waiver plan investments are directed to fund these activities.

Regarding the expansion of MAT, the County reports that the funding for Phase 2 implementation of MAT will be dependent on County action in response to a funding request that will be submitted.

In its interviews with County staff, in addition to the presence of the Medicaid barrier, it was reported that the MAT office needed additional staff support to manage the anticipated expansion.

Development of a joint DMH/DCFS Master Person Index

The Master Person Index is an element of the information system under development and will permit matching of children between DCFS and DMH information systems. Complete client matching beyond the interim matching of the proxy class will not be possible until a possible confidentiality barrier is resolved. County attorneys do not believe that current California statutes will permit matching between the two systems at a level of detail needed to provide comprehensive information about the plaintiff class. Without resolution, this barrier will severely limit the information about the class ultimately available for IBHIS. It may also impede the interim tracking of the proxy class.

Attorneys for the County and plaintiffs are now considering preparation of a request to the court to provide authority for DCFS and DMH to conduct the comprehensive matching needed to enable the court to track achievement of the Katie A. outcomes for the plaintiff class.

Implementation of the DMH Behavioral Health Information System

The County reports that the completion of the DMH information system (IBHIS) remains projected for completion in June 2008. However, the RFP for securing a provider to develop and implement the system is projected to be released April 30, 2007. In the Panel's experience, the development and implementation of large, complex information systems such as this often takes longer than anticipated. The Panel will continue to track the milestones for completion of this task.

The Panel is concerned that delays in the implementation will impact the Panel's ability to determine if County efforts result in any meaningful improvements in mental health service delivery and utilization by the member class. The Panel continues to request that the County produce mental health utilization data for the member class. The County is receptive to this request and has performed, as noted above, the initial DCFS and DMH matching and is currently reviewing the accuracy of the data. Release of the reports on utilization will be dependent on resolution of confidentiality concerns.

Contract with the UCLA School of Medicine to Conduct an Independent Implementation Evaluation

The County Reports that UCLA chose to decline participation in this role. The County has selected a different provider to conduct this evaluation, Health Management Associates (HMA), a Michigan firm. The Panel met with HMA during its March visit and noted some of the Panel's concerns about implementation challenges. The County expects HMA to address the following issues:

a. How adequately is the DMH Child Welfare Mental Health Services Division functioning? Are children and families receiving needed assistance and services?

b. Have additional staff, provided to the Child Welfare Mental Health Hotline, improved access to and responsiveness of the Hotline?

c. How effective is the development of DMH Co-Located DCFS Regional Office Operations in regard to access, enhanced screening and assessment?

d. What is the status and functioning of Medical Hubs?

e. In Service Areas without Medical Hubs, has the use of Regional Office Team Decision-Making adequately addressed needs that would otherwise be addressed by the Medical Hubs?

f. Is there evidence that Service Areas are promptly providing the necessary, individualized mental health services to children/youth in their own homes, a family setting, or the most homelike setting appropriate to their needs?

g. What is the current status and use of system navigators? How effective are system navigators in meeting stated objectives?

h. Has service capacity within DMH directly operated programs and the network of local contracted providers expanded? How adequate is this expansion relative to known need?

i. How many programs and providers have implemented specialized and evidence-based approaches as an alternative approach to congregate care? What barriers, if any, have limited implementation and/or access to evidence-based approaches?

j. What facets of Phase I have worked well? What areas require improvement? What suggestions do stakeholders have for improvements?

As the Panel understands the provider's work plan, the evaluation methodology for field work is as follows:

- Six interviews with key DMH/DCFS staff (multiple staff participation possible in some)
- Twelve interviews with provider representatives in the three Phase 1 Service Areas (up to sixteen providers per service area)
- One day site visits to Service Areas 1, 6 and 7
- One focus group with line staff in each of the three Service Areas
- Five case file reviews in each of the three Service Areas by the team's clinical expert

The Panel has no question about the qualifications of the evaluation provider, but given the broad scope of analysis evident in the required scope of work, wonders what level of confidence evaluation findings produced by such a small amount of data gathering would yield.

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

The County reports that it is willing to review the Panel's proposal to consider qualitative approaches effectively used elsewhere. It is waiting for

additional information from the Panel, which it will provide. The Panel is also considering conducting 5-10 case specific reviews of service quality to better inform the County and the Court over of progress and barriers.

Development of a DMH Performance-Based Contracting System

The County reports that its performance-based contracting approach is being developed in conjunction with the County's Auditor/Controller's Department and will share it with the Panel once it is adopted by DMH.

It appears to the Panel that apart from negotiating performance based contracts with providers, the success of this effort will be highly dependent on the availability of technical assistance and training for providers and the availability of the new DMH tracking system. The County reports that the contracting process for technical assistance and training with the California Institute for Mental Health has been delayed and that it should be executed April 15, 2007. The County cautions that the CIMH technical assistance is limited to support of the development of in-home services.

The Panel remains concerned about the level of technical assistance available to providers, especially given the caution evidenced by some providers who decline to respond to requests for proposals. The Panel also believes that it would be helpful for the County to share the draft performance-based standards and outcomes with the Panel prior to finalizing them.

Training for Staff Providing Intensive In-Home Services to Children Needing Mental Health Services

The County reports that DMH Service Area Managers have hired a training coordinator and that training is occurring in a number of locations. The County provided the Panel with its training plan, which consists primarily of brief overviews of child welfare and the new intensive mental health approaches and their processes for County staff. This training certainly appears essential to orient staff to these approaches and to provide expectations about the outcomes expected. However, for staff and providers to adopt what for some will be new methods of mental health practice, training of a clinical nature seems also to be essential. The County reports that CIMH plans to deliver clinical training to staff and providers. The Panel requested information about the full scope of CIMH work anticipated and resources committed to this effort. The County's reply is provided below.

> On March 20, 2007 the Los Angeles County Board of Supervisors approved the DMH request to amend our contract with CIMH for the purpose of training providers in selected evidence-based approaches to be used for the provision of intensive in-home mental health services as part of our plan. These evidence-based models include Multidimensional Treatment Foster Care, Multisystemic Therapy, Functional Family Therapy, Incredible Years, and Trauma-Focused Cognitive Behavior Therapy. This three-year contract amendment is budgeted for over $2,000,000. CIMH is now in the process of sub-contracting with the developers of these models to provide training to selected providers. A series of pre-training meetings are now being scheduled with providers and CIMH and DMH are assembling community development teams to be used to support the training, implementation, and sustaining of these programs. We anticipate that clinical training and service provision will occur in the summer of 2007.

It may be helpful for the Panel to meet with CIMH at a later date to gather more information about the technical assistance planned.

Expansion for Funding to Support Implementation of the Joint Plan

The County has provided the Panel data on the macro level about of service expansion. However, the Panel does not feel fully informed about the details of financing strategies. The Panel asked the County for additional details about anticipated revenue and the strategies for maximizing federal funds. It is probably most informative to share the County's reply, which is provided below.

> We have not developed the specific cost projections for the planned expansions. Once those are developed, we will determine the available funding sources. The MacLaren Designation will be one source of funding, as will EPSDT (Medicaid) and appropriate non-Waiver Title IV-E funding. The County is still in negotiations with the State on the details of the planned implementation of the Title IV-E Waiver. In addition, there is a work group tasked with determining the appropriate allocation of available funding between the Probation Department and the Department of Children and Family Services. The use of Title IV-E Waiver funding will be considered as the County develops its spending plan under the Waiver.

