

**The Katie A. Advisory Panel
Report to the Court
First Reporting Period of 2012
May 16, 2012**

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Executive Summary

The County is implementing a series of promising strategies directed at achieving the objectives of the Katie A. Settlement. These address areas of mental health service expansion, improvements in front-line practice and reducing placement of young children in congregate settings, among others. It is also joining the Panel in an assessment of Wraparound in an effort to prepare the program to maximize its effectiveness in advance of the opportunities for expansion anticipated through the settlement of the State Katie A. case. And the County is addressing implementation challenges related to Treatment Foster Care, Medical Hubs and the quality of the Multidisciplinary Assessment Team process.

The County has also completed Qualitative Service Reviews in 14 offices, providing sufficient data to examine needed practice improvement in a number of key practice areas. This Executive Summary will highlight some of the recent progress by the County as well as the challenges of strengthening front-line practice.

System Progress

Teaming and Coordination

The County recently completed an initiative to improve the coordination and information sharing between DMH and DCFS regarding children served by DCFS who also receive mental health services. The two agencies have begun to conduct a weekly matching of client records which will regularly produce at the DCFS child social worker level information about recent mental health contacts with children in their caseload. The following will be provided:

- Name of provider agency
- Name of rendering providers
- Name of MH program (Full Service Partnership, Wraparound, Therapeutic Behavioral Services, etc.)
- Service information (type, location, date)
- Contact phone number

The County expects this information sharing to facilitate follow-up conversations that will enhance teaming and coordination. Appropriate confidentiality safeguards will be in place. Teaming and coordination have been identified as challenges in Qualitative Service Reviews, where among the offices reviewed to date, scores indicate that 84 percent of cases reviewed needed improvement in this area. The Panel commends the County for this creative step. The Panel has not seen this matching process employed in other systems and believes that it can be an innovative model for California, other states and local governments.

Reducing Placement of Young Children in Group Care

In its last report the Panel noted its concern about the rising number of young children age 0-12 in group care, which had reached 190. In considering strategies to reduce this number, the Panel recommended that the County start by focusing on the youngest children, those 0-8, by forbidding placement of children in this age range from being placed in group homes. The Panel recognizes that there may need to be rare exceptions to this limit until a broader array of home-based mental health services are available. The County accepted and implemented this recommendation.

Recently, the DCFS Director took the initiative to extend this group home placement prohibition to children 0-12, requiring the DCFS Director's or Deputy Director's approval for group home placement of children in this broader age group and setting out alternative steps to be taken prior to requesting executive approval. This action reflects a strong commitment to the Katie A. principles and is a credit to the County's effort to implement the settlement.

Expanding Home Based Mental Health Services

After the Panel recommended that the County make contact with an innovative provider in Arizona who might offer a model for expanding home-based mental health services, the County invited him to meet with a group of providers from Los Angeles. While the response of many providers reflected limited interest, according to the County, the County did enlist the interest of a major provider. The County now plans to pilot the approach with that provider, proving an opportunity to use the experience to expand the innovation.

Expanding Treatment Foster Care

The County has undertaken a range of strategies to increase TFC capacity through recruitment initiatives. It is also seeking approval to add three positions to support additional recruitment efforts.

Improving the Rate of Referral of Children to Medical Hubs

The County undertook a study of the reasons that some newly detained children were not referred to Hubs and used those findings to develop multiple strategies to increase referrals.

Implementation of a Qualitative Service Review of Wraparound Cases

The County is joining the Panel in a review of Wraparound cases to identify trends and themes in service provision. The Panel believes that this study can further strengthen Wraparound and also provide important information to the State Katie A. workgroups in developing implementation and design strategies. Undertaking this initiative adds to the already full schedule of QSR and other staff and the Panel appreciates the conscientious manner under which this effort has been undertaken.

Implementation Challenges

The County is continuing to work on implementation challenges and recommendations made by the Panel in its last report. These areas, strengthening training and coaching, expanding

Treatment Foster Care, expanding the availability of home-based mental health services, conducting initial Hub medical assessments of newly-detained children and reducing the number of young children in group homes remain challenging, but the County has efforts under way in each to improve implementation, as this report describes.

In this report, the Panel is including the results of initial Qualitative Service Reviews (QSR). These findings, displayed in Section IV. of the report, reflect a core challenge all systems face in implementing an ambitious practice model like the County's.

The QSR reviews to date reveal a number of strengths of the County's practice and services. In the 153 cases reviewed, in the area of Child and Family Status, 99 percent of cases scored acceptably for Child Safety and in most offices, Safety scores were 100 percent. Stability was also a positive in the offices reviewed. Eighty-one percent of cases scored acceptable in Stability. The suitability of the child's current Living Arrangement was found acceptable in 95 percent of cases. Ninety-seven percent of children reviewed were found to have acceptable Health and Physical Well-Being. Current Caregiver Functioning was also at a high level, where 96 percent of cases scored acceptably.

Challenges in the Child and Family Status category were the important indicators of Permanency at 57 percent acceptable, Family Functioning at 60 percent acceptable and maintaining Family Connections at 68 percent acceptability.

Within Practice Performance indicators, the QSR process sets a high standard for performance, which no system approaches meeting in their baseline reviews. Initial scores are commonly quite low, but the County performed at a somewhat higher level than most systems on several Practice Performance indicators. Engagement scored at 56 percent acceptability, Family Voice and Choice (meaning involvement in case planning and decision making) was at 50 percent acceptability and Assessment scored at 51 percent acceptability. The score for Service and Supports (resource availability) was at 64 percent acceptability. These indicators still need improving, but foundational work makes the challenge less substantial than in many systems.

The most significant practice challenges faced by the County were identified as Teamwork, at 16 percent acceptability, Planning, at 40 percent acceptability, Long-Term View, at 40 percent acceptability and Tracking and Adjusting, at 44 percent acceptability. The County and Panel will devote time to examining these findings in their June 2012 meeting and the Panel hopes that further practice improvement strategies will be identified.

The phased implementation of Katie A. Strategic Plan provides the County the best opportunity to develop and sustain high quality front-line practice. Training and coaching are time intensive and must occur during the daily workload demands experienced by CSW's, mental health practitioners and their supervisors, so implementing the practice model office by office is a necessity for creating sustainable change. The work underway in the Compton pilot should provide a guide for effective implementation in other offices and should make the next phase of implementation more efficient and effective. The County's conscientious attention to challenges at this stage promises to yield further progress as the next phase of implementation gets underway.

Panel Recommendations

The Panel makes the following recommendations for County action:

1. Continue to reduce the group home population by developing sufficient intensive services around children and caregivers that their needs are met and their behaviors are managed. The Panel is impressed with initial steps taken by the Department to reduce the number of young children placed in group care. The overall group home population continues to be larger than needed due to the lack of home-based alternatives.
2. Utilize the findings of the assessment of reasons some youth leaving Treatment Foster Care move to a higher level of care to develop a strategy to address this pattern.
3. Continue to document the effectiveness of coaching in Compton and keep the Panel informed of ways it can be supportive as the County moves implementation to the next office.

The County is still working on implementing several prior Panel recommendations – analysis of data on the mental health service pattern and intensity of children placed in D-Rate, Kinship and FFA settings, reducing the number of young children in group care and a QSR review of active Wrap cases – so the Panel is not making additional major recommendations at this time.

**Katie A. Advisory Panel
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I. Introduction

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

II. Background

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

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

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

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

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

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

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

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

Additionally, the Settlement directs that:

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

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the 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. That Corrective Action Plan was completed and provided to the Court. In subsequent discussions with the

Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs. The County has now completed its Strategic Plan and received County Board approval for implementation.

III. Panel Activities Since the Last Report

The Panel met in December 2011 and March 2012 with the County. In the March meeting the Panel spent one day observing the coaching practice in Compton. A summary of that observation is in a subsequent section of the report. Paul Vincent, Marty Beyer and Edward Walker each participated in a QSR. Marty Beyer and Paul Vincent provided brief training in needs-based practice and child and family teaming to County staff. Also Marty Beyer provided training for MAT staff and provided feedback on coaching and MAT documents.

IV. Current Implementation Plan Status

Co-location of DMH Staff

The County reports that the status of co-location of DMH staff in DCFS is unchanged from the prior report. The County has allocated 316 DMH positions to directly support Katie A. implementation. These include central office managers and staff who have either managerial, clinical or administrative roles and staff in each service area. Service area staff also have a similar mix of roles. Katie A. DMH staff are allocated as follows:

LOCATION	NO. OF ITEMS
Child Welfare Division	48
D-Rate	12
Service Area 1	29
Service Area 2	24
Service Area 3	34
Service Area 4	17
Service Area 5	4
Service Area 6	84
Service Area 7	39
Service Area 8	23
MHSA Items	3
TOTAL	317

Additional staffing for the DMH ACCESS Hotline

The County has found that all three positions originally committed to the function are not needed and that duties can be fulfilled by the single position currently filled.

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

There is agreement between the parties about the outcome indicators to be tracked.

Development of Multidisciplinary Assessment Teams (MAT)

The County reports the following status of MAT implementation.

In January 2012, 98 percent of all eligible newly detained children Countywide were referred to a Multidisciplinary Assessment Team (MAT) assessment. This compares to a 90 percent referral rate reported in the prior Panel Report. From July 2011 through January 2012, there were 3,448 MAT referrals and 2,973 MAT assessments completed. Assessments were not completed on 14 percent of those referred.

The performance of individual Service Planning Areas for January 2012 is reflected in the following table.

Table 1: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	31	29	94%
SPA 2	57	57	100%
SPA 3	80	80	100%
SPA 4	25	25	100%
SPA 5	7	7	100%
SPA 6	98	92	94%
SPA 7	53	53	100%
SPA 8	69	68	99%
Total number of DCFS MAT referrals:	420	411	98%

It is important to note that the referral rate in SPA 1 jumped from 34 percent in August 2011 to 94 percent in January 2012. SPA 1 has added two new providers to conduct MAT assessments in order to address the previous capacity deficit. When the capacity is limited, the county reports that the DMH Specialized Foster Care (SFC) staff is able to prepare a comprehensive mental health assessment and provide linkage to mental health services as needed.

From July 2011 through January 2012, the average timeline from MAT referral acceptance to completion of the final SOF (Summary of Findings) report was 45 days, which is the expected timeline for completion. The percentage completed in 45 days or less was approximately 65 percent. The percent completed by the 50th day was 81 percent.

In terms of completing the MAT assessment by case disposition, DCFS MAT Coordinators report approximately 73 percent of MATs are completed prior to disposition. The remaining 27 percent are delayed for numerous reasons including:

The Panel asked for additional information about why MAT assessments were not completed on the 14 percent of referrals not assessed and the County provided the following:

This 14 percent represents the number of kids who are referred to MAT but have not completed the MAT process for a number of reasons. Primarily, approximately half or seven percent of the referred children have not completed the MAT process yet. Due to the expected time it takes between referral and the completion of the MAT process, there will always be a difference between the number referred and the number of completed assessments. The other approximately 7 percent of children referred did not receive an assessment due to, what is commonly referred to as, a “MAT Cancellations Reason.” These reasons include:

- Children who are returned home soon after the initial detention and MAT referral. If they go home then they are no longer MAT eligible. (This is the main reason for not completing the MAT assessment).
- Children who are originally referred to MAT and then we discover that they have private insurance. These are no longer MAT eligible.
- Children who run away and are not available to complete the assessment. (These are referred for Mental health services once they return from AWOL but many of them do not receive the MAT assessment because the case has already been adjudicated and the MAT is no longer useful to court).
- Children who are placed in a psychiatric hospital or in juvenile detention so cannot complete the MAT due to billing and access issues.
- Children who are moved out of state or outside the county and providers are unable to complete the assessment process.
- Children who lose their Medi-cal eligibility after the referral so we cannot proceed with the MAT assessment.

To further clarify, when children become MAT ineligible but still need mental health services, they are referred to DMH co-located staff for an assessment. Indigent and privately insured families are also referred for mental health services, as needed. However, an important consideration is the right of families and/or youth to refuse mental health services even when children are screened positive for mental health needs per our Mental Health Screening Tool.

Implementation of the DMH Behavioral Health Information System (IBHIS)

The State RFP process for IBHIS has been complex and protracted, resulting in a new State estimate for completion in 2013. The County provided the following update about the status of this initiative.

INTEGRATED BEHAVIORAL HEALTH INFORMATION SYSTEM (IBHIS)

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

Status: DMH selected the Avatar system from Netsmart, Inc. (Netsmart) as the result of an RFP process. The Board of Supervisors approved an Agreement with Netsmart on October 18, 2011. Work with Vendor began in November 2011; the project team is currently engaged in planning and discovery work that will lead to decision making about how the system will be configured for DMH.

The target date for first production use of IBHIS is mid-2013.