Once we know the total funding need and the available resources, there may be additional County General Funds needed to fully implement the expanded plan. The ability to fully implement the plan will be contingent on Board of Supervisor's approval of all necessary funding.

The Panel finds it difficult to conceptualize needed funding strategies unless it knows the amount required to meet the needs of the plaintiff class. It is clear that the County is still developing its own understanding of the full dimensions of the class, a process it believes is dependent on mental health assessments of individual members. The Panel believes that the creation of a more detailed financing plan will be important to setting funding targets and the acquisition of resources. Such a more detailed strategy seems particularly essential to ensuring that anticipated revenue resulting from savings achieved through the Waiver is fully realized.

Regarding the revenue maximization issue, the Panel offered some ideas about financing strategies regarding Medicaid which the County has been receptive to and the County is currently working with Panel members to explore opportunities under the IV-E Waiver to redirect significant resources. The Panel and the County are in discussions about the IV-E Waiver overall financing and service redirection plans. These discussions have been fruitful and we anticipate clarity on the overall strategy before the end of May, 2007.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

The County reports that six medical hubs are fully operational. The Panel visited the Harbor-UCLA Center in its January visit and was impressed with the progress made and the expanded attention to children with mental health needs. It appears that space limitations are impeding full operating capacity at two of the Hubs, UCLA/Harbor and Olive View. Both are expected to have needed space by the end of 2007.

In a document reflecting the number of visits at each of the six hubs, the County reports for the period July 06 to January 07 the following pattern of service is present.

	HARBOR/UCLA MEDICAL CENTER												
	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Total
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	7	11	6	12	13	3	9						**61**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	13	24	31	35	31	33	40						**207**

(% of target = 119 initial exams/month)	(11%)	(20%)	(26%)	(29%)	(26%)	(28%)	(34%)						
Follow-up Medical Care for Detained Children	4	7	9	8	15	15	15						**73**
Medical Service for Non-Detained Children	29	35	46	50	40	29	21						**250**
TOTAL VISITS	**53**	**77**	**92**	**105**	**99**	**80**	**85**						**591**
Positive Mental Health Screens	NR	NR	NR	NR	13	30	36						**79**

	HIGH DESERT HEALTH SYSTEM												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	19	13	17	22	32	0	16						**119**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	27	63	68	85	58	58	87						**446**
(% of target = 48 initial exams/month)	(56%)	(131%)	(142%)	(177%)	(121%)	(121%)	(181%)						
Follow-up Medical Care for Detained Children	2	3	11	12	14	10	18						**70**
Medical Service for Non-Detained Children	0	0	0	0	0	0	0						**0**
TOTAL VISITS	**48**	**79**	**96**	**119**	**104**	**68**	**121**						**635**
Positive Mental Health Screens	NR	NR	12	NR	NR	7	21						**40**

	KING/DREW MEDICAL CENTER												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children	27	19	30	31	11	18	9						**145**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	7	25	41	35	43	42	29						**222**
(% of target = 176 initial exams/month)	(4%)	(14%)	(23%)	(20%)	(24%)	(24%)	(16%)						
Follow-up Medical Care for Detained Children	4	18	27	17	32	30	27						**155**
Medical Service for Non-Detained Children	2	2	1	3	2	4	4						**18**
TOTAL VISITS	**40**	**64**	**99**	**86**	**88**	**94**	**69**						**540**
Positive Mental Health Screens	NR	NR	NR	NR	NR	NR	NR						**NR**

	LAC+USC MEDICAL CENTER												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	110	217	195	248	221	159	281						**1,431**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	242	376	311	381	353	298	431						**2,392**
(% of target = 398 initial exams/month)	(61%)	(94%)	(78%)	(96%)	(89%)	(75%)	(108%)						
Follow-up Medical Care for Detained Children	56	144	121	100	109	98	128						**756**
Medical Service for Non-Detained Children	163	8	38	28	14	9	34						**294**
TOTAL VISITS	**571**	**745**	**665**	**757**	**697**	**564**	**874**						**4,873**

Positive Mental Health Screens	NR	NR	NR	NR	NR	NR	86						**86**

	OLIVE VIEW-UCLA MEDICAL CENTER												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	17	3	1	0	4	0	4						**29**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	18	24	18	44	26	38	30						**198**
(% of target = 96 initial exams/month)	(19%)	(25%)	(19%)	(46%)	(27%)	(40%)	(31%)						
Follow-up Medical Care for Detained Children	11	27	30	27	23	12	23						**153**
Medical Service for Non-Detained Children	22	68	52	44	50	28	21						**285**
TOTAL VISITS	**68**	**122**	**101**	**115**	**103**	**78**	**78**						**665**
Positive Mental Health Screens	NR	NR	NR	NR	NR	NR	10						**10**

	CHILDRENS HOSPITAL LOS ANGELES												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	8	14	9	6	0	6	9						**52**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	8	12	13	22	14	29	32						**130**
(% of target=32 initial exams/month)	(25%)	(38%)	(41%)	(69%)	(44%)	(91%)	(100%)						
Follow-up Medical Care for Detained Children	5	3	0	4	0	2	8						**22**
Medical Service for Non-Detained Children	4	0	0	2	0	0	3						**9**
TOTAL VISITS	**25**	**29**	**22**	**34**	**14**	**37**	**52**						**213**
Positive Mental Health Screens	NR	NR	NR	NR	NR	25	21						**46**

	ALL DHS HUB FACILITIES												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	180	263	249	313	281	180	319						**1,785**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	307	512	469	580	511	469	617						**3,465**
(% of target=837 initial exams/month)	(37%)	(61%)	(56%)	(69%)	(61%)	(56%)	(74%)						
Follow-up Medical Care for Detained Children	77	199	198	164	193	165	211						**1,207**
Medical Service for Non-Detained Children	216	113	137	125	106	70	80						**847**
TOTAL VISITS	**780**	**1,087**	**1,053**	**1,182**	**1,091**	**884**	**1,227**						**7,304**
Positive Mental Health Screens	NR	NR	12	NR	13	37	153						**215**

	ALL HUB FACILITIES												
	Jul 06	**Aug 06**	**Sep 06**	**Oct 06**	**Nov 06**	**Dec 06**	**Jan 07**	**Feb 07**	**Mar 07**	**Apr 07**	**May 07**	**Jun 07**	**Total**
Forensic Evaluation for Newly Detained Children *(Includes Mental Health Screen)*	188	277	258	319	281	186	328						**1,837**
Initial Medical Exam for Newly Detained Children *(Includes Mental Health Screen)*	315	524	482	602	525	498	649						**3,595**

(% of target=869 initial exams/month)	(36%)	(60%)	(55%)	(69%)	(60%)	(57%)	(75%)						
Follow-up Medical Care for Detained Children	82	202	198	168	193	167	219						**1,229**
Medical Service for Non-Detained Children	220	113	137	127	106	70	83						**856**
TOTAL VISITS	**805**	**1,116**	**1,075**	**1,216**	**1,105**	**921**	**1,279**						**7,517**
Positive Mental Health Screens	NR	NR	12	NR	13	62	174						**261**

While the Hubs are new and can be expected to have the start up challenges of any new initiative this complex, some of the data referenced above raise additional questions about capacity.

The County advises that new Hub positions requested for 2006-2007 have been allocated and two thirds have been filled. The County also reports that the Hubs have the capacity to serve more children than are currently being seen. A next step for the County, in addition to addressing the space issue, is completing an agreement between DCFS and DMH for follow-up care of children examined.

Expansion of TDM Capacity Sufficient to Meet the Needs of the Plaintiff Class

The County reports that it currently has 62 Team Decision Making facilitators and has requested 31 more. The Panel concurs that the current number is insufficient.

Implementation of the DMH Mental Health Screening Tool

The Panel has reviewed the screening tool and believes that it is appropriate for the needs of the plaintiff class. The County reports that it in use in all of the Hubs and for every 6-month D-Rate reevaluation. The Panel is encouraged that the County is considering utilizing the screening tool for all children currently in care.

Expansion of Wraparound Capacity

The County reports that Wraparound capacity had grown to 851 slots by the end of February, 2006, the date of the most recent County Update. The County appears to have resolved some of the screening and eligibility issues and the Wrap population has grown faster than the plan anticipated. At the current rate the County is expecting to grow to 1250 slots by the end of the year. The County also reports that the number of providers has grown from 8 to 34.

The Panel commends this expansion effort, but as is the case with Treatment Foster Care, the absence of a bundled rate for this service will make expansion unnecessarily costly for the County and more difficult than necessary. In addition, Wraparound providers are experiencing the arbitrary restriction as noted above for MAT providers. At a previous site visit the Panel, County DMH and DCFS performed an EPSDT case review, utilizing CDMH ACL 06-05 on billing for Wraparound services, with providers that revealed that EPSDT was being approximately 30% under billed. This represented a significant lost opportunity to maximize mental health revenue.

The County developed a training plan for providers that has been stalled as a result of the current California Department of Mental Health audit environment which appears to be contradictory to the State's position articulated in ACL 06-05.

Expansion of Mental Health Services

- **Intensive In-Home Mental health Services**
- **Early Intervention Foster care**
- **Multidimensional Treatment Foster Care (MTFC)**
- **MTFC "Lite"**
- **Multisystemic Therapy**
- **Functional Family Therapy**
- **Incredible Years**
- **Trauma Focused Cognitive Behavioral Therapy**
- **Positive Parenting Program**

The County reports that it plans to expand services to deliver intensive in-home mental health services for 474 children for:

80 Multidimensional Treatment Foster Care slots
80 Multi-systemic Therapy slots
314 Slots for a Combination of Evidence-based Approaches and Intensive Case Management Services.

The County states that it is responding to the court's order to expand Treatment Foster Care to 300 slots by adding an additional 220 slots using an Intensive treatment Foster Care model.

Recognizing the need to respond more quickly to deliver these services, the County recently reported to the Panel that it will also use Procurement Through Negotiation (Sole Source Contracting) for providers already

licensed in LA County and the State of California to deliver Treatment Foster Care The Panel is quite encouraged by this approach as it will result in rapid high quality implementation and not be prone to the delays of an RFSQ or RFP process.

The Panel is also encouraged by this approach because these services are a necessary ingredient of the system's capability to redirect children from the group care system and support them with "individualized mental health services in their own home, a family setting or the most homelike setting appropriate to their needs." Previous reports by the County's expert consultant, Dr. Lyons, have found that approximately 50% of children served in the group care system do not have the clinical severity to warrant that restrictive a care option. The Panel is encouraged by reports by the County during the March site visit that over the next 6-12 the County is undertaking a systematic review of all RCL 10 and under group care services with the goal of transitioning children to less restrictive environments. The County reports that the review of RCL 11-14 placements will be performed under the IV-E Waiver. The Panel requested that the County update its plans to demonstrate how these reviews will be accomplished so that adequacy of resources could be assessed.

Targeted Mental Health Services for D-Rate Homes

The County reports the D-rate unit is fully operational and that of the 528 cases reviewed in February 2007, 423 were linked to DMH providers and 50 cases were linked to private providers. The Panel is unclear if the 423 were already linked to providers or if they represent linkages as a result of the D-Rate review. The County also reports that 823 cases have been referred to MAT with 485 assessments completed. The D-rate caseload has declined from 2,850 to 2450 in January, with reductions primarily due to children exiting the system. The County reports that 90% of the children in D-rate homes have been linked to mental health services. The Panel has requested that the County provide a mental health service delivery report for children in D-rate homes that could be compared to service levels reported in 2004 to confirm that service levels have, in fact, increased. The County has performed the initial DCFS and DMH data match and reports that there are significant problems with the data accuracy which they hope to resolve by the end of April, 2007. These data are viewed by the Panel as critical confirmation that mental health service delivery and utilization has improved substantially.

V. Challenges Facing the County

Workforce and Infrastructure Issues

The county has identified workforce and infrastructure issues as impediments that have delayed implementation of the County plan. Regarding workforce, the County has had difficulty is recruiting qualified staff to fill some of its mental health positions. Providers have raised this issue as a barrier as well. Both the County and providers are recruiting from the same employment pool, increasing the competition for staff. Based on interviews with staff in some areas, the unavailability of qualified staff appears to be greater in some locations, especially when trying to recruit bi-lingual staff. The difficulty in filling positions has slowed progress in some areas.

The Panel has suggested that the County review it's approach to staff qualification as it seems to be highly professionalized and focused on licensed clinical staff. The Los Angeles County Department of Mental Health, Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services, Update March, 2005 allows for staff with a Bachelors degree with under two years experience to be supervised by a qualified mental health professional and co-sign all progress notes until the staff has obtained the necessary two years experience. Many of the services delivered under these alternative models and Wraparound are rehabilitative in nature and can be provided with a high degree of fidelity and quality by paraprofessional staff that reside in the community. This is a standard model across the country and the State of California. This alternative qualification and emphasis would greatly relieve the workforce issues.

In a related barrier, current offices were not designed to house the number of staff added by co-location and other new initiatives, meaning that there has not been sufficient space to house additional staff in some offices. The need to acquire new space was also mentioned by some staff involved with Hub development, resulting in delays in implementation while additional space was located.

In the opinion of the Panel there is a third barrier that is related to the workforce challenge. The Panel believes that some providers are unprepared to deliver the new, evidence based services that the County is developing. Panel experience in systems elsewhere suggests that at least some if not many providers will need significant training in the new service design. Given the

workforce development issues noted above, fidelity and intensity of training becomes even more important with the use of paraprofessionals. The CIMH technical assistance planned is described by the County as their strategy to develop providers. The Panel would like to review the scope of the CIMH work and resources committed to it.

EPSDT Claiming

The Panel has advised the County in writing that it believes that providers are significantly under-claiming Title XIX (Medi-Cal) funding for mental health services such as Wraparound and the new MAT efforts due to two factors (Noted above in the Sections on Wraparound and MATs). First, the Panel has reviewed County documents related to Medi-Cal billing parameters, intended to guide claiming. The Panel found that the description was overly child centered rather than child focused and family centered and this appears to force a narrowing of the definition of assessment and plan development activities. The Panel believes that the County's definition of collateral and assessment, which is influenced by the State's guidance on the matter, is narrower than the State definition. The Panel member most knowledgeable about this issue met with the County to assist in finding language that will permit greater use of Medi-Cal funds and remain within the state and federal billing parameters. A joint discussion between the Panel, the State and County would be important to resolving this issue.