Critical Future Policy Issues: **Workforce Issues:** An electronic health record (EHR) with integrated administrative and financial functionality will create a work environment in which nearly all DMH employees will need to be computer literate. Computer literacy is not universal in DMH, although nearly so now with the implementation of e-timekeeping. “Opting out” of using the IBHIS to do assigned work will not be possible; so substantial training may be required. Existing job specifications may need to be modified, and potentially union MOUs, in order to make computer literacy and use of an information system a requirement for most existing job classifications.

Contract Providers: Approximately half of all DMH clients receive services delivered through contract providers of mental health services. The contract providers currently have direct access to DMH’s computer system, but, under the IBHIS, they will not. They will, instead, exchange information with DMH electronically. Initially the content of this exchange will be only slightly expanded from the current focus on health care claims, but may eventually include substantial portions of the consumer health record. This is a major change for most contract providers. The LA County DMH MHSa IT Plan includes the use of MHSa funds to facilitate this transition for contract providers.

Consumer Access to Healthcare Information: The Avatar system includes a client portal. This will allow DMH clients to securely access

selected portions of their healthcare record from any location in which they have access to the Internet.

Key Future Milestones: Initial Production Use – June 2013

Fiscal/Financial Information:

IBHIS expenses are projected to be approximately \$11 million if FY 11-12. A \$51,660,413 million allocation in the DMH MHSA IT Plan is being applied to IBHIS initial costs. Additional funding comes from the DMH IT budget as obsolete systems to be replaced by IBHIS are no longer updated and finally shut down.

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

Innovative County Information Sharing Initiative

In reviewing Qualitative Service Review results, the County and Panel have observed that the frequency and timeliness of teaming, information sharing and coordination between DFCS, DMH and other providers at the case level is uneven, resulting in vital facts about child and family functioning and service provision not being exchanged among team members. In an effort to improve timely information sharing, the County has developed a weekly data matching process to determine which clients are receiving services from the two departments. This matching process has been occurring for several years under the authority granted by the Federal District Court to assist in the tracking of outcomes.

Under this new initiative, selected mental health information about joint clients will be shared weekly for the purpose of coordinating care. Now DCFS workers will have more timely information about individual clients who are receiving mental health services including:

- Name of provider agency
- Name of rendering providers
- Name of program (FSP, Wraparound, TBS, etc. if available)
- Service information (type, location, date)
- Contact phone number

The County expects this information to lead to increased follow-up communication regarding common clients and should facilitate the emerging teaming process. The Panel considers this initiative to be an important innovation and commends the county for its initiative and creative problem solving.

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

The County continues its implementation of the Qualitative Service Review process, which satisfies this provision. This Panel report includes Qualitative Service Review findings to date in a subsequent section of this report.

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

The County reports the following status of its training.

DMH has convened an Intensive Home Based Services/Intensive Care Coordination Workgroup composed of representatives from DMH, DCFS, and community providers to review the Settlement Agreement in the Katie A. State case related to these service models and to propose how these services might be expanded in Los Angeles County. The County anticipates that a pilot project will be initiated based upon the thinking of this workgroup and that further training and implementation will follow the release of the documentation manual from the State later this year.

Expansion of Funding

According to the County, the FY 2010-11 Katie A. budget closed with \$16.2 million in net County cost savings, an amount slightly higher than projected in the last report. The budget closed with \$22 million in net County cost savings in 2009-2010. The savings were primarily due to vacant Wraparound slots. As done with prior year savings, the Chief Executive Office (CEO) has rolled the FY 2010-11 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 and FY 2012-13 in support of the incremental rollout of the Strategic Plan. The County reports that most of the **current** savings occurred due to a slower roll-out than projected.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

In Fiscal Year (FY) 2010-2011, approximately 70 percent of newly detained children received an Initial Medical Examination at a Medical Hub. In FY 2009-2010, 80 percent of newly detained children received an Initial Medical Examination at a Hub. As of March 2012, 82 percent of newly detained children were referred to a Hub.

The County's initial medical examination goal is 100 percent of children. In its last report, noting the lag in achievement of referring all newly detained children to a Hub, the Panel recommended that the County survey a sample of supervisors of cases where referrals were not made to Hubs to develop a better understanding of why children were not being referred. The County conducted the study and has provided the Panel a copy of its report of findings. A copy of the report findings is included in Section V.

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

The County reports that for calendar year 2011, there was a total of 15,496 TDMs held. The Department currently has 83 TDM facilitator items (3 vacancies). Fourteen are Permanency

Planning conference facilitators responsible for facilitating the RMP and PPC TDMs and there are 3 Pregnant and Parenting Teen (PPT) conference facilitators. By year, the County has completed TDMs as follows:

Calendar Year 2010: 16,602 TDMs completed
Calendar Year 2011: 15,497 TDMs completed
Calendar Year 2012- 1st Quarter: 4,242 TDMs completed

Implementation of the DMH Mental Health Screening Tool, Coordinated Services Action Team (CSAT) and Referral Tracking System

The County reported the following performance related to the revised mental health screening tool and associated rollout.

Number of Children Screened - (of a total of 26,753 children):

- 27,243 children required a screen, (32,845) children minus those currently receiving mental health services, in a closed case, who ran away, or were abducted);
- 26,753 (98.20%) children were screened.
- 490 (1.80%) screens are showing pending.
- 17,554 (65.62%) of those children screened (26,753) were determined to be in potential need of mental health services (received positive screens).

Screening Compliance – (of the 26,753 children screened):

- 18,110 (67.69%) children screened positive of those children requiring screens (27,243);
- 8,643 (31.73%) children screened negative of those children requiring screens (27,243);

Acuity Determination (18,110 children screened positive):

- 23 (0.13%) children were determined to have acute needs;
- 572 (3.16%) children were determined to have urgent needs;
- 16,959 (93.64%) children were determined to have routine needs;
- 556 (3.07%) children's acuity level was pending determination and/or data entry.

Number of Children Referred for Mental Health Services:

- 17,554 children could be referred to mental health services (18,110 children who screened positive minus children for whom consent was declined, whose case was closed, who ran away, or who were abducted).
- 17,134 (97.61%) children were referred for mental health services.

The following chart provides a breakdown of timeliness from screening to referral as of January 2012 (data current to March 27, 2012).

Number of children/number of days from positive screening to referral to mental health.

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	21 - 30 days	%	31 days or over	%	Total
Acute	22	95.65							1	4.35			23
Urgent	487	85.14	49	8.57	20	3.50	7	0.01	4	0.70	5	0.87	572
Routine	10,729	64.87	2,335	14.12	1,273	7.70	780	4.72	615	3.72	807	4.88	16,539
Total	11,238	65.59	2,384	13.91	1,293	7.55	787	4.59	620	3.62	812	4.74	17,134

The County plans to address the lesser timeliness for routine referrals as follows:

1. The regional CSAT staff will work closely with each unit supervisor to ensure CSWs submit referral packets to CSAT without delay. CSAT staff will be assigned to review the “pending referral report” on a weekly basis and alert CSWs when a referral is needed.

CSAT staff will be trained to download the list of newly screened children each week. They will search eligibility to determine which children are privately insured and which children should be referred to DMH and alert the CSWs to take appropriate action.

CSWs will bring incomplete referral packets to CSAT and CSAT staff must return the packets for completion before the child can be referred to DMH.

2. CSAT central management is working to develop a user friendly web-based referral form where demographic and family information self populates. The present form requires that the CSW complete a separate form for every child, a time consuming and tedious task. In the interim, management is working with DMH to streamline the referral process by accepting a positive screen to make a referral (rather than requiring a completed packet).

3. A child receives a positive screen, but the parent(s) do not provide their consent to provide mental health services. Sometimes, DMH co-located staff review the

screen, contact the parents, and subsequently obtain their consent; however, the referral to DMH is delayed.

4. As CSWs are becoming more adept with engaging families and the service linkage process, CSAT central management anticipates fewer refusals by parents to consent to their child’s mental health treatment.

Children Receiving a Mental Health Service Activity:

- Of 17,134 children referred for mental health services: 16,842 (98.30%) children began receiving mental health service activities such as assessment, treatment, case management and consultation.

Number of Days from Screening to Start of Service):

- Average of 12 days from case opening/case plan update to mental health screening;
- Average of 5 days from receipt of a positive screen to a referral for mental health services;
- Average of 2 days from referral to the start of mental health service activities.

The Panel also asked for additional timeliness data on the receipt (vs. referral) of mental health services. The following table reflects that performance, which is also positive, especially for children with acute or urgent needs as of January 2012.

Days/ number of children referred for mental health services

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	21 days and over	%	Total
Acute	31	100.00									31
Urgent	677	98.40	8	1.16	2	0.29			1	0.15	688
Routine	16,132	88.71	558	3.07	482	2.65	394	2.17	619	3.40	18,185
Total	16,840	89.08	566	2.99	484	2.56	394	2.08	620	3.28	18,904

The County has made significant strides in implementing the screening process and promptly referring children for mental health services.

Coordinated Services Action Team (CSAT)

The County reports that the CSAT process requires expedited screening and response times based upon the urgency of a child’s needs for mental health services. As a result of a January

2010 Board Motion and subsequent case review, the Child Welfare Mental Health Screening Tool (MHST), the CSAT Screening and Assessment Policy, and the related DMH practice guidelines were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs identified. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. The CSAT redesign training and implementation was completed in August 2011.

Expansion of Mental Health Services

Treatment Foster Care (TFC)

Table 2: TFC Placement and Capacity (as of September 30, 2011)					
	No. of Placed Children	Certified Homes	Certified Home Vacancies	Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
	47	54	7	15	8
Multidimensional Treatment Foster Care (MTFC)					
	16	26	10	13	6
Grand Total	63	80	17	28	14

TFC Trends per Fiscal Year

	FY 08-09	FY 09-10	FY 10-11	FY 11-12 (through 4/30/12)
Number of youth placed into TFC homes during FY	26	30	68	55
Number of youth who transitioned out during FY	14	27	36	35
Youth who moved to Higher Level of Care (GH, Hosp)	9 of 14 (64%)	12 of 27 (44%)	17 of 36 (47%)	13 of 35 (37%)
Youth who moved to a Lower Level of Care (HOP, LG)	5 of 14 (36%)	15 of 27 (55%)	19 of 36 (53%)	22 of 35 (63%)
Total Youth who received TFC services during FY	30	41	81	97

The County sees improvements in outcome trends since the beginning of TFC implementation. It reported:

Overall, a total of 131 youth have received TFC services. One hundred and eight (108) youth have transitioned out of the program with 44 percent recidivating to a higher level of care and 56 percent graduating to a lower level of care (i.e. home of parent, legal guardian, relative and/or foster home). The success of TFC is also evidenced by those youth who remain stable in their TFC placements as this is a successful step toward

permanency, pro-social stability, and as a result, present the County with a significant annual fiscal savings.

County Update on TFC: Since the December 2011 Panel Retreat where TFC recruitment strategies were of central concern, the County has made significant TFC investments to enhance TFC recruitment and retention efforts. The activities consist of the following:

- The County has been participating on the two state workgroups which are examining various elements of TFC, including rate setting, contracting, service provision, and evaluation since October 2011 and will continue to do so through Sept 2012 when a statewide implementation plan is expected to be developed and a documentation manual produced. The County cannot promote a rate increase contrary to the rate put forward by the State, but it is providing counsel and guidance in these important discussions with the Katie A. State Implementation Team and the Department of Social Services TFC State workgroups.
- On March 27, 2012, a proposal from the California Alliance of Child and Family Services was submitted to the State Department of Social Services for an interim increase in AFDC-Foster Care Rates for the existing model of Intensive Treatment Foster Care (ITFC) programs pending implementation of the Katie A. State Settlement Agreement and the re-evaluation of the ITFC program model. The proposal recommends increasing the California Necessities Index (CNI) not previously provided to ITFCs which would increase the foster parent stipend to \$2,168/month and the FFA rate by roughly 11 percent.
- The County has requested three (3) additional positions to support the expansion of the Treatment Foster Care (TFC) programs in the FY 2012-13 budget. Two (2) Psychiatric Social Workers and one (1) Children's Services Administrator is being requested to help with on-going recruitment efforts, facilitate provider meetings, collaborate with regional staff, provide on-going training and support to the Foster Family Agencies (FFA), and participate in qualitative program evaluation reviews. The need for additional positions has been learned after several years of program development and a better understanding of the time and support needed from the County to assist FFA agencies with recruitment and provision of quality services.
- On February 17, 2012, DCFS and DMH along with 12 FFAs hosted a foster parent recognition, training, and recruitment event. The goal was to offer support and training to existing TFC caregivers to help sustain existing homes. Each caregiver was encouraged to bring individuals interested in becoming a TFC caregiver. There were approximately 22 potential new caregivers invited.
- TFC, DMH, and DCFS staff are working with several faith-based organizations to expand recruitment efforts. This work has included e-mails, phone calls and presentations to organizations whose membership include clergy and other religious leaders.
- In December 2011, the TFC administrative team and the DCFS Placement and Recruitment Unit (PRU) began an ongoing partnership to expand its support, marketing and targeted recruitment efforts for TFC. Activities completed to date include the following:

- TFC inserts and recruitment flyers were created and included with paystubs across 33 different county departments;
- TFC recruitment flyers have been included in foster care warrants and Adoption Assistance Program checks;
- TFC recruitment flyers have been inserted into DCFS foster parent general orientation packets;
- TFC recruitment Flyers have been posted on the ShareYourHeartLA.org website as well as the DCFS external website;
- A link to the TFC recruitment flyer has been placed on the DCFS Facebook page;
- Promotional ink pens with TFC information have been produced and distributed;
- A purchase order for TFC brochures has been submitted and is currently pending approval;
- All calls received through the DCFS general recruitment line are briefly screened for interest in becoming a TFC caregiver, resulting in hundreds of potential caregiver names being forwarded to TFC FFAs for additional screening and possible certification as appropriate;
- A purchase order has been submitted for an advertisement on Pandora Internet Radio; and,
- TFC recruitment activities will be included in PRU's budget for the upcoming fiscal year.

While the transition of TFC youth to more restrictive placements remains a concern, there has been some recent progress in this area. The County has also undertaken multiple strategies to increase TFC capacity while it advocates with state workgroups for attention to statewide barriers to TFC implementation. The Panel commends the County for its intensive efforts to expand this valuable resource.

Training and Coaching

In February, 2012, 18 trained coaches (some DCFS, some DMH, some private provider, and one university staff) began coaching in the Compton office with both Emergency Response and Continuing Service units. The Panel has emphasized the importance of coaching as a hands-on application follow-up to training in the Core Practice Model: identifying strengths and needs and building strong teams can best be learned with coaching. The Panel has encouraged the County's approach to coaching, which relies on building the skills of the 18 coaches so they can build the coaching abilities of supervisors, as described by the County: "supervisors in Compton will begin to coach their staff independently and the coaches will move on to other offices. This strategy will be repeated until all supervisors in child welfare and mental health are capable of coaching their staff on the practice model." Coaches are in Compton at least three days per week to model effective engagement, teaming, and assessment approaches with staff, families, and partners. Their activities include coaches accompanying supervisors in the field for home calls, shadowing individual supervisors in conducting group case conferencing and individual discussions with CSWs; and modeling of team formation and facilitation. With the encouragement of the Panel,

the County sent a group of individuals involved in designing coaching to Utah to observe their coaching model, which participants described as beneficial.

In March 2012, the Panel spent a day observing the coaches in action in Compton. A well-conceived schedule allowed each Panel member to observe a different coaching activity in the morning and afternoon with different coaches. The Panel observed impressive coaching in two Family Team Meetings, coaching of four cases by supervisors and two MAT Summary of Findings meetings. It was remarkable that in such a short time since coaching began, the Compton staff trust the coaches and were able to proceed with activities such as a Family Team Meeting while the Panel observed. The Panel also was able to observe how the coaches provide feedback in a written form and receive feedback from the individuals being coached, which is part of the design of the evaluation of the coaching program. In the Panel's debrief with the coaches and the coaching leadership team, their excitement about the benefits of the coaching and their commitment to learn new skills themselves and guide others in their development were evident. The leadership in Compton is working hard to make coaching successful and are looking forward to higher performance scores in their next QSR as a result of the cooperative efforts of DMH and FCFS.

In addition to coaching, DCFS and DMH have formed the Aligning Family Team Meetings Workgroup where Department and Program representatives were meeting to align, support, and improve multiple family team meeting structures currently in place, such as: MAT, TDM, RUM/RMP, Family Preservation MCPC, Wraparound, FSP, and 241.1 Cross-over Youth MDT meetings. Managers from the various programs that utilize various family team meeting processes are developing a plan for alignment of each program's family team process as recommended by the Panel or The Child Welfare Group (CWG). The Panel concurs with the County's effort to unify its multiple teaming approaches into a more cohesive, common model responsive to child and family needs.

Since the Panel's observation in Compton, the County has (verbally) set the expectation for all supervisors and each social worker in the six Compton pilot units that they should begin using family teams in their work and select at least one case on which they can receive teaming facilitation coaching. While this is a small step, it does reflect increasing attention to building County capacity to employ teams with each case.

While it might appear that utilizing 18 coaches for 3 months in each of 18 offices is a slow, costly endeavor, the Panel commends the County for recognizing that changing practice cannot be done primarily through training or at any faster pace.

Expansion of Wraparound by 500 Slots

The County reports that as of December 30, 2011, cumulatively 2,813 children have been enrolled in Tier II Wraparound, which is compared with 2154 children in June 2011. Enrollments continue to be greater than the projected target of 2,275. Tier I enrollments (1,031) have decreased and the County is looking to implement some new efforts that will lead to the increase in referrals. Specifically, the memo the Director issued on group home placements and the implementation of the Playbook. The County describes the playbook as, "*The "Playbook" is a new process where the support staff from the Coordinated Service Action Team, Resources*

Utilization Management (RUM), Wraparound Liaisons, Department of Mental Health (DMH) co-located staff, and Team Decision-Making (TDM) Facilitators meet at the beginning of each week to review all 7-day notices to ensure all the cases have TDM/Resource Management Process (RMPs) meetings before the expiration of the 7-day and that one of the team will be there to cover and make sure the right people are present at the meeting and to support the Children's Social Worker (CSW)."

As of December 30, 2011, there were 1,031 filled Tier I slots and 1,171 filled Tier II slots. The County also reports the following:

The Wraparound program is also undergoing a major redesign process in preparation for the new contract in 2014. All of the workgroups have completed, or are finalizing their tasks. The workgroups were created to address different focus areas: Fiscal, Contracts, Program, Practice, and Quality Improvement/Assurance. The objective of these workgroups was to make Wraparound more efficient and incorporate lessons learned, new advances in the field, and feedback from consumers and community stakeholders. The fiscal workgroup is the only workgroup that has not submitted their final recommendation, but at the last meeting in February, the group discussed the latest funding proposal: The two tier system will be replaced by an EPSDT case rate and a non-EPSDT case rate. The fiscal redesign workgroup members conducted several cost analysis reports on Tier I and Tier II to help inform the case rate discussion and the ability to maximize EPSDT. DMH continues to increase mental health contracts to support the expansion of the Wraparound program and is in the process of starting an EPSDT roundtable to assist with EPSDT billing.

The County completed its annual report on the Wraparound program, which was discussed at the March, 2012 Panel meeting. Noteworthy findings included:

- In 2011, the youth served in Wrap were 56% Hispanic, 29% African American, 11% Caucasian, and 2% Asian/Pacific Islander.
- In 2011, the average age of youth served in Wrap was 15, with the Tier II youth being younger.
- A third of youth in Wrap were diagnosed with Mood Disorder (with more in Tier I) and a third with Disruptive Disorder (with more in Tier II), with small percentages of other diagnoses. About 20% had no mental health diagnosis.
- About three-fourths of Wrap youth graduate successfully from the program, with 88% of Tier II and 62% of Tier I.
- Wrap participation nationally averages about 18 months, but in LA it has dropped to about 12 months to graduation; this may be due to shorter enrollment in Tier II, and the county is now following cases to study recidivism, to ensure that leaving Wrap more quickly does not result in re-entries into care.
- EPSDT reimbursement for Wrap has increased dramatically, with about \$21 million for Tier I and \$20 million for Tier II in 2011.

The Panel asked the County for additional information about the reasons approximately 25% of children do not graduate from Wrap. The County provided the following information preliminary information and continues to examine the pattern:

- Some families refuse services, as it is not what they were told and is too intrusive;
- Some youth continue to escalate and require placement (DCFS or Probation);
- Some teams do not address underlying needs well and the youth goes into placement (DCFS or Probation);
- Some youth are placed with a foster parent who refuses to have Wrap in their home;
- Some CSWs do not actively participate on the Wrap team and do not support the plan made; and
- Some teams must call the child abuse hotline and the family gets angry and refuses services.

The Panel and the County are working together on a study of 20 Tier II Wrap cases, utilizing the QSR format with supplemental questions. Cases will be sampled from throughout the county and a variety of the 36 Wrap providers. This study will provide case-based information about the needs of youth in Wrap and the services and supports provided to youth and to families and caregivers to meet their needs.

Mental Health Services for Children in D-Rate and FFA Settings

In the Panel's last effort with the County in 2010 to understand the expansion of mental health services, it was learned that that most of the 1,500 children in D-Rate homes and almost two-thirds of the 6,000 children in FFA homes received mental health services (taking out the 1,920 children age 4 and under in FFA homes, this percentage goes up to 73% for the children over 4 in FFA homes receiving mental health services). Children in D-Rate and FFA homes primarily rely on regular outpatient services, not the four specialized mental health programs (Wraparound, Intensive In-Home, Full Service Partnership and System of Care. Questions about the intensity of mental health services for children in FFAs and D-Rate were raised by that study. In response to concerns that several hundred D-Rate children were identified as not receiving mental health services, a follow-up study by the County found that half of a sample of these children were receiving mental health services (through DMH contracted providers, fee-for-service or private practitioners) that did not show up on the DMH database; several children had refused services and for others mental health service referrals were made as a result of the follow-up.

The Panel requested that the County use 2011 data to do a new analysis of children over age 4 in FFAs, D-Rate and relative homes to determine: how many are receiving mental health services, of those, how many are enrolled in Wraparound, FSP, SOC or Intensive In Home, and of those not enrolled in these programs, how many are getting what frequency of outpatient therapy. The results of that study will be discussed at the Panel's June 2012 meeting with the County.

Caseload/Workload Reduction

The County reports that the DCFS total out-of-home caseload has declined from 15,425 (April 2011) to 15,191 (January 2012). According to the County, the individual CSW generic caseload average in January 2012 was 26.38, a slight reduction of .18 children per social worker since April 2011 caseloads of 26.56. The ER caseloads depict a very slight increase (.06) in number of referrals from April 2011(15.74) to January 2012 (15.80).

The Panel asked the County to provide caseload data by office to assess the variability of caseloads.

The County provided a table reflecting the average caseload of each supervisory unit, by office. In assessing the data, the County looked for patterns of significantly higher caseloads, arbitrarily selecting caseloads of 31 and over as notable. Twenty-seven percent of unit caseloads (43 units) exceeded 30 cases out of a total of 159 supervisory units. The highest caseload pattern was in the Vermont Corridor (10 caseloads out of 30) and Wateridge (13 caseloads out of 30). The County advises that recruitment and retention are particularly challenging in these offices and efforts continue to stabilize the workforce there.

Young Children in Group Homes

There were 100 children age 0-12 in group homes at the end of 2009 and 163 children age 0-12 in group homes at the end of 2010. The County reports that in February 2011, 179 children age 0-12 were in group homes, so the number has almost doubled since 2009, but is starting to drop again. The RMD sends out monthly reports to the regional offices, highlighting the number of youth from their office and whether a RMP or a Permanency Planning Conference (PPC) has been held. Additionally, the Director's December 1, 2011 memo on placing youth age eight and under is having an impact. In that memo staff were advised that the Director's approval was necessary before any child 0-8 was placed in group care. Between January through March, a total of 4 children age 8 and under were admitted into group care. DCFS will not have placement numbers for April until mid-May.

GROUP HOME REPORTS FOR CHILDREN 0 TO 12 (by office location) FEBRUARY 2012

OFFICE NAME	NUMBER OF CHILDREN
Adoption	1
Asian Pacific/American Indian	1
Belvedere	7
Compton	15
Deaf Unit	1
El Monte	4
Family First Unit	1
Glendora	12
Lancaster	10
Medical Placement Units	3
Metro North	4
Palmdale	3
Pasadena	14
Pomona	12
Santa Fe Springs	8
San Fernando Valley	10
Santa Clarita	8
South County	11
Torrance	6

Vermont Corridor	11
Wateridge	23
West Los Angeles	7
West San Fernando Valley	5
TOTAL	177

There were 190 children age 0-12 placed in group homes at the time of the last Panel report. As of February 2012, there were 13 fewer young children placed in group homes.