The second factor is a more complex one. As previously mentioned, both the County and the provider community have, in the Panel's view, an unnecessarily heightened fear of Medi-Cal audit exceptions. The provider community is aware of Medi-Cal audit disallowances affecting some agencies and feels vulnerable to such disallowances themselves. The Panel fears that the message being communicated by the State about the claimability of EPSDT services through the audit approach and written guidance is having a chilling effect on provider willingness to offer new evidence based mental health services.

The Panel believes that clear claiming guidance and training of providers on documentation will provide greater confidence to the provider community about the limits of Medi-Cal claiming, permitting a greater use of federal dollars to support the expansion of services. If the problem of full and allowable Medi-Cal claiming is not solved, the Panel believes that the expansion of services needed to meet the needs of the plaintiff class will be compromised.

Previously in the report the Panel made specific recommendations about addressing the claiming and documentation challenges affecting MAT. A number of those recommendations are relevant to all EPSDT claiming.

The Panel strongly recommends that the County, State representatives and the Panel meet jointly to seek strategies to permit providers to fully claim Medi-Cal funds consistent with Federal regulations and the State Plan.

IV-E Waiver

The Title IV-E Capped Allocation Waiver allows States to assume risk by offering funding and regulatory flexibility in exchange for defined funding over a five-year period. In addition, each state is required to contract for an independent evaluation. California's DSS, on March 31, 2006 reached a contractual agreement (Waiver Terms and Conditions) with the U.S. Department of Health and Human Services for such a waiver. CDSS has offered the opportunity to counties to voluntarily participate in this waiver.

The terms that CDSS have offered to the counties are not necessarily favorable. All of the financial and program risks are passed on to the counties directly through a Memorandum of Understanding (MOU) and a series of All County information transmittals.

This is a tremendous opportunity for Los Angeles County Department of Children and Family Services (DCFS) to free itself from several restraints imposed by CDSS in the fundamental organization and delivery of services. A recent study by the U.S. Government Accounting Office revealed that the two biggest challenges to improving performance are: caseload size and availability of direct services.

Under the CAP Waiver, DCFS could reduce caseload sizes to the established national standard and -- with other county partners – create a structured array of mental health services for members of the *Katie A.* class.

- Funding for caseload reduction would come in the form of captured savings from service interventions that both reduce intake and accelerate permanency.
- Funding for mental health services would be funding under the terms of Medicaid as authorized by EPSDT.

With these two strategies, DCFS could become the premier urban child welfare agency.

The immediate tasks before DCFS include:

- Negotiating a more favorable MOU in which the State shares risk at least to the level of its own growth projections
- Obtaining a waiver from CDSS on caseload size and the assurance that post waiver environment will support reformed system
- Overcoming state objections to wrap around and intensive foster care models supported by EPSDT by directly linking these investment to reductions in the County's comparative utilization of high-end child welfare services (e.g., congregate care, hospitalizations, etc.).

In order to achieve these ends, DCFS will be required to develop an airtight and integrated planning and financing framework which can meet the goals embedded in: Title IV-E outcome requirements, AB 636, and *Katie A.*

The Panel has prepared a detailed analysis of: the risks inherent in the waiver, the unsuccessful experiences of other states and counties in CAP implementation, and a planning and financing approach which would allow DCFS to achieve these ends. This report can be provided to the court if desired.

Data Trend Information

The County appears to be near completion of its initial report on the Proxy class, which represents meaningful progress. It appears that the greatest immediate barrier facing the County regarding data is resolving the confidentiality barrier to producing comprehensive and accurate information on the plaintiff class. As the Panel understands the confidentially issue, State statute limits the sharing of confidential records, such as those created by DCFS and DMH, only to cases where both agencies are involved in the same case. Because the information systems of both agencies are separate, there is no systematic way for the agencies to know which children are clients of both agencies without matching the two data bases. This will inevitably result in information about clients that are known to only one agency being shared with the other.

The Statute also cites specifically the individuals that may access these records, such as judges, law enforcement, social workers and others. The statues permits others to access the data pursuant to a court order. To try and address this problem, until the statute can be amended by the legislature,

counsel for the County defendants and plaintiffs are considering a request to Judge Matz, requesting authority to conduct this data match.

The Panel believes that a solution to this problem is vital to knowing how the two systems are performing and encourages the parties to quickly place this issue before the court.

Exit Criteria

Background

The court has expressed interest in the development of clear exit criteria related to the Katie A. Settlement. Both parties share this interest as well. The following background information on exit criteria reflects the Panel's experience with exit criteria and standards and is intended to assist the parties in beginning discussion on this issue.

In 2005, The Child Welfare League of America and The ABA Center on Children and the Law reported in their publication, ***Child Welfare Consent Decrees:*** *An Analysis of Thirty-Five Court Actions from 1995 to 2005,* that there were "twenty-one states where there was a currently operative court approved consent decree or order, or where there was pending litigation brought against a public child welfare agency". So the issue of the standards by which a system may exit court oversight in these settlements is both sizable and significant.

In the settlement agreements in the 1980's and into the 1990's, exit standards were often implicitly represented by achievement of the enforceable provisions of implementation plans or by completing the discrete requirements expressed in the settlement language. Such requirements might include developing new policy, maintaining caseloads below a certain ratio, completing training of staff in new methods or meeting timeliness deadlines for certain case actions, like responding to abuse and neglect reports.

In the Child Welfare League of America study referenced previously, the League found in a review of 35 settlement agreements, the following areas of system functioning were addressed:

- Seventy-seven percent addressed placement issues such as foster care recruitment, retention, licensing and training of foster parents, relatives and group homes

- Sixty-six percent addressed protective services

- Sixty-eight percent required the defendants to ensure the provision of certain services to children and their families, such as medical, dental, mental health examinations, parent-child and sibling visitation and independent living training

- Sixty-four percent required the defendants to address issues concerning caseworkers, such as adequate staffing, maximum caseloads and enhanced training and supervision

- Fifty-three percent addressed planning issues such as permanency and identified case goals

- Fifty-three percent required some sort of new resource development, such as the creation of universal information systems or quality assurance reviews

- Thirty four percent addressed adoption issues

- Twenty-three percent addressed reforms to the judicial system

System Performance

Many systems experienced considerable difficulty in meeting the numerous requirements of their settlements agreements and some settlements continued for lengthy periods with progress occurring only intermittently or at times, not at all. The reasons for uneven progress were complex, but included:

- Lack of system commitment
- Turnover in leadership
- Poor leadership
- Inadequate strategic planning
- Bureaucratic impediments
- Lack of financial resources
- Underestimation of the difficulty in satisfying settlement agreement requirements
- The sheer volume of compliance requirements
- The lack of phased scheduling of compliance deadlines (requiring too many major organizational changes simultaneously)

In settlements negotiated in the past fifteen years, as experience with these settlement agreements evolved, it became increasing apparent to the parties that improving procedural performance alone did not necessarily translate into improving outcomes for children and families. Settlement agreements began to change in design with adoption of a set of "best practice" principles as a guide to system redesign and increasing attention to measuring the achievement of outcomes. An example of an early version of a litigation-driven reform that was based on best practice principles is found in the Appendix, where the Alabama RC principles are found. In that case, the system was expected to develop a system of care operating on these principles. Compliance was based on implementation of an enforceable plan (addressing new policy, resource expansion, training, caseloads and quality assurance, for example) and a combination of improved practice quality and outcome trends. A qualitative review tool was used to measure practice quality.

Other settlements reflected some of the same mixture of requirements and added a focus on specific outcome achievement targets, such as a reduction in the average length of stay in foster care from 22 months to 15 months or for siblings in separate foster care placements, an increase of 20 percent of siblings placed together.

Almost all settlements include measurement of procedural compliance, referring to agency actions on behalf of children and families thought to contribute to improved outcomes. Examples would include responding to high priority reports of abuse and neglect within twenty-four hours in 95 percent of cases or conducting child mental health assessments within 30 days of foster care entry in 90 percent of cases. The list of tasks to be measured in some settlements became quite extensive.

In the past five years, another trend has emerged in settlement agreements in this field, related to a role for court appointed panels made up of human services professionals. In one case, an advisory panel was required to set outcome targets for exit and select the elements of the reform's implementation plan that would be enforceable in court. In another case, the advisory panel was tasked with establishing professional standards, outcomes, benchmarks and action steps to improve the conditions of children served.

In the case of Katie A., the court has expressed an interest in the development of clear exit criteria for the case and the parties have expressed a willingness to work together to craft an exit design. It is for that reason that the Panel

will outline some approaches used elsewhere in the following section. The Panel is also providing the parties with examples of other settlement agreements that contain exit standards.

In preparing this analysis, the Panel Chair spoke with several colleagues who have been in a court advisory and monitoring role about their experience with compliance measures and exit criteria.

Examples of Exit Criteria

The Panel has broad experience with class action settlements. Collectively, the Panel has had direct involvement in systems with child welfare and mental health settlements in Alabama, Arizona, New York City, North Carolina, Milwaukee, Utah, Oregon, Tennessee, Illinois, Washington DC, Florida, New Jersey and now Los Angeles.

The Panel has reviewed the following settlement agreements to survey the range and design of compliance requirements and exit criteria:

- Alabama – RC v. Walley (Children with mental health needs in child welfare)
- Washington, DC – LaShawn v. Williams (Children in foster care and children that are the subject of child abuse and neglect reports)
- Hawaii – Jennifer Felix v. Cavetano (Children with disabilities in need of mental health and special education services)
- New Jersey – Charlie and Nadine H. v. Codey (Children in out-of-home care)
- Braam v. State of Washington (Children in foster care)

The structure of these settlements is different in content and scope and there are differences in the plaintiff class as well as in the remedies sought. However, there are commonalities that the parties can examine that may help in crafting Katie A. exit criteria.

In preparing this analysis, the Panel Chair spoke with several colleagues who have been in a court advisory and monitoring role about their experience with compliance measures and exit criteria.

Strategic Plans and Tasks

Many settlements require completion of the tasks that are part of formal implementation plans as a condition for exit. In some cases, core elements of

the plan, not every single step described, are the areas subject to enforceability. As referenced earlier, the most common areas addressed are:

Organizational Structure – Successful change may necessitate the creation of new organizational units, different levels of professional competencies in key positions or different accountability relationships between the central office and local service delivery offices.

Policy Development – Settlements may require the creation of policy on a range of issues, from expressing new standards for foster parents and congregate providers and revising the protocols for investigating alleged abuse and neglect to addressing the treatment of youth who are near aging out of the system. Revisions in the case/permanency planning process are very frequently addressed in child welfare settlements.

Workforce Development – It is very common for settlements to require new training of staff, both at the entry level and among experienced staff. Provider training may also be necessary. Salary adjustments may also be required to attract qualified staff.

Information Systems – With the increasing reliance on information systems to not only manage the case volume but also to track performance and outcomes, many settlements address the requirement to develop an effective automated information system.

Workload – Caseload standards are an almost universal requirement in settlement agreements. Adhering to maximum caseload ceilings is normally a critical factor in demonstrating compliance. Some settlements not only require that staff turnover be addressed, but may also set maximum allowable percentages of turnover that may not be exceeded.

Supervision and Accountability – Some settlements address the span of control of supervisors, the creation of tools for evaluating worker performance and training of supervisors.

Resource Development – Because the lack of appropriate resources is often seen as a reason for poor child and family outcomes, settlements frequently require the creation of new resources and services, such as more family foster homes and therapeutic foster homes, expanded mental health supports and reunification supports.

Quality Assurance - The lack of effective quality assurance systems may be seen as a contributor to the poor system performance that led to the original litigation. Frequently, systems are required to develop new feedback mechanisms that will assess how children and families are being treated, track compliance with agency policy and identify barriers to expected performance.

Performance of Casework/Clinical Tasks

One of the most common methods of measuring compliance as a basis for exit is through the review of a sample of individual case records and other methods of documentation to determine if agency policy was followed. This process examines issues such as timeliness of action (Was a child and family assessment completed within 30 days of case opening?), thoroughness (Were all adult household members interviewed in regard to abuse allegations?) or follow through (Were all of the services prescribed in the plan or court order delivered?).

Exit standards may be set to require achievement of each task at a specified level. Such standards often range from 80-95 percent achievement, depending on the importance of the action being measured. Such provisions place high importance on thorough written documentation, which is not without consequences in terms of caseworker time spent documenting activities. The number of items selected for measurement should be considered in light of the high time demands of documentation and its effect on time available for direct work with families. The Panel can provide the parties with examples of such case review instruments, if desired.

In the case of Katie A., at least some of the procedural performance relevant to good outcomes should be able to be measured through the use of the automated information systems of DCFS and DMH, once the new DMH system is complete in 2008. Issues such as prompt receipt of mental health services, the types of services delivered and the intensity of services provided should be accessible once the DMH system is complete.

Outcome Indicator Tracking

The trend toward use of outcome measurement as a basis for measuring success and determining exit is a valuable contribution to the field. Increasingly, some requirements related to outcome achievement become part of many of the more recent settlement agreements. These may be expressed as absolute targets that must be met, such as reducing the

frequency of placement changes by 25 percent, or they may specify incremental targets. In that case the requirement may be for a 10 percent improvement in each of the next three years.

Other settlements may not initially set any outcome targets, but as mentioned previously, defer that decision to an expert panel that can analyze the baseline of performance, study the implementation plan and systemic barriers present and confer with the parties. There is not agreement in the field about where outcome targets should be set, as there is not reliable evidence on which to base confidence in specific benchmarks. Decisions are often made based on professional judgment and negotiations between the parties.

At least on an interim basis, the parties and the Panel have reached agreement on a set of outcome indicators that will provide some evidence of the progress of class members (using the proxy class definition) toward the objectives of the settlement. These should be revised once the more comprehensive DMH information system is available. For ease of reference, the indicators are listed below.

Number of children referred per month
Number of children referred by disposition type
Number of referrals by response type
Number and type of referrals on active cases for the past 12 months
Number of reports of abuse and neglect in out-of-home care
Number of children entering foster care after receiving family maintenance services
Number of children in foster care by facility type
Number of placements for children in foster care for 12 months
Number of children entering foster care with previous FCFS cases
Number of children re-entering foster care within 12 months of reunification
Length of stay in foster care
Number of children adopted within 24 months
Number of children reunified within 12 months
Number of children exiting foster care by termination reason
Number of siblings placed together in foster care
Number of AWO (runaway) children

Data collected on these indicators will add considerably to knowledge of the effects of Katie A. on the plaintiff class. For example, using the interim data system, the court and the parties will see trends about:

- The effectiveness of prevention (family maintenance) efforts to keep class members in their own homes though the provision of services

- The ability of the County to serve children in the least restrictive (family based) settings versus placement in group homes and residential settings

- The County's progress in using mental health and other supports to keep placements stable

- The ability of the County to make reunification of class members with their families lasting

- The ability of the County to prevent class members from growing up in foster care

- The ability of the County to prevent class members from entering juvenile correction facilities, running away and entering psychiatric hospitals

- The extent to which children removed from their families continue to live with their siblings.