**GROUP HOME REPORTS FOR CHILDREN 12 YEARS AND OVER (by office location)
FEBRUARY 29, 2012**

OFFICE AGE	13	14	15	16	17	18	19	20	21	Total (Age 13 and Older)	12	Total (Age 12 and Older)
Adoption			1	1			1			1	1	2
Asian Pac / Am Indian	1	1	2	2	6	2	1			15		15
Belvedere	6	7	7	14	8	3				45	2	47
Compton	6	14	10	20	23	7	1			81	7	88
Deaf Unit			1	2						3	1	4
El Monte	1	2		4	2	2				11	2	13
Family First Unit		1		1						2	1	3
Glendora	6	4	13	10	12	11		1		57	2	59
Lancaster	1	6	9	8	3	1				28	3	31
Medical Placement Units	4	2	2	7	7	3				25	3	28
Metro North	4	2	5	9	8	5	1			34	1	35
Palmdale	6	1	6	8	4	3	1			29	1	30
Pasadena	6	9	8	13	9	6	3	1		55	4	59
Pomona	3	6	12	6	11	6	2			46	4	50
S F Springs	1	11	9	11	9	5				46	4	50
San Fernando Valley	7	12	8	10	13	1	1			52	3	55
Santa Clarita	3	2	5	5	4	2				21	2	23
South County	5	12	10	17	14	8	1			67	1	68
Torrance	2	6	3	9	8	4				32	1	33
Vermont Corridor	14	16	7	17	23	13	2	1		93	5	98
Wateridge	8	11	17	14	19	5	2			76	7	83
West LA	1	2	7	5	6	3		2		23	3	26
West San Fernando Valley	2	1	6	4	3	2				18	1	19
Grand Total	83	131	151	194	181	93	15	3		851	58	909

At the time of the last Panel report there were 912 older youth in group care. As of February 2012, there were 3 fewer.

The Panel has expressed concern that 78 children age 10 and under in group care is still a high figure. In March, 2012 there were two 6-year olds, four 7-year olds, and 20 8-year olds in group

care. With new measures in place to orchestrate intensive services for these children and their caretakers in foster homes, only one of these 8-year olds was a recent admission, but four 9-year olds and three 10-years olds were placed in group care in January, 2012. Several of them were children who had been admitted to a psychiatric hospital with acute mental health symptoms and their parents were unwilling or unable to resume caring for them. However, half of the recent placements of children 10 and under in groups homes were children who had been in care for years, with their behaviors worsening.

In April 2012, on its own initiative, the County took the additional step of expanding limitations on placement of any child under 12 years old in group care. The DCFS Director instructed all staff to apply the earlier limitation requiring the DCFS Director or Deputy Director's approval before placing children age 8 and younger in group care to children age 12 and younger. In addition, staff were instructed to take certain alternative steps before a referral of a child age 0-12. The Panel highly commends the Department for this initiative.

The County reports that its RBS program is also demonstrating success in transitioning young children out of group care. The program is based on the recognition that emotionally disturbed young children are placed in residential facilities because their needs are so difficult for parents, foster parents, relatives, outpatient providers and schools to meet. They often have multiple placements because of the necessity for periodic intense support that may not be available quickly enough. In recent months, the RBS program has shown noteworthy success with several children. For example, a 9-year old who was removed with his three older siblings when he was 5 years old. He lived in seven foster homes until he was placed at a residential treatment center. In the RBS program, he was part of the Boy Scouts, received trauma treatment and had regular behavior support in school. The RBS team worked to make it possible for his adult cousin to gain approval for his placement in her home, with intensive support services after he made the move.

Qualitative Service Review (QSR)

The County has continued to implement the QSR process at a rapid pace. The QSR staff has worked hard to achieve receptiveness to feedback in each office where reviews have been conducted, making it more likely that findings will be accepted and practice outcomes will improve. The QSR program DCFS and DMH managers have encouraged the involvement of individuals in many different positions to team with an expert reviewer in each case reviewed, resulting in broadening the understanding of the depth of the QSR and a familiarity with desired practice.

The County reports that to date, 153 cases have been randomly selected and reviewed. An average of nine children, youth, caregivers, family members, service providers and other professionals per case have been interviewed and the results have been fairly consistent across the 14 DCFS regional offices reviewed – Belvedere, Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Lancaster, Palmdale, Pomona, Glendale, El Monte, Pasadena, San Fernando Valley, Santa Clarita and West San Fernando Valley. There are presently just 4 regional offices remaining to complete the QSR baseline cycle: Metro North, West Los Angeles, Torrance, and South County. In July 2012, there will be a Special County-wide Study of Wraparound Services using the QSR evaluation methodology.

The QSR baseline schedule through August 2012 is below:

Office(s)	QSR dates
Torrance	May 14 -18, 2012
WRAP QSR (County Wide Special Study)	July 23 – 27, 2012
South County	August 20 - 24, 2012

The QSR assesses both current outcomes for children and families (which it describes as Child and Family Status) and the system’s Practice Performance. This occurs by utilizing a pair of trained reviewers who review each case in the sample by reading the case file and interviewing all of the major participants in the child’s case over a two-day period. These interviews include the child and parents, substitute caregiver where applicable, all providers and in some cases, attorneys. Using a structured protocol, the team assesses status and performance indicators to be able to determine facts such as:

Child and Family Status

- Is the child safe?
- Is the child stable?
- Is the child making progress toward permanency?
- Is the child making progress emotionally and behaviorally?
- Is the child succeeding in school?
- Is the child healthy?
- Are the child’s parents making progress toward acquiring necessary parenting skills and capacity?

Practice Performance

- Are the child and family meaningfully engaged and involved in case decision making (called Voice and Choice)?
- Is there a functional team made up of appropriate participants?
- Does the team understand the child and family’s strengths and needs?
- Is there a functional and individualized plan?
- Are necessary services available to implement the plan?
- Does the plan change when family circumstances change?

These indicators are scored and scores are aggregated across the cases reviewed in each office producing a table reflecting overall scores. A written case story about each case is also produced to provide context to the scores. It is important to recognize that some indicators should be considered as having greater importance than others. Regarding Child and Family Status Indicators, Permanency and Family Functioning, for example, are vitally important. If children do not achieve permanency their future outcomes are more likely to be poor. If families

(parents) do not gain or regain the ability to meet their children’s needs, the likelihood of permanency achievement is poor. Stability and Emotional Well-Being are also critical status indicators. Both are also closely linked and relevant to permanency achievement. Safety is an obvious vital indicator: however it usually scores high due to the fact that once a case is opened immediate attention is given child safety and where significant unmanaged threats are present the child is removed.

Under Practice Performance, Family Engagement, Teaming and Planning are considered the most important indicators. With these indicators the County has to achieve a performance level of 70 percent acceptability for each of these three indicators to meet exit conditions.

Like other systems measuring their performance against the QSR, initial baseline scores are always generally low among the most critical indicators due to the high standard of performance necessary to achieve an acceptable score. Over time as the County fully implements its practice model and the strategic plan, experience has shown that its performance should improve.

The QSR Exit Standard is stated as follows:

QUALITY SERVICE REVIEW			
Description: Regional offices will exit individually by meeting the passing standards for both the Child and Family Status indicators and the System Performance indicators (85% of cases with overall score of acceptable respectively and 70% acceptable score on Family Engagement, Teamwork and Planning). Once the targets have been reached, at the next review cycle the regional office must not score lower than 75% respectively on the overall Child and Family Status and System Performance indicators, and no lower than 65% on a subset of System Performance indicators respectively (engagement, teamwork, and assessment). The County will continue the QSR process for at least one year following exit and will post scores on a dedicated Katie A. website.			
Child and Family Status Indicators:		System Performance Indicators:	
<ol style="list-style-type: none"> 1. Safety 2. Stability 3. Permanency 4. Living arrangements 5. Health/physical well-being 6. Emotional well-being 7. Learning & development 8. Family functioning & resourcefulness 9. Caregiver functioning 10. Family connections 		<ol style="list-style-type: none"> 1. Engagement 2. Voice & choice 3. Teamwork 4. Assessment 5. Long-term view 6. Planning 7. Supports & services 8. Intervention adequacy 9. Tracking and adjustment 	
Overall Score	Passing Score: 85%	Passing Score: 85%	

The following tables reflect the performance of the each of the 14 offices reviewed.

**Child and Family Status Indicators
Percent of Cases Scoring Acceptable**

Office	Safety	Stability	Living Arrangements	Health	Emotional Well-Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Status
Belvedere	100	92	100	100	54	77	73	100	N/A	85%
Santa Fe Springs	100	71	86	93	64	79	40	100	71	71%
Compton	100	85	85	100	54	77	64	88	56	77%
Vermont Corridor	100	86	93	93	64	79	36	80	67	86%
Wateridge	100	71	93	100	57	64	60	100	50	93%
Lancaster	100	91	100	100	100	82	83	100	60	100%
Palmdale	100	83	100	100	83	83	33	100	82	92%
Pomona	100	75	100	100	75	92	78	75	100	92%
Glendora	100	83	92	83	75	92	63	100	67	83%
El Monte	100	86	93	100	93	93	73	100	70	93%
Pasadena	100	83	100	100	83	100	67	100	60	92%
San Fernando Valley	92	75	92	92	83	75	56	100	67	92%
Santa Clarita West SFV	92	92	100	100	58	83	63	100	67	92%
Metro North	100	64	100	100	73	73	67	100	67	100%
Overall	99	81	95	97	72	82	60	96	68	89%

**Practice Performance Indicators
Percent of Cases Scoring Acceptable**

Office	Engage-ment	Voice & Choice	Team-work	Assess-ment	Long-term View	Plannin-g	Supports & Services	Interventio-n Adequacy	Tracking & Adjustmen-t	Overall Practic-e
Belvedere	46	31	8	45	23	38	62	38	31	31%
Santa Fe Springs	79	64	29	52	36	36	57	43	36	36%
Compton	38	46	0	59	23	23	69	54	46	31%
Vermont Corridor	36	36	7	30	36	14	57	43	14	21%
Wateridge	43	43	0	32	21	14	43	21	21	14%
Lancaster	36	55	36	51	45	45	64	55	45	45%
Palmdale	50	50	33	52	50	58	67	58	58	50%
Pomona	58	58	8	35	25	42	67	50	50	42%
Glendora	58	50	25	52	58	42	67	58	50	50%
El Monte	79	64	29	50	71	64	79	79	64	71%
Pasadena	58	42	0	33	42	50	50	42	50	50%
San Fernando Valley	67	50	8	67	42	42	50	50	50	50%
Santa Clarita West SFV	75	58	25	75	58	50	75	50	58	58%
Metro North	64	55	27	64	36	55	91	73	55	64%
Overall	56	50	16	51	40	40	64	51	44	43%

The complete QSR findings can be found in the Appendix.

Analysis of QSR Findings

Among the strengths found in the County’s QSR performance, Safety scores were high, with 99 percent of cases scoring acceptably. Stability scores were also high, especially compared with other systems in their baseline year. Eighty-one percent of cases scored acceptably in Stability. Child Health, Living Arrangement (suitability) and Child Learning and Development also scored relatively high. Child Emotional Well-Being scores were mixed, but the score of 72 percent acceptability is higher than many other baseline reviews.

First-year scores in Practice Performance in all systems implementing the QSR are considerably lower than Status scores and current County performance fits that same pattern. Scores in Caregiver Functioning at 63 percent acceptability and Supports and Services at 64 percent acceptability are a strength of the County's performance at this initial stage, compared to scores in other systems in their baseline QSR year. As is the case in all systems, the core functions of Teamwork (16 percent acceptability), Assessment (51 percent acceptability) and Planning (40 percent acceptability) present the biggest County practice challenges. Long-term View and Tracking and Adjusting performance also requires considerable strengthening. The Panel does not find these initial QSR scores surprising compared to performance in other systems nationally. It is encouraged by the County's efforts to improve practice and believe that such intensive practice development will be reflected positively in future reviews.

Exit Criteria

The County Board concurred with the County's proposal for exit conditions and the Court subsequently approved them.

V. Panel Analysis of Strategic Plan Implementation

In its last report the Panel made a series of specific recommendations related to areas of importance in Strategic Plan implementation. The following describes the recommendations and the County's response. The full County written response to these recommendations is found in the Appendix. The County response also contains specific plans to achieve the goals of the recommendation.

Panel Training and Coaching Recommendation

- Develop expectations that CSWs in Compton will begin using family teams in their work with families and assist the office to determine the types of cases with which to begin and pace of implementation.
- In an effort to address concerns about workload, allocate additional staff to Compton to reflect recognition of the need for time to implement regular family meetings.
- Assist the new coaches assigned to master the teaming process so they can coach and mentor Compton staff. Possible approaches for beginning the development process could include sending a few coaches to Utah to observe their teaming work and observing staff of the Child Welfare Group providing teaming training and coaching for other systems. The Panel will also try to identify possible coaching resources. If resources for significant numbers of additional staff in Compton are limited, at least allocate additional staff to several units and begin the effort with them.

County Response

The DCFS Director has authorized an additional 17 CSWs for Compton to facilitate the more frequent use of family teaming. The County also sent 18 external coaches to Utah to observe coaching and development of Child and Family Team practice. These coaches are now

mentoring staff in Compton. Participants report that the Utah observation experience was helpful in building practice in Los Angeles.

Panel Treatment Foster Care Recommendation

The Panel had two specific recommendations related Treatment Foster Care. First, the County notes that providers do not have resources for recruitment and retention activities. Since TFC is considerably underspending what costs would be at full implementation, it seems likely that unspent funds might be available for redeployment. The Panel recommends that the County allocate a supplementary amount of funds to providers to support recruitment and retention efforts.

Second, to enable the County to better understand the reasons that a significant percentage of children transition to higher levels of care after discharge from TFC, conduct a QSR on a sample of children recently transition to higher levels of care to assess the reasons the service is not preventing such placements.

County Response

The County reports that it is unable to supplement the rate paid to providers as rate setting is a state-driven matter. The County hopes that a state workgroup, on which it is a participant, will develop recommendations that positively impacts TFC rates. DCFS and DMH have requested several staff for 2012-2013 who could assist in targeted recruitment and other areas in support of TFC. DMH contacted an Arizona organization with experience in TFC about approaches to strengthen TFC in Los Angeles. Other recruitment activities are underway. DCFS has also agreed to provide resources to support targeted recruitment efforts. A complete description of the County's TFC strategies is found in Section IV.

The County concurred with the Panel's recommendation to conduct a Qualitative Service Review on a sample of TFC children who transitioned to a higher level of care. Only 4 cases were reviewed from 39 children who fit this profile: however findings may be useful in developing remedial strategies. Findings were:

- Each youth experienced multiple placement disruptions, more than 20.
- Each youth experienced multiple psychiatric hospitalizations (avg = 23).
- Each youth moved directly from a psychiatric hospitalization into a TFC Home.
- Each youth was found to have undiagnosed Fetal Alcohol Spectrum Disorder (FASD) after TFC placement was terminated. Each youth was found to have been severely overmedicated as a result of misdiagnosed symptoms related to FASD.

The Panel is unaware of steps planned by the County to utilize this finding to address transitions to higher levels of care.

Panel Home-Based Mental Health Services Recommendation

Following the same approach as the pilot underway with DCFS staff in Compton, focus on mental health providers serving the Compton office as the target for intensive home-based mental health service implementation. To achieve this, the Panel recommends the following steps:

- Amend the contracts of mental health providers with a significant presence in Compton or serving significant numbers of children and families in the Compton community to require the delivery of home-based services consistent with the County's model of practice. Require each contract provider to address how they will build home-based service capacity within the LA practice model framework to strengthen the practice of their work force. Bring in Arizona mental health experts the County has visited before to help orient mental health providers to new approaches to practice. If there is a way to expedite the County procurement process, which has been a consistent barrier because of its complexity and lengthy time frame for completion, employ such options to speed up the amendment process.
- Ensure that focused consultative attention is also attentive to MAT staff, directed at improving their ability to conduct strength and needs-based assessments and link their role with the family team.
- Conduct a QSR of a small sample of cases served by major mental health providers for Compton and solicit participation of provider agency leadership as shadows or invite them to join already planned QSR reviews. Observing the QSR is very effective in helping professionals understand practice expectations.

County Response

The County reports that it is exploring the possibility of amending provider contracts to require the provision of home-based services consistent with the practice model and the Katie A. State case definition of Intensive Home-Based Services. In December 2011 the County invited an innovative home-based mental health provider from Arizona to make a presentation to LA providers about his approach. As the County states, "This model focuses on the provision of individually tailored rehabilitative and support services, including skills training, family support, case management, and personal care, delivered largely by paraprofessionals in the home. When properly delivered and documented, these services are generally reimbursable with EPSDT. These services are available 24/7, including weekends and holidays, and in some instances are provided 24 hours per day. On average the services are provided roughly 22 hours per week."

The County reports that the approach received a cool reception from most providers, who were concerned about workforce issues, supervision, risk management and audit exceptions. As a result the County has decided to explore a pilot program using this approach with the largest children's mental health services provider in the county. A workgroup will also assess how to implement the approach on a larger scale.

Panel Medical Hub Recommendation

Currently, the County is assessing the reasons that it is not closer to reaching its goal of securing medical examinations for all newly detained children and hopes a new tracking system will help identify barriers. In the meantime, the Panel recommends that the County, assuming that it can identify children who were not referred, select a sample of recent non-referred children for follow-up. Each worker and/or supervisor with a selected case should be contacted and interviewed about the reasons for non-referral. The Panel suspects that accountability issues may be a factor, either with CSWs or foster parents. From such interviews and the results of tracking system reports, the County should develop a clear plan to increase referrals to the Hubs. Such a plan should include accountability for non-performance.

County Response

The County concurred with this recommendation and designed a study to examine a group of newly detained children not referred to a Hub. The study and report have been completed and provide useful information about the nature of non-referrals. The study found:

Among the 60 selected cases, 10 cases were eliminated from the analysis as they were not newly detained cases. Thus, there was a final survey response population of 50.

Of the 50 newly detained children, although initially identified as non-referred, 16 (32.0%) were subsequently identified as referred to the Medical Hub for the exam and 34 (68.0%) were not. The following is the breakdown of reasons for children not being referred:

- 10 (29.4%) of the 34 children were referred to the caregiver's own health care provider;
- 5 (14.7%) children were hospitalized;
- 3 (8.8%) children's Court petitions were dismissed;
- 2 (5.9%) children were placed outside of Los Angeles County;
- 2 (5.9%) children were released to their parent;
- 2 (5.9%) were referred to a hospital;
- 1 (2.9%) child was AWOL and became a Welfare and Institutions Code (WIC) 602, which is under the supervision of Probation Department;
- 1 (2.9%) child's case plan was Voluntary Family Reunification; and,
- 1 (2.9%) child was referred for a forensic evaluation and not for an initial medical exam.

In addition, the respondents did not provide a reason for seven (20.6%) of the children not being referred to a Medical Hub. According to the study, the reasons that were considered valid for not referring a child were as follows:

- Child was hospitalized;
- Child's Court petition was dismissed at Court;
- Child was placed in out-of-home care outside of Los Angeles County;
- Child was released to their parent;
- Child was AWOL and became a WIC 602, under the supervision of Probation Department); and,
- Child's case plan was Voluntary Family Reunification.

Conversely, the non-valid reasons for not referring a child to a Medical Hub were as follows:

- Child's caregiver used his/her own health care provider;
- Child was referred to a hospital; and,
- Child only referred for a forensic, but not for an initial medical exam.

Recommendations

Based on the Survey Findings, the following are the County's recommended actions (i.e., corrective action plan) that will be initiated in March 2012:

1. DCFS will revise its Procedural Guide, Utilization of the Medical Hubs, targeted for May 31, 2012. The revised policy will indicate that the CSW who detains the child(ren) will be responsible for submitting the Medical Hub Referral Form. The policy will also include the information outlined in the FYI titled, "Requesting Court order for Initial Medical Exam" which was released on 2/15/2012. The FYI notifies staff of the requirement to include a recommendation in the Detention Report for the court to order medical services at a Medical Hub;
2. DCFS will attend the Regional Office general staff meetings to present on the newly revised Utilization of Medical Hubs Procedural Guide starting June 2012. In addition, DCFS will continue its training on the required use of the Medical Hubs at the Core Training Academy for newly hired CSWs;
3. On a monthly basis, to hold DCFS regional offices accountable, the Child Welfare Health Services Section will implement for the Regional Administrators/Assistant Regional Administrators, a Progress Report titled, "Tracking Newly Detained Children Referred to the Medical Hubs" that will provide the current percentage of newly detained children referred. In addition, a reminder of the mandate to refer all newly detained children to a Medical Hub will be included along with an attachment of the DCFS E-mHub Initial Medical Examination Report. DCFS will share this information with DHS Administration and the Hub MDs as a step to inform and engage stakeholders in our efforts; and,
4. Via the DCFS Stats initiative there will be focused attention on increasing the percentage of newly detained children referred to the Medical Hubs for the Initial Medical Exam. DCFS Stats provides a departmental data dashboard that maintains an inventory of measures related to Safety, Permanence and Well-Being. Implementing Medical Hub referral data on DCFS Stats will promote continuous attention to, and review of, progress towards 100% of the newly detained children being referred to the Medical Hub for the required exam.

The Panel commends the County for this analysis and believes the findings will contribute to improvements in use of Medical Hubs to assess newly detained children.

Panel Multidisciplinary Assessment Team (MAT) Recommendation

The Panel recommended that a follow-up review of MAT cases be conducted to assess quality and timeliness issues. The Panel was unable to participate in such a review, but the County reports that DCFS and DMH conducted a review of twenty-five cases and found improvements in quality and comprehensiveness, identification of underlying needs and trauma. The County also reports that additional work is needed to state needs more specifically and with more individualization, identifying strengths in a more individualized manner and expanding the focus on the family's informal supports. The Panel has been provided a copy of the report of findings in this assessment.

Panel Recommendation on Informing Providers about the Practice Model

The Panel recommended that to heighten the awareness of mental health providers serving the pilot site (Compton) about practice model expectations for performance, that several providers be selected to observe a QSR in Compton.

County Response

The County reports that given its already ambitious review schedule, which includes conducting a specialized review of Wraparound cases suggested by the Panel, it does not have the capacity to add a specialized review in Compton. The County did invite mental health providers to attend QSR training in January and February 2012. Following the training representatives from three providers shadowed a subsequent review. The County plans to have other providers shadow the next six reviews.

Panel Recommendation on Young Children in Group Care Settings

As previously mentioned, based on experience elsewhere, the Panel believes that uneven gate-keeping, lack of individualized home-based mental health services and lack of appropriate foster home resources are likely factors contributing to the increase of young children in group homes. Two immediate recommendations are made.

- First, the County should forbid the placement of any child under age 10 in a group home.
- For any child 0-12 for whom a group home placement would have been considered as the only option, issue a child/sibling group-specific RFP to providers asking that they design a specific program of services and supports leading to permanency for the child. Services should be provided in a family-based setting. This might necessitate a partnership between, for example, a Wraparound provider and a FFA or related caregiver.

County Response

In December 2011, the (now) DCFS Director issued a letter to all DCFS staff acknowledging the progress made in reducing the overall group home population, emphasizing the current process for making appropriate placements and requiring the approval of the Director for placement of any child age eight or younger. Staff were encouraged to utilize community based interventions like Wraparound. This policy was later expanded to apply to all children age 0-12.

VI. Panel Recommendations

The Panel makes the following recommendations for County action:

1. Continue to reduce the group home population by orchestrating sufficient intensive services around children and caregivers that their needs are met and their behaviors are managed. The Panel is impressed with steps taken by the Department to reduce the number of young children placed in group care.
2. Utilize the findings of the assessment of reasons some youth leaving Treatment Foster Care move to a higher level of care to develop a strategy to address this pattern.
3. Continue to document the effectiveness of coaching in Compton and keep the Panel informed of ways it can be supportive as the County moves implementation to the next office.

The County is still working on implementing several prior Panel recommendations – analysis of data on the mental health service pattern and intensity of children placed in D-Rate, Kinship and FFA settings, reducing the number of young children in group care and a QSR review of active Wrap cases – so the Panel is not making additional major recommendations at this time.

VII. Glossary of Terms

ADHD – Attention deficit hyperactivity disorder

CASSP – Child and Adolescent Service System Program, a federal initiative

Child and Family Team (CFT) – A team consisting of the child and family, their informal supports, professionals and others that regularly meet face-to-face to assess, plan, coordinate, implement and adjust the services and supports provided.

Comprehensive Children’s Services Program (CSSP) – Services and supports including a combination of intensive case management and access to several evidence-based treatment practices, including Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy and Incredible Years.

Coordinated Services Action Teams (CSAT) – A process to coordinate structure and streamline existing programs and resources to expedite mental health assessments and service linkage.

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)

Full Service Partnership (FSP) – An approach to mental health services that is strength-based, individualized, child and family driven, coordinated and flexible in response to child and family needs.

FGDM – Family Group Decision Making

FM – Family maintenance services, provided for families with children living at home.

Hub – Six regional sites where children will receive a comprehensive medical evaluation, mental health screening and referral for services.