Once the interim system produces data on the proxy class, which the Panel hopes will be soon, the parties will have a baseline of trends on which to base discussions about targets for improvement. These targets could become core exit standards.

Assessing Practice Quality

Several systems that are defendants in class action child welfare or mental health settlements utilize as part of the exit criteria performance a qualitative review process, which measures practice quality. It is useful to note that two of these systems, Alabama and Hawaii, have exited court jurisdiction in part, in the opinion of the Panel, because practice and outcome change were the primary reform elements of their reform strategy. The third, Utah, expects to exit in 2007.

The Panel has discussed in earlier reports its belief that the County should adopt a quality assurance approach that examines practice quality, not just case process and will not restate its arguments here. However, what these three systems found in focusing on practice and using qualitative

measurements was that staff find the qualitative reviews more practically useful than other system quality assurance processes, the findings help identify the reasons that outcomes are not changing and that better practice produces better outcomes.

Washington DC, New Jersey and Milwaukee are systems under court jurisdiction where qualitative measures are not part of the settlement requirements. However they have adopted the process voluntarily as an internal quality assurance mechanism to help them strengthen practice and speed compliance with other settlement provisions.

Next Steps

The Panel recommends that the parties review the examples of exit strategy provided by the Panel. Further research may be needed in this area.

The Panel also recommends that in discussing exit criteria, the parties identify elements subject to measurement and relevant to the objectives of the settlement in the areas discussed above: County Plan and Tasks, Performance of Clinical/Casework Tasks and Outcome Indicators. Within each category, key elements should be identified that when accomplished, will contribute most significantly to achievement of settlement outcomes. Once these are identified that parties should review progress in the County's Plan implementation and current data baselines, where available, as a basis for setting targets. In some cases, such as strategic plan tasks, new deadlines and numbers of children served may become part of the exit target. In clinical/case process performance, timeliness, thoroughness, scope and intensity of service provision seem appropriate as core measures on which to place quantitative targets.

Regarding outcomes, once a baseline is evident, the Panel recommends the adoption of phased outcome targets, using the agreed upon indicators at a minimum, projected at intervals of time. For example, an outcome related to multiple moves might require a 20 percent reduction in the number of children with more than two moves in one year by January 2008 growing to a 30 percent reduction by July 08.

Last, the Panel recommends that the County consider the use of a qualitative measurement tool to assess practice quality, even if this approach is not part of the formal exit standards. The Panel repeats its invitation to the County to visit one of several systems using this approach.

VI. RECOMMENDATIONS

Based on data gathered from the County's reports and Panel observations in its site visits to DCFS and DMH, the Panel has the following recommendations.

1. Provide the Panel with current drafts of the performance based contracting standards and outcomes for comment before they are implemented.

2. Provide the Panel with information about the scope of anticipated CIMH work and the resources committed to this technical assistance. Assess the extent of training needed to develop providers and co-located staff.

3. Describe in writing the financing strategies underway and planned to generate the revenue needed to serve the plaintiff class. This should include the dollars needed to provide intensive, home-based services to class members at-risk of entering foster care.

4. Develop more formal written fiscal strategies and forecasts required to achieve the goals of the waiver.

5. Assist in convening a meeting of appropriate County and State officials on the issue of EPSDT claiming and documentation. Also consider the Panel's specific suggestions on MAT and EPSDT claiming included in an earlier section of this report.

6. Quickly approach the court regarding authority to match the data on class members served in both DCFS and DMH, stored on the information systems of the two organizations.

7. Begin the process of discussing with plaintiffs and the Panel the design of exit criteria applicable to the Katie A. settlement agreement.

VII. GLOSSARY OF TERMS

ADHD-attention deficit hyperactivity disorder

D-Rate-special rate for a certified foster home for children with severe emotional problems

DMH-Department of Mental Health

EPSDT- Early Periodic Screening, Diagnosis and Treatment (a process enabling children to get Medicaid support for services, including mental health and developmental services)

ER-emergency response

FFA-foster family agency (there are about 13,000 FFA beds in over 60 FFAs and
about 7,000 beds in county foster homes)

Treatment Foster Care – A therapeutic approach to foster care for children with emotional or behavioral needs, provided by highly trained caregivers and supportive intensive services

FGDM-Family Group Decision Making

FM-family maintenance services

Hub-six regional sites where children will receive a comprehensive medical evaluation, mental health screening and referral for services

IEP-individual education plan

MAT-Multi-Disciplinary Assessment and Treatment Team

PTSD-post-traumatic stress disorder

RCL-Rate Classification Level (levels of group home care, with RCL 14 being
considered residential treatment; about 2,000 children are in about 125 group homes)

RPRT-Regional Permanency Review Teams

SPA-Service Planning Area (LA is divided into 8 regions)

TBS-therapeutic behavioral services

TDM-team decision making (a family conferencing approach)

Title XIX-Medicaid

VIII. Appendix

Appendix 1

February 11, 2007
Dr. Charles Sophy
Medical Director
Los Angeles County
Department of Children and Family Services

RE: Multidisciplinary Assessment Team (MAT) Medi-Cal Reimbursement

It is my understanding that full implementation of the MAT's at each Medical Hub has been delayed as a result of limitations in funding. As a result, the Department of Mental Health and the Department of Children and Family Services has undertaken a review and articulation of the Medi-Cal billing parameters to guide providers. Per your request, I have reviewed the draft (dated 12/5/2006) description of the Multidisciplinary Assessment Team (MAT) Medi-Cal reimbursement parameters. This review was done in the context of the Los Angeles County Department of Mental Health, Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services, Update March, 2005.

Assessment and Collateral

The description of activities and services is overly child centered rather than child focused and family centered and this seems to force a narrowing of the definition of the assessment and plan development activities. Service to children and adolescents require a much higher degree of collaboration with a multi-disciplinary team, a broader range of collateral contacts, and a much more in-depth and comprehensive assessment of factors impacting the mental health condition and its treatment. I have included the recent **California Code of Regulations,Title 9. Rehabilitative and Developmental Services Division 1, Department of Mental Health regulations for Medi-Cal Specialty Mental Health Services** definition of "Collateral" and "Assessment" for your reference.

In my opinion, the definition of collateral and assessment articulated are more narrow than the state definition and should be looked at for implications related to assessment, plan development, and targeted case management. For example, in the section on assessment it states "It is the LAC DMH's current understanding that the interpretation of the assessment code (90801 or 90802) is a face-to-face procedure, that is, the client must be present." As you can see from the state definitions there is no limitation to face-to-face when the client is present. In fact, the definition of collateral specific indicates that the "beneficiary may or may not be present." In addition, the state definition of assessment does not place an arbitrary number of "two" contacts within which to determine medical necessity.

1810.206. Collateral.

"Collateral" means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to

assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

1810.204. Assessment.

"Assessment" means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

MAT Meeting and Summary

In describing the MAT Meeting and the MAT Summary of Findings Report Preparation there seems to be a desire to differentiate a social welfare activity from a mental health activity. This separation seems unnecessarily artificial and fails to recognize the interrelationship between environmental conditions, familial functioning, and broader life circumstances on the development and amelioration of mental health issues. Developing an appropriate mental health treatment plan means understanding the psychosocial factors including family relationships; living arrangements; patient's developmental history; and economic, cultural, religious, educational, and vocational background as they impinge on the understanding, treatment, and relapse prevention of the mental health disorder.