IEP – Individual Education Plan

Intensive Home-Based Mental Health Services (IHBS) – Definition needed

MAT – Multi-Disciplinary Assessment Team

PTSD – Post-traumatic stress disorder

RCL – Rate Classification Level (levels of group home care, with RCL 14 being considered residential treatment; about 2,332 children are in 83 group homes)

RPRT – Regional Permanency Review Teams

TAY – Transitional Age Youth

VIII. Appendix

**QUALITY SERVICE REVIEW (QSR)
STATUS INDICATORS**

CHILD AND FAMILY STATUS INDICATORS		SAFETY OVERALL	Safety: Exposure to harm				Safety: Risk to self/others		STABILITY OVERALL	Stability		Permanency
			Home - Parent	Caregiver Home	School /child care	Other settings	Risk to self	Risk to others		Stability: home	Stability: School	
BELVEDERE	Unacceptable	0%	0%	0%	0%	0%	10%	0%	8%	8%	10%	78%
	Acceptable	100%	100%	100%	100%	100%	90%	100%	92%	92%	90%	22%
SANTA FE SPRINGS	Unacceptable	0%	0%	0%	0%	0%	0%	0%	29%	29%	30%	40%
	Acceptable	100%	100%	100%	100%	100%	100%	100%	71%	71%	70%	60%
COMPTON	Unacceptable	0%	0%	0%	8%	20%	15%	15%	15%	15%	30%	38%
	Acceptable	100%	100%	100%	92%	80%	85%	85%	85%	85%	70%	62%
VERMONT CORRIDOR	Unacceptable	0%	0%	10%	0%	0%	8%	0%	14%	21%	25%	57%
	Acceptable	100%	100%	90%	100%	100%	92%	100%	86%	79%	75%	43%
WATERIDGE	Unacceptable	0%	20%	0%	9%	0%	30%	0%	29%	29%	40%	36%
	Acceptable	100%	80%	100%	91%	100%	70%	100%	71%	71%	60%	64%
LANCASTER	Unacceptable	0%	0%	0%	0%	0%	0%	0%	9%	27%	11%	36%
	Acceptable	100%	100%	100%	100%	100%	100%	100%	91%	73%	89%	64%
PALMDALE	Unacceptable	0%	17%	0%	0%	0%	17%	17%	17%	17%	20%	50%
	Acceptable	100%	83%	100%	100%	100%	83%	83%	83%	83%	80%	50%
POMONA	Unacceptable	0%	0%	0%	0%	0%	10%	10%	25%	33%	22%	50%
	Acceptable	100%	100%	100%	100%	100%	90%	90%	75%	67%	78%	50%
GLENDORA	Unacceptable	0%	0%	0%	0%	0%	0%	0%	17%	25%	22%	42%
	Acceptable	100%	100%	100%	100%	100%	100%	100%	83%	75%	78%	58%

CHILD AND FAMILY STATUS INDICATORS		SAFETY OVERALL	Safety: Exposure to harm				Safety: Risk to self/others		STABILITY OVERALL	Stability		Permanency
			Home - Parent	Caregiver Home	School /child care	Other settings	Risk to self	Risk to others		Stability: home	Stability: School	
EL MONTE	Unacceptable	0%	0%	0%	0%	20%	0%	0%	14%	14%	10%	21%
	Acceptable	100%	100%	100%	100%	80%	100%	100%	86%	86%	90%	79%
PASADENA	Unacceptable	0%	0%	0%	0%	0%	9%	0%	17%	25%	38%	33%
	Acceptable	100%	100%	100%	100%	100%	91%	100%	83%	75%	63%	67%
SAN FERNANDO VALLEY	Unacceptable	8%	33%	0%	0%	0%	9%	10%	25%	25%	27%	42%
	Acceptable	92%	67%	100%	100%	100%	91%	90%	75%	75%	73%	58%
SANTA CLARITA/WEST SFV	Unacceptable	8%	0%	0%	10%	0%	18%	9%	8%	0%	0%	33%
	Acceptable	92%	100%	100%	90%	100%	82%	91%	92%	100%	100%	67%
METRO NORTH	Unacceptable	0%	0%	0%	0%	0%	0%	0%	36%	36%	11%	55%
	Acceptable	100%	100%	100%	100%	100%	100%	100%	64%	64%	89%	45%
OVERALL	Unacceptable	1%	4%	1%	2%	3%	9%	5%	19%	22%	21%	43%
	Acceptable	99%	96%	99%	98%	97%	91%	95%	81%	78%	79%	57%

CHILD AND FAMILY STATUS INDICATORS		Living Arrangements OVERALL	Living Arrangements		Health/ Physical Well-being	Emotional Well-being	Learning & Develop.	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
			Parent home	Caregiver							
BELVEDERE	Unacceptable	0%	14%	0%	0%	46%	23%	27%	0%	N/A	15%
	Acceptable	100%	86%	100%	100%	54%	77%	73%	100%	N/A	85%
SANTA FE SPRINGS	Unacceptable	14%	17%	13%	7%	36%	21%	60%	0%	29%	29%
	Acceptable	86%	83%	88%	93%	64%	79%	40%	100%	71%	71%
COMPTON	Unacceptable	15%	0%	25%	0%	46%	23%	36%	13%	44%	23%

CHILD AND FAMILY STATUS INDICATORS		Living Arrangements OVERALL	Living Arrangements		Health/ Physical Well-being	Emotional Well-being	Learning & Develop.	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
			Parent home	Caregiver							
	Acceptable	85%	100%	75%	100%	54%	77%	64%	88%	56%	77%
VERMONT CORRIDOR	Unacceptable	7%	0%	10%	7%	36%	21%	64%	20%	33%	14%
	Acceptable	93%	100%	90%	93%	64%	79%	36%	80%	67%	86%
WATERIDGE	Unacceptable	7%	20%	0%	0%	43%	36%	40%	0%	50%	7%
	Acceptable	93%	80%	100%	100%	57%	64%	60%	100%	50%	93%
LANCASTER	Unacceptable	0%	0%	0%	0%	0%	18%	17%	0%	40%	0%
	Acceptable	100%	100%	100%	100%	100%	82%	83%	100%	60%	100%
PALMDALE	Unacceptable	0%	0%	0%	0%	17%	17%	67%	0%	18%	8%
	Acceptable	100%	100%	100%	100%	83%	83%	33%	100%	82%	92%
POMONA	Unacceptable	0%	0%	0%	0%	25%	8%	22%	25%	0%	8%
	Acceptable	100%	100%	100%	100%	75%	92%	78%	75%	100%	92%
GLENDDORA	Unacceptable	8%	0%	14%	17%	25%	8%	38%	0%	33%	17%
	Acceptable	92%	100%	86%	83%	75%	92%	63%	100%	67%	83%
EL MONTE	Unacceptable	7%	0%	11%	0%	7%	7%	27%	0%	30%	7%
	Acceptable	93%	100%	89%	100%	93%	93%	73%	100%	70%	93%
PASADENA	Unacceptable	0%	0%	0%	0%	17%	0%	33%	0%	40%	8%
	Acceptable	100%	100%	100%	100%	83%	100%	67%	100%	60%	92%
SAN FERNANDO VALLEY	Unacceptable	8%	33%	0%	8%	17%	25%	44%	0%	33%	8%
	Acceptable	92%	67%	100%	92%	83%	75%	56%	100%	67%	92%
SANTA CLARITA/WEST SFV	Unacceptable	0%	0%	0%	0%	42%	17%	38%	0%	33%	8%
	Acceptable	100%	100%	100%	100%	58%	83%	63%	100%	67%	92%
METRO NORTH	Unacceptable	0%	0%	0%	0%	27%	27%	33%	0%	33%	0%
	Acceptable	100%	100%	100%	100%	73%	73%	67%	100%	67%	100%
OVERALL	Unacceptable	5%	6%	5%	3%	28%	18%	40%	4%	32%	11%
	Acceptable	95%	94%	95%	97%	72%	82%	60%	96%	68%	89%

QUALITY SERVICE REVIEW PRACTICE INDICATORS (QSR)

PRACTICE INDICATORS		Engagement	Voice & Choice	Team work	Assessment OVERALL	Assessment Child	Assessment Family	Caregiver	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
BELVEDERE	Unacceptable	54%	69%	92%	55%	46%	70%	50%	77%	62%	38%	62%	69%	69%
	Acceptable	46%	31%	8%	45%	54%	30%	50%	23%	38%	62%	38%	31%	31%
SANTA FE SPRINGS	Unacceptable	21%	36%	71%	48%	29%	73%	43%	64%	64%	43%	57%	64%	64%
	Acceptable	79%	64%	29%	52%	71%	27%	57%	36%	36%	57%	43%	36%	36%
COMPTON	Unacceptable	62%	54%	100%	41%	46%	64%	13%	77%	77%	31%	46%	54%	69%
	Acceptable	38%	46%	0%	59%	54%	36%	88%	23%	23%	69%	54%	46%	31%
VERMONT CORRIDOR	Unacceptable	64%	64%	93%	70%	57%	91%	63%	64%	86%	43%	57%	86%	79%
	Acceptable	36%	36%	7%	30%	43%	9%	38%	36%	14%	57%	43%	14%	21%
WATERIDGE	Unacceptable	57%	57%	100%	68%	57%	91%	56%	79%	86%	57%	79%	79%	86%
	Acceptable	43%	43%	0%	32%	43%	9%	44%	21%	14%	43%	21%	21%	14%
LANCASTER	Unacceptable	64%	45%	64%	49%	55%	43%	50%	55%	55%	36%	45%	55%	55%
	Acceptable	36%	55%	36%	51%	45%	57%	50%	45%	45%	64%	55%	45%	45%
PALMDALE	Unacceptable	50%	50%	67%	48%	42%	64%	38%	50%	42%	33%	42%	42%	50%
	Acceptable	50%	50%	33%	52%	58%	36%	63%	50%	58%	67%	58%	58%	50%
POMONA	Unacceptable	42%	42%	92%	65%	58%	80%	57%	75%	58%	33%	50%	50%	58%
	Acceptable	58%	58%	8%	35%	42%	20%	43%	25%	42%	67%	50%	50%	42%
GLENDDORA	Unacceptable	42%	50%	75%	48%	42%	70%	33%	42%	58%	33%	42%	50%	50%
	Acceptable	58%	50%	25%	52%	58%	30%	67%	58%	42%	67%	58%	50%	50%
EL MONTE	Unacceptable	21%	36%	71%	50%	36%	50%	25%	29%	36%	21%	21%	36%	29%
	Acceptable	79%	64%	29%	50%	64%	50%	75%	71%	64%	79%	79%	64%	71%
PASADENA	Unacceptable	42%	58%	100%	67%	50%	60%	40%	58%	50%	50%	58%	50%	50%
	Acceptable	58%	42%	0%	33%	50%	40%	60%	42%	50%	50%	42%	50%	50%

SAN FERNANDO VALLEY	Unacceptable	33%	50%	92%	33%	18%	60%	22%	58%	58%	50%	50%	50%	50%
	Acceptable	67%	50%	8%	67%	82%	40%	78%	42%	42%	50%	50%	50%	50%
SANTA CLARITA/ WEST SFV	Unacceptable	25%	42%	75%	25%	17%	50%	20%	42%	50%	25%	50%	42%	42%
	Acceptable	75%	58%	25%	75%	83%	50%	80%	58%	50%	75%	50%	58%	58%
METRO NORTH	Unacceptable	36%	45%	73%	36%	10%	60%	14%	64%	45%	9%	27%	45%	36%
	Acceptable	64%	55%	27%	64%	90%	40%	86%	36%	55%	91%	73%	55%	64%
OVERALL	Unacceptable	44%	50%	84%	49%	41%	67%	37%	60%	60%	36%	49%	56%	57%
	Acceptable	56%	50%	16%	51%	59%	33%	63%	40%	40%	64%	51%	44%	43%

COUNTY'S UPDATE AND PLAN TO THE KATIE A. ADVISORY PANEL'S REPORT TO THE COURT FOR THE SECOND REPORTING PERIOD OF 2011

TRAINING AND COACHING

Recommendation 1: The County should use the Compton Department of Children and Family Services ("DCFS") office as both a laboratory for perfecting its implementation approach and for building its internal capacity to move beyond Compton to other service areas, and:

- a) Develop expectations that Children's Social Workers ("CSWs") in Compton will begin using family teams in their work with families and assist the office to determine the types of cases with which to begin and establish the pace of implementation;
- b) Allocate additional staff to Compton to reflect recognition of the need for time to implement regular family meetings; and
- c) Assist the new coaches assigned to master the teaming process so they can coach and mentor Compton staff.

Update 1:

The County decided to forgo the route of a master coach and focused on sending a subset of the 18 external coaches to Utah to observe coaching and development of the Child and Family Team (CFT) practice. On January 17 and 18, 2012, a combination of DCFS, Department of Mental Health (DMH) and Los Angeles Training Consortium (LATC) coaches and administrators traveled to Utah to observe their staff in child and family team meetings, coaching, and to learn in general from their leaders about how they successfully implemented their Core Practice Model (CPM). This trip was very useful in facilitating needed learning for Los Angeles County lead coaches by observing coaching in action and consulting with Utah staff about "lessons learned" and pitfalls to avoid as we move forward in our Los Angeles County coaching efforts.

In an effort to support the 18 external coaches assigned to coach and mentor the Compton staff and mental health providers the initiation of weekly meetings began in January 2012. These weekly meetings are designed to assist the external coaches to coach and mentor to the shared CPM and the Quality Service Review (QSR) practice indicators. These sessions provide a venue where they can enhance their skills, cultivate new skills, and explore alternatives to dilemmas that may arise.