The MAT Meeting is the vehicle for developing the mental health long-term goals, identifying the priority presenting problems or symptoms, describing the functional impairments, identified barriers to meeting goals, and examining the linguistic/cultural, co-occurring, health, and or familial factors that may impact the clients mental health goal achievement. Given this view of mental health treatment planning the entire MAT Meeting would be considered a billable activity. This would appear to be in line with Medi-Cal reimbursement requirements.

The MAT process is described in the Countywide Enhanced Specialized Mental Health Services Joint Plan as one of the vehicles for improving the mental health services of foster youth. As such, the MAT Summary Report could be reviewed as the clinical assessment report developing out of this assessment and treatment planning process. In fact, there are significant overlaps with the LA County Mental Health Child/Adolescent Initial Assessment form and the Coordination plan. It would seem more helpful to find ways to bring these two documents together to serve multiple purposes than attempting to differentiate them as social welfare and mental health.

I would be happy to talk further about these ideas. If it would be helpful to have a face-to-face we could set up a meeting before the end of February or when I am in town during the March 12-14 site visit.

Sincerely,

Richard T. Clarke, Ph.D.

Appendix2

ALABAMA R. C. CONSENT DECREE GOALS AND PRINCIPLES

The consent decree spells out as the goals of the new system of care, to:

1. *Protect class members from abuse and neglect; and*

2. *Enable class members to:*

   - *live with their families; and when that cannot be achieved through the provision of services, to live near their home;*

   - *achieve stability and permanency in their living situation;*

   - *achieve success in school; and*
     become stable, gainfully employed adults.

To achieve these goals, the new system of care is expected to operate according to the following principles:

1. Class members shall live with their families. Exceptions are to be made only when:

   - *it is not possible, through the provision of services (including intensive home-based services), to protect a class member living with his/her family from imminent, serious harm; or*

   - *it is not possible, though the provision of services, including intensive home-based services, to protect a class member from serious harm upon reunification with his/her family.*

2. *Class members and their families shall have access to a comprehensive array of services, including intensive home-based services, designed to enable class members to live with their families.*

   These services should be designed to enhance the natural support networks of class members and their families. Other services to which class members and their families shall have access, if required to enable class members to live with their families, are:

parenting skills and household management training; peer support; homemaker services; day care; respite care; help with housing; crisis services; mental health services; services for substance abuse; and "facilitative" services. Class members and their families shall have access to such services when the class member is living with his/her family or when the goal is for the class member to return home or live with a relative. When the goal is for the class member to return home, services should also be provided to the parents to prepare and enable them to care for the class member when he/she returns home. When the goal is for the class member to live with a family member, services should be also provided to the family member to prepare and enable the family member to care for the class member.

3. *Class members, while in foster care or DHR custody, shall have access to a comprehensive array of services that address their physical, emotional, social and educational needs.*

3. *Both class members and family members may refuse placement-prevention services.*

   Class members and family members may refuse other services, to the extent permitted under law.

4. *Class members and their families shall be encouraged and supported to access services.*

   To this end, the "system of care" shall develop and implement strategies to promote the utilization of services by class members and their families. These strategies shall include the use of community aides, the provision of transportation services, the development of ethnically and culturally sensitive services, and referral to peer support groups. When class members or their families refuse or fail to access services, the reasons for their doing so shall be assessed and the services that have been offered shall be modified or alternative services shall be offered to encourage acceptance of services.

5. *Class members and their families shall receive individualized services based on their unique strengths and needs.*

   The strengths and needs of the class member and his/her family shall dictate the type and mix of services provided; the type and mix of services provided shall not be dictated by what services are available. Services must be adapted to class members and their families; class members and their families must not be required to adapt to inflexible, pre-existing services that are unlikely to be effective.

7. *Services to class members and their families shall be delivered pursuant to an individualized service plan.*

   There must be a reasonable prospect that the services provided will achieve their purpose. The services must be of a type and mix likely

to achieve the goal for the child. The services must also be of a type and mix likely to be effective in meeting the needs to which the plan is designed to respond.

a. *Individualized service plans shall be based on a comprehensive, individualized assessment of the strengths and needs of the class member and his/her family. In the case of class members in foster care or DHR custody, this assessment shall include an examination of the class member's (i) developmental, behavioral, emotional, family, and educational history and (ii) strengths and weaknesses in behavioral, emotional, educational, and medical/physical areas.*

b. *Individualized service plans shall include specific services to reinforce the strengths and meet the needs of the class member and his/her family. Each plan shall identify the specific steps to be taken by DHR staff, other service providers, class members, and the class members' parents and family toward meeting the short-term and long term objectives of the plan.*

c. *The "system of care" shall carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan.*

d. *The goal and the objectives of the individualized service plan will be updated as needed. Services identified in the plan will be modified as needed to meet the goal and objectives of the plan (for example, by adding new services or providing services in a different way). Steps shall be taken to prevent and address deterioration in the functioning of class members.*

8. *The "system of care" shall address the needs of class members believed to be victims of sexual abuse.*

   a. *Timely, professional assessments shall be conducted of class members believed to be victims of sexual abuse. DHR shall ensure that such assessments provide clear, prescriptive guidelines for treatment of the sexual abuse.*

   b. *The individualized service plans of class members believed to be victims of sexual abuse shall specifically identify both the class member's needs as a sex abuse victim and services to be provided in response to those needs.*

9. *Class members, parents, and foster parents shall be accurately and timely informed, in language understandable to them, concerning: rights under the decree (including the right to be treated in accordance with the "principles" or "standards"); the goal for the class member; individualized service plans, including objectives; services, including placements; and options.*

10. *Class members, parents, and foster parents shall be encouraged and assisted to*

articulate their own strengths and needs, the goals they are seeking for themselves, and what services they think are required to meet these goals.

11. *Class members, their parents, and foster parents shall be involved in the planning and delivery of services.*

    This includes the ISP. The right of class members, parents, and foster parents to participate in treatment planning and delivery may be restricted only according to a specified administrative process. DHR shall promulgate a policy, acceptable to both parties, describing under what circumstances and according to what procedures restrictions may be imposed.

    a. The class member shall be treated as a partner in the planning and delivery of services if the class member is age 10 or older and, if the class member is under the age of 10, when possible.

    b. The class member's parents shall be treated as partners in the planning and delivery of services if the class member is living at home or if the goal is for the class member to return home.

    c. Foster parents shall be treated as partners in the planning and delivery of services whether or not the goal for the class member is to return home.

    d. When necessary, services shall be provided class members and parents to enable them to participate as partners. Such services shall include transportation assistance, advance discussions, and assistance with understanding written materials.

12. *The "system of care" shall promote class members' visitation with their parents and family.*

    a. The matter of visitation shall be addressed in the class member's individualized service plan. The frequency and circumstances of visitation shall depend on age and need. Visitation shall be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visitation will be actively encouraged; assistance with transportation will also be provided.

b. Visitation may be arranged by the class member, the class member's parents or family, or the foster parents, as well as by DHR staff and the staff of residential facilities, in accordance with the individualized service plan.

c. Supervision of visitation shall be required only when there is a danger that the parent or family member with whom the class member is visiting will harm the class member unless the visit is supervised. 'When supervision of visitation is required, such supervision may be provided, as appropriate, by the class member's foster parents, as well as by DHR staff, the staff of residential facilities, or other designated persons.