Moreover, the County has expanded the coaching efforts to include DMH staff from the Compton office and mental health providers in the service area. A total of two DMH co-located supervisors and 15 additional contract providers have been identified as lead coaches within their organizations.

The departments are slowly building their own capacity to coach. On January 31, 2012, a DMH external coach was able to teach and model engagement skills during a live Multi-disciplinary Assessment Team (MAT) Summary of Findings (SOF) meeting. Prior to the meeting, she prepared the DCFS MAT Coordinator, Supervising Children's Social Workers (SCSW), and Intensive Service Worker (ISW) by exploring the strengths and underlying needs of this family. The external coach also met with the MAT

supervisor from the mental health contract provider and the MAT assessor to explore their perspectives of this family's strengths/needs. She also guided the MAT supervisor and assessor to engage and prepare the family for the MAT SOF meeting. After the MAT SOF meeting, the external coaches debriefed with the staff as to the coaching process. This is one strategy that has assisted both DCFS and the mental health providers to begin the discussion and the development of the CFT process.

On January 31, 2012, Dr. Beyer was able to spend the day with the 18 lead coaches and help them through some vignettes to make sure they were able to clearly identify underlying needs. She also assisted by consulting with the County about logistical plans to implement case coaching in the Compton office. Paul Vincent is scheduled to conduct training on teaming and engagement on February 28-29, 2012 with staff from Compton in order to provide the practical application skills needed for lead coaches in the Compton Pilot.

On February 14, 2012, a Compton Coaching Kick Off event was held that was attended by 260 DCFS, DMH, and community partners, along with LATC coaches to showcase the effort and mark the official beginning of the coaching effort.

Coaching has formally begun in the Compton office with "internal" coaches from the office and a set of 18 "external" coaches provided by the DCFS Training Division, the DMH Child Welfare Division, and the LATC.

A formal evaluation of the Compton Pilot is under development and pending further consultation with the Panel to inform the rollout of the coaching effort in the other DCFS offices.

Coaching groups have now been initiated in all DCFS Regional Offices, with in-depth coaching scheduled to begin in May in the Pomona and Torrance DCFS offices as part of the California Partners for Permanency (CAPP) initiative.

The County will take lessons learned from these coaching efforts to plan for coaching in the remaining DCFS offices and associated DMH service areas. In accordance with the Panel's recommendation to allocate additional staff to the Compton office, 10 additional CSWs were identified in February for permanency assignment in the Compton office, with a plan to allocate seven (7) additional CSWs and two (2) additional SCSWs by June 2012.

Implementation Plan 1

- Build external coaching capacity in-house and via consultants through contracts with LATC, Inter University Consortium (IUC), and California State University Long Beach for coaching. Contracts finalized in December 2011. Eighteen (18), external coaches identified for Compton coaching pilot, along with internal coaches from DCFS and DMH staff in the Compton office, and supervisors from the mental health provider community. The County decided this was the most viable option for the coaching pilot instead of hiring a Master Coach Consultant.

- One-day training seminars on teaming conducted on December 5 and 12, 2011, to convey teaming expectations for Compton staff in Emergency Response, Intensive Services and Continuing Services.
- Coaches traveled to Utah January 17-18, 2012, to observe coaching in the context of CFT and to implement lessons learned in Los Angeles County.
- Coaching meetings scheduled and coaching activities/tracking matrix developed January 2012.
- Provide coaching modeling and application of practice model to lead coaches. January 31, 2012, Dr. Beyer met with lead coaches to practice skills using training vignettes and debriefed on the identification of child and family underlying needs. Paul Vincent is scheduled to conduct teaming seminar in Compton on February 28-29, 2012.
- Compton coaching pilot kick-off held on February 14, 2012, 260 staff from DCFS, DMH, and the provider community were in attendance.
- Draft coaching evaluation plan and evaluation tools developed February 2012 and shared with the Panel for feedback.
- DCFS to continue its Caseload Reduction Workgroup and the implementation of a series of strategies and timelines for addressing caseloads department-wide. For example, a Business Process Reengineering workgroup is underway and targeted for completion in March 2012 to identify opportunities for increased efficiencies and the feasibility of transferring additional staff to DCFS line operations for future offices implementing the “in-depth” coaching model.
- DCFS is allocating 10 additional CSWs to Compton in February 2012 and will allocated seven (7) additional CSWs and two (2) SCSWs to Compton by June 2012.
- DMH to contract with Children’s Institute International (CII) to provide trauma-informed training and ongoing consultation to the 18 external coaches as part of the CPM in March 2012.
- CII to initiate trauma training and consultation to external coaches via monthly didactic trainings and weekly coaching phone calls in April 2012.
- External coaches to be deployed to the Torrance and Pomona offices in May 2012 to support in-depth coaching to the CPM in these offices, along with selected DCFS, DMH staff, and community providers. Evaluation of this effort will take place within the CAPP initiative.
- DMH and DCFS to develop countywide coaching plan based upon evaluations of experiences in the Compton, Torrance, and Pomona offices by July 2012.

DEVELOPMENT OF TREATMENT FOSTER CARE (TFC) BEDS

Recommendation 2: The Panel recommends that the County allocate a supplementary amount of funds to providers to support recruitment and retention efforts.

Update 2:

The County agrees the rate currently paid by Los Angeles County to agencies and/or foster parents for TFC may be insufficient to recruit and retain foster parents. However, the County is not in the position to supplement funds to providers. This is largely a State driven matter in which the County is currently an active participant. The County has identified representatives from DCFS and DMH who participate on a statewide workgroup that is examining possible changes to Intensive Treatment Foster Care (ITFC) which supplies the board and care rate for Foster Family Agencies (FFAs) which, in turn, establish a rate that can be paid to foster parents.

This workgroup is a collection of TFC providers, County child welfare managers, mental health professionals and interested parties that was convened as stipulated in SB-1380 and has been administered by the California Department of Social Services since November 2010. The goal of this workgroup is to determine the specific activities that would fall under the existing TFC Statute [Welfare and Institutions Code 18358] to determine which would be defined as care and supervision and, therefore, fall appropriately under state and federal Title IV-E definitions and which would be defined as mental health services and need to be billed to Medi-Cal Early Periodic Screening Diagnosis and Treatment (EPSDT). This workgroup is currently engaged in discussions on rates and the participating providers have submitted suggested rate levels associated with TFC program delivery.

Based on the provider recommendations, a review of national rate structures and relevant cost of living increases, the California Alliance of Child and Family Services has presented a suggested rate adjustment that is currently being evaluated for feasibility. Consensus has not yet been reached, yet the level of engagement and involvement will have a universally positive impact on the delivery of TFC statewide. Much of what this workgroup decides will inform the decisions of the second State workgroup described below.

DMH and DCFS are also participating as member of the Katie A. State Settlement Implementation Workgroup, comprised of State and County leadership, legal representation, along with several other Katie A. stakeholders. This group focuses on broader issues related to the Katie A. State Settlement and the implementation of the five point plan that has been negotiated and approved by the Court. Although the goal of this second group is broader, one of the major foci is TFC and the associated implementation and growth concerns. With regard to TFC, this group is engaged in discussions related to TFC rates, EPSDT billable activities, Title IV-E funding, and contractual concerns. At this time, no recommendations have been finalized.

Pending the results of the State workgroups, the County is documenting justification for the assignment of additional resources to TFC from both DMH and DCFS. Currently, DMH has a full-time Clinical Psychologist and has assigned a Mental Health Service Coordinator to dedicate a portion of her duties to TFC. DCFS has a part-time TFC Program Manager, a full-time Program Coordinator, and a part-time Intermediate Typist Clerk. DMH has put in a request for two (2) new positions for Fiscal Year (FY) 2012-13, and DCFS has requested one (1) new position. Targeted recruitment, program evaluation and quality assurance are some of the many duties for which these individuals will be responsible. Recruitment activities include developing a primary contact mechanism for interested potential TFC caregivers, facilitating communication with FFAs, helping to coordinate recruitment events and fairs, and conducting presentations about becoming a TFC caregiver to various groups.

On February 17, 2012, DMH District Chief Greg Lecklitner and Plaintiff Attorney Kimberly Lewis had a consultation call regarding TFC implementation with Mr. Mike Terkeltaub with the Arizona-based Child and Family Support Services organization.

Mr. Terkeltaub has implemented TFC programs in several states and was able to provide an important set of considerations for Los Angeles County, such as the matter of permanency, recruitment of foster parents, covered services, and the role of the foster parent as a member of the TFC treatment team.

The departments conducted a TFC foster parent training/recruitment event February 17, 2012. The purpose of this event was to provide specific training and support to current TFC caregivers with a focus

on understanding trauma-related symptoms and their impact on children and families. In addition, the training also addressed behavior management strategies, including de-escalation techniques, to help prevent crisis situations as well as positively reinforcing pro-social behavior. The event also provided an opportunity for those individuals who were interested in becoming a TFC caregiver to learn more about the program, the target population, and the resources available to them. Finally, the event acknowledged those caregivers who have demonstrated a particular strength and skill recognized as an asset to the overall TFC program. Approximately 50 foster parents were in attendance and provided positive responses to an evaluation survey examining the content and format of the training and recruitment event.

TFC administration (DCFS and DMH) are currently providing consultative support for an exploratory pilot project involving D-rate foster homes who are currently receiving Wraparound services. This pilot incorporates best practices from both TFC and Wraparound philosophies and entails closer collaboration and creativity among FFAs currently providing both TFC and Wraparound services in an effort to expand the continuum of care captured within the framework of TFC. The workgroup's next steps during March 2012 include finalizing pilot details to have a focused discussion with the FFAs in April 2012 on pilot logistics and implementation feasibility.

Implementation Plan 2:

- The County has been participating on the two state workgroups which are examining various elements of TFC, including rate setting, contracting, service provision, and evaluation since October 2011 and will continue to do so through June 2012 when a statewide implementation plan is developed. The County cannot promote a rate increase contrary to the rate put forward by the State, but is providing counsel and guidance in these important discussions with the Katie A. State Implementation Team workgroup and the Department of Social Services TFC State workgroup.
- The County has requested three (3) additional positions to support the expansion of the ITFC and Multi-dimensional Treatment Foster Care (MTFC) programs in the FY 2012-13 budget.
- The County is assessing the feasibility of a voluntary pilot with FFAs to provide a continuum of care within TFC and Wraparound that could benefit children and caregivers in D-rate homes. A decision and timeline to move forward with the pilot will be identified in May 2012.
- The County has launched training and recruitment events to increase the pool of foster parents and the number of eventual placements for TFC with training/recruitment event planned on February 17, 2012.
- TFC, DMH, and DCFS staff has been working with several faith based organizations to expand recruitment efforts. This work has included emails, phone calls and presentations to clergy and other religious leaders.
- The Department of Children and Family Services Director, Phillip Browning, granted resources from their Placement and Recruitment Unit (PRU) to support TFC targeted recruitment efforts. TFC administration met with PRU administration on January 31, 2012, to discuss available resources, plausible outreach approaches, and logistical support related to this recruitment modality.

This group is scheduled to reconvene on February 29, 2012, to discuss progress and determine next steps. The following identifies the deliverables discussed in the initial meeting and their current status:

- TFC flyers were created and placed inside all general Foster Parent Orientation packets on February 6, 2012. These packets are distributed during all of DCFS' regularly scheduled orientation events. All resulting inquiries will be passed from DCFS PRU to identified DMH TFC staff for follow-up with the potential caregiver.
- TFC flyers were placed inside all County employee pay warrants and provided as an attachment in digital format to those receiving electronic paystubs. The first flyers were distributed with the pay warrants dated February 15, 2012. The digital attachment will be available through December 31, 2012.
- As of February 1, 2012, TFC is prominently represented on DCFS' website under four different home page tabs. Visitors are able to access the TFC recruitment flyer from the Permanency, Community, For Parents and Adoptions tabs located on the website's home page.
- PRU has created a family friendly TFC brochure aimed at potential care givers. Prior versions had been primarily dedicated to County professionals working with TFC staff and youth.
- DCFS recruitment staff began incorporating information about TFC in their screening discussions with all inquiries to their general recruitment line.
- TFC administration provided PRU staff with a requested matrix detailing the motivating factors that make TFC parents seek and maintain this particular fostering modality. This information will be utilized to formulate a marketing campaign with maximized reach.
- PRU staff is actively working on determining the fiscal and logistical feasibility of an array of social media, internet radio, and web site recruitment opportunities for TFC.
- Projected Program Growth
 - Based on the increased targeted recruitment efforts and the proposed increased centralized staffing infrastructure, a 10-15 percent projected growth rate for TFC slots may be expected. At this rate, we will reach the mandated 300 slots by 2015.
 - This growth rate has been based on evidence from program growth illustrated during the period from 2008-2011, additional executive leadership support to assist with program improvement, monthly ITFC administrative support calls, and expansion of referrals with clarified program eligibility requirements.