13. *The "system of care" shall be sensitive to cultural differences and the special needs of minority ethnic and racial groups.*

    Services shall be provided in a manner that respects these differences and attends to these special needs. These differences and special needs shall not be used as an excuse for failing to provide services.

14. *The "system of care" shall conduct timely investigations of allegations that class members are being abused or neglected while living at home or with a relative or while in foster care or DHR custody.*

14. *The "system of care" shall embrace the philosophy of service delivery in home-based and community-based settings.*

    Class members shall receive services in the least restrictive, most normalized environment that is appropriate to their strengths and needs.

    a. Class members shall be placed in the least restrictive, most normalized living conditions appropriate to their strengths and needs. The class member's own home shall be considered the least restrictive, most normal placement. Following are other placements listed in ascending order in terms of restrictiveness: independent living; a foster home; a therapeutic foster home; a group foster home; a group home; a child care institution; an institution. Institutional care shall be used only in an emergency and as a last resort. Class members shall be placed in family settings, whenever they can be cared for in such a setting with supportive services.
    b. Siblings shall be placed together. DHR may promulgate a policy, acceptable to both parties, identifying circumstances in which exceptions to this principle may be permitted.
    c. The "system of care" shall not initiate or consent to the placement of a class member in an institution or other facility operated by DMH/MR or by DYS unless the placement is the least restrictive, most normalized placement appropriate to the strengths and needs of the class member.
    d. Class members, when in foster care or DHR custody, shall be integrated to the maximum extent feasible into normalized leisure and work activities.
    e. DHR shall vigorously seek to assure that class members, when in foster care or DHR custody, are integrated to the maximum extent feasible into normalized school settings and activities.

16. *Class members from Jefferson, Mobile, Montgomery, Madison, Houston, Tuscaloosa, Etowah, Calhoun, Walker, Lee, and Dallas counties shall be placed within their home county when removed from their homes.*

    Class members from other counties shall be placed within the region in which their home county is

located. Exceptions to this principle are to be permitted only in exceptional circumstances with the written permission of the Director of the Division of Family and Children's Services or his/her designee. DHR shall promulgate a policy, acceptable to both parties, that describes when such exceptional circumstances are present.

17. The "system of care" shall promote permanency in class members' living situations.
a. 'When the goal is that the class member shall return home or be discharged to a family member, the "system of care" shall vigorously seek to achieve this goal. b. When the goal of return home or discharge to family has been achieved, the "system of care" shall vigorously seek to avoid reentry of the class member into foster care.
c. The "system of care" shall make timely, competent decisions concerning whether and when class members should return home.
d. When a decision is made that a class member should not return home, DHR shall seek a timely dispositional hearing.
e. When the goal is that the class member not return home, the "system of care" shall vigorously seek a permanent living situation for the class member.

18. The "system of care" shall promote stability in class members' living situations.
a. The "system of care" shall be designed to minimize multiple placements. The "system of care" shall be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the class member.
b. Individualized service plans shall identify whether a class member is at risk of experiencing a placement disruption and, if so, will identify the steps to be taken to minimize or eliminate the risk.
c. Appropriate training will be required for, and appropriate supportive services will be provided to, foster parents and staff of residential facilities in order to minimize placement disruptions. In the case of foster parents, the services shall include intensive home-based services and respite care.
d. The "system of care" shall forbid summary discharges from placements. DHR shall promulgate a policy, acceptable to both parties, that describes steps that must be taken prior to a class member's discharge from a placement. The policy may permit in exceptional circumstances the placement of a class member in a temporary, emergency setting without prior notice to DHR.
e. The "system of care" will avoid temporary, interim placements. Class members shall be placed in settings that could reasonably be expected to deliver long term care if necessary. To this end, DHR will not place class members in shelters unless (i) the full array of services the class member needs can be provided the class member while residing in the shelter and (ii) it is likely that the class member's stay in foster care will not extend beyond his/her stay in the shelter. f. The "system of care" will vigorously seek to ensure that law enforcement officers, juvenile court personnel, and others do not remove class members from their home and place them in foster care or DHR custody without first notifying the "system of care" and providing the system an opportunity to intervene to prevent the removal or placement.

19. The "system of care" shall ensure that the services identified in individualized service plans are accessed and delivered in a coordinated and therapeutic manner.

20. Services shall be provided by competent staff who are adequately trained and supervised and who have appropriate caseloads.
The competence of staff staff's training and supervision, and staff's caseloads shall be deemed adequate when the "system of care" is able to comply with the standards set forth in this decree.

21. Services provided class members and their families shall meet relevant professional standards in the

fields of child welfare, social work, and mental health.

22. *The "system of care" shall require that any behavior modification program employed in the treatment or management of a class member be individualized and meet generally accepted professional standards, including that:*
    a. The program rely primarily on rewards instead of punishments;
    b. The program be based on a careful assessment of the antecedents of the behavior that the program is designed to change; and
    c. The program be consistently implemented throughout the day, including in school, residential, and leisure activity settings.
    d. The "system of care" shall take an active role in seeking to ensure that local education agencies and the Alabama Department of Education (i) recognize class members' educational rights and (ii) provide class members with educational services in accord with those rights. Among other things, the "system of care" shall advocate for class members who are subjected to inappropriate and/or illegal disciplinary measures.

23. *The "system of care" shall promote smooth transitions for class members to adult service systems and/or independent living when class members "age out" of the system.*
    The individualized service plans of class members who are expected to "age out" of the system shall provide for such transitions.

24. *The "system of care" shall accord class members the following rights: the right of access to counsel and the courts, the right of access to family members, the right to be free of excessive medication, and the right to be free from unnecessary seclusion and restraint.*
    DHR shall promulgate policies, acceptable to both parties, describing and protecting these rights. The policies shall provide that:
    a. Class members shall be permitted to freely communicate by telephone or mail with (i) legal counsel of the class member's choosing, including the class member's guardian ad litem, and (ii) organizations that provide legal services. b. Class members shall be permitted to freely communicate by telephone or mail with (i) the class member's parents and family members and (ii) adult friends of the class member including former foster parents. This right may be restricted only pursuant to procedures and in circumstances specifically identified in written policy. c. Class members retain the right to communicate and visit with their parents and family even when the class member is in the permanent custody of DHR (i.e., parental rights have been terminated). When the class member is in permanent custody, the matter of his/her communication with parents and family members shall be addressed in the class member's individualized service plan. Such communication may be restricted when it would undermine or defeat attainment of th~ goal or objectives identified in the plan.

25. Class members, parents and foster parents shall be made aware, in an effective manner, of the availability of advocacy services to assist them in protecting and advancing their rights and entitlements.

26. Class members shall be provided effective assistance and support in applying for SSI benefits. (Where it is necessary that the class member's parents apply for benefits, such assistance and support shall be provided to the parents.)

26. Class members shall be enrolled, if eligible, in the EPSDT program and shall receive comprehensive screens that meet the requirements of federal law and are provided according to a professionally

acceptable schedule.

27. The “system of care” shall promote early identification and timely intervention in order to enhance the likelihood of positive outcomes.

29. The “system of care” will identify, assess, and disseminate state-of-the-art methods, strategies, and materials for serving class members and their families.