Recommendation 3: To enable the County to better understand the reasons that a significant percentage of children transition to higher levels of care after discharge from TFC, the County will conduct a QSR on a sample of children recently transitioned to higher levels of care to assess the reasons the service is not preventing such placements.

Update 3:

The County agrees with this recommendation. The TFC, DCFS, and DMH staff decided to conduct a QSR on 10 percent of the youth who had to return to a higher level of care after entering a TFC home. At the time of this initial selection, there were 39 youth who fit this profile. The QSR subsequently randomly selected two ITFC and two MTFC youth from this group to be included in the QSR review.

Each case was randomly selected from the population of TFC youth that disenrolled from treatment prior to successful completion, subsequently resulting in placement in a higher level of care.

The outcomes of the QSR process provided specific lessons that have supported programmatic efforts related to youth's acuity of needs, youth most appropriate for TFC home placement, increased resource utilization, increased staff and foster parent cross training.

Youth Acuity of Needs:

Each youth reviewed during this process entered TFC homes with the following risk factors related to permanency and community safety/stability:

- Each youth experienced multiple placement disruptions, more than 20.
- Each youth experienced multiple psychiatric hospitalizations (avg = 23).
- Each youth moved directly from a psychiatric hospitalization into a TFC Home.
- Each youth was found to have undiagnosed Fetal Alcohol Spectrum Disorder (FASD) after TFC placement was terminated. Each youth was found to have been severely overmedicated as a result of misdiagnosed symptoms related to FASD.

Appropriate staff received QSR training on November 9, 2011, and the first two TFC cases for QSR review occurred in November 2011. The next two cases for QSR review have been selected and tentatively scheduled for the last week in February 27, 2012 through March 6, 2012.

Implementation Plan 3:

- Review findings from QSR reviews during March 2012 to identify themes or recurring obstacles impacting program growth.
- Develop corrective action plan April 2012 to address program barriers.

AVAILABILITY OF HOME-BASED MENTAL HEALTH SERVICES

Recommendation 4: The County should utilize the Compton office as a target for intensive home-based mental health service implementation and:

- a) Amend the contracts of Compton mental health service providers to require the delivery of home-based services consistent with the CPM and to require providers to address how they will build appropriate service capacity¹;
- b) Ensure that consultation is focused to MAT staff to improve their ability to conduct strength and needs-based assessments and better engage with the family team; and
- c) Conduct a QSR of a small sample of cases served by major mental health providers for Compton and involves the leadership of such agencies in QSR reviews.

¹ As part of this recommendation, the Panel states the County should bring in Arizona mental health experts to help orient mental health providers to new approaches to practice and, to the extent possible, expedite the contract procurement process.

Update 4:

Home Based Mental Health Services

The County continues to explore the possibility of amending provider contracts to require the provision of home-based services consistent with the CPM as well as the Katie A. State Case definition of Intensive Home Based Services (IHBS) and Intensive Case Coordination (ICC). In December of last year, providers attended a presentation by Tim Penrod, with the Arizona-based Child and Family Support Services, in which he described the unique model of direct support services provided by his organization. This model focuses on the provision of individually tailored rehabilitative and support services, including skills training, family support, case management, and personal care, delivered largely by paraprofessionals in the home. When properly delivered and documented, these services are generally reimbursable with EPSDT. These services are available 24/7, including weekends and holidays, and in some instances are provided 24 hours per day. On average the services are provided roughly 22 hours per week.

Outside of more intensive service programs such as Wraparound and Full Service Partnerships, this approach is largely foreign to the provider system in Los Angeles County and concerns were raised by the providers about workforce development, supervision, funding, risk management, and audit exceptions (disallowances). In view of the cool reception to the program model, we are currently exploring a pilot program with the largest provider of children's mental health services in the County as a way to address these concerns. In this pilot effort, we will work closely with the Arizona mental health experts.

Los Angeles County is also participating in the Implementation Planning Workgroup for the recently settled Katie A. State Case in an effort to align the language that will be produced in a documentation manual regarding IHBS and ICC. This language will need to be carefully considered in any contract amendments on this subject that are proposed for the County. Guidance on these matters is expected by September 2012.

In the meantime, DMH will establish an IHBS/ICC workgroup to begin considering how best to establish this program within Los Angeles County. This workgroup will be initiated in March 2012 with a work plan to be completed by May 2012.

The County is also engaged in conversation with members of the Katie A. Advisory Panel regarding the definition of IHBS and this matter will be discussed as part of the agenda for the March 8, 2012 Panel Retreat.

MAT

Although, the Katie A. Panel was unable to participate in the quality review of the MAT SOF scheduled for March 2012, the Panel will be observing a MAT SOF meeting during the March Retreat.

DMH and DCFS conducted a review of the MAT SOF reports in February 2012. Twenty-five cases were reviewed using the MAT Quality Improvement Checklist. As a result, it was determined that the overall quality and comprehensiveness of the assessments has significantly improved. Additionally,

there has been progress in the identification of underlying needs; particularly in the area of distinguishing needs from services. Extensive training was provided to the MAT assessors to assist them in improving their ability to identify the underlying needs of the children and families being assessed. Considerable progress has been demonstrated in the SOF reports as a result of these trainings.

Another area of noted improvement was the MAT assessors' ability to identify and label the various forms of trauma experienced by the child and family. While the assessments have improved in identifying the basic underlying needs of the children and families, the results of the review clearly indicated that the needs should be more specific and individualized and less global. Similarly, while the MAT SOF reports reflect an improvement in the identification of the strengths of the children and families, it was apparent that this aspect of the assessment needs to become more individualized. Additionally, the assessments need to reflect improved engagement with both formal and informal supports. Although, many of the assessments were successful in identifying trauma, improvement is needed in addressing its impact in relation to the underlying needs of the children and families. DMH continues to provide trainings to further assist MAT providers with improving the quality of their SOF reports. The following trainings have been offered: Best Practice in 0 to 5 Intervention Strategies; Best Practices in the Assessment and Treatment of Young Children and the Integration of Risk and Resilience; MAT Documentation; and Marty Beyer's training on Strengths and Underlying Needs.

Other forums that have been carried out to improve the overall MAT process include the First Annual Countywide MAT providers' meeting held in November. This forum provided a discussion on the history of MAT, its progress and information sharing with the providers. In February, the Best Practices Workgroup was re-introduced with its primary focus on problem solving systemic issues. The Best Practices Workgroup convenes on a quarterly basis. Three subgroups were developed from the Best Practices Workgroup that includes: Medi-Cal documentation subgroup; a subgroup devoted to improving the SOF meetings; and a subgroup focused on improving the identification of underlying needs.

Compton and QSR

Los Angeles County's QSR resources are fully allocated toward meeting the vigorous monthly review schedule and therefore, is unable to conduct a QSR on a small sample served by major mental health providers for Compton as recommended by the Panel.

At this time, the County is engaged in a discussion with the Panel to use a QSR strategy to review a sample of Wraparound cases and this effort will be a matter of discussion at the next Panel Retreat in March.

The QSR baseline for the Compton office was completed in 2010 and is scheduled for a second QSR cycle in 2013. The County has outreached to approximately 15 DMH contract providers in the Compton service area and encouraged their participation in the QSR Shadow Review trainings scheduled on January 12, 2012 and February 7, 2012.

The following DMH contract providers participated in the training:

- Alafia;
- Children's Institute, Inc. (CII);
- Counseling 4Kids;

- Drew Child Development;
- Hathaway-Sycamores;
- Kedren Mental Health;
- Los Angeles Child Guidance;
- Saint Francis;
- Shields for Families;
- Starview; and
- Vista Del Mar.

Following the training, representatives from Hathaway-Sycamores, Vista Del Mar, and Saint Francis participated as shadow reviewers. There are six reviews scheduled between January and June 2012 and the continued plan is to reserve 2-3 slots for DMH contract providers from the Compton service area, with the goal to provide a review experience for all 15 providers by the end of June 2012.

DMH continues to make efforts to outreach and engage the remaining four DMH contract providers in the Compton area in the QSR process.

Implementation Plan 4:

- DMH and DCFS will continue to participate in weekly meetings as part of the Kate A. State Implementation Workgroup which is defining IHBS and ICC as part of the State Settlement Agreement. The DMH Child Welfare Division will also be convening a workgroup in March of this year to consider how best to implement these types of services in Los Angeles County, including contract language, training, tracking, and quality improvement strategies. The workgroup will prepare a report of recommendations by May 2012.
- DMH will also be working with a large children's mental health provider to initiate a pilot program within the next three months and will use this pilot experience to inform going forward.
- The re-establishment of the MAT Best Practices Workgroup is scheduled for May 10, 2012 and quarterly thereafter. Three subgroups were developed from the Best Practices Workgroup that includes: 1) Medi-Cal documentation subgroup; 2) a subgroup devoted to improving the SOF meetings; and 3) a subgroup focused on improving the identification of underlying needs. These subgroups will be meeting on a monthly basis commencing March 2012.
- The County will continue to make efforts to outreach and engage the Compton mental health providers for their participation in the QSR process. The plan is to reserve 2-3 slots for the mental health providers with the goals of all 15 providers' participation in one shadow review experience by June 2012.

MEDICAL HUBS

Recommendation 5: To the extent possible, the County should identify children who were not referred to medical hubs ("hubs") and investigate the reasons for non-referral. The County should then develop a clear plan to increase referrals to the hubs including some mechanisms imposing accountability for non-performance.

Update 5:

The County agrees with this recommendation and designed a study that examined newly detained children from July 2011 who were not referred to a Hub. A Stratified Random Sample of 50 cases from both large and small DCFS offices was pulled to determine the reasons for non-referral. The selection of a sample and the development of an interview guide were completed in December. In January 2012, the CSWs were contacted and interviewed on the reasons for the non-referral. Findings from this study are in the process of being compiled and the report, along with a set of corrective actions stemming from the findings, will be provided to the Panel by March 2012.

At the December Panel retreat, the Department demonstrated the DCFS Medical Hub Referral Form interface with the E-mHub System, which enables the Department to transmit electronic information to the Hubs and receive results of the initial medical exam or forensic exam in real-time, which is forwarded to the CSW/SCSW, public health nurses and Coordinated Services Action Team stationed in every DCFS office. From the electronic information received from the Hubs, DCFS has created a reporting system which will enable the Department to actively track cases that should be referred to the Hubs, as well as monitor the progress of those cases that have already been referred to the Hubs.

This reporting system provides scheduling details and medical exams, and will enable the Department to track the Hub compliance rates much more effectively than the manual process used in the past.

Implementation Plan 5:

- A stratified random sample of 50 detained cases from July 2011 never referred to a medical hub from both large and small DCFS offices was developed in December 2011;
- An Interview Guide was developed in December 2011 to be used when contacting the CSWs and SCSWs about the reasons for non-referral;
- In January 2012, CSWs were interviewed to determine reasons for non-referral to the Medical Hub; and a
- Final report with a set of corrective actions is targeted to be completed in March 2012.

CHILDREN IN GROUP CARE SETTINGS

Recommendation 6: County should forbid the placement of any child under age 10 in a group home.

Update 6:

On December 20, 2011, Interim Director Philip Browning, who has subsequently been appointed as the permanent Director on February 16, 2012, issued a letter to all DCFS staff regarding the placement of children and youth in group home care. In the letter, Mr. Browning acknowledged the progress DCFS has made to date in reducing the number of children in group home care and emphasized the need to continue the reduction. Mr. Browning emphasized the policy on the Resource Management Process (RMP) for any child entering, being replaced or exiting, group home care as a way to pull together the family, their supports, staff and any other involved parties to ensure the child's needs are being met.

“The RMP provides a critical opportunity for the team to meet and identify the child’s needs, placement options and possible services and supports needed to prevent group home placement.”

Mr. Browning also articulated the DCFS vision for group home care, ensuring that group homes are a short-term intervention that is focused on the needs of the child and that children should be transitioned back into the community as quickly and safely as possible.

One of the newest strategies Mr. Browning employed concerned the placement of children age eight years and younger in group homes. Now, before any child age 8 or younger is placed in a group home, approval must be obtained from the Chief Deputy or Director of DCFS.

In November 2011, the month before the letter was released, there were 192 youth age 12 and younger in group home care. In January 2012, there were 179 – a 7 percent decline. DCFS has compiled the detailed group home numbers for January 2012, which will be shared with the Panel and discussed at the upcoming Panel Retreat.

Mr. Browning also encouraged the use of community-based interventions, such as TFC and Wraparound, to prevent the long-term placement of children in group home care. One of the interventions is a two-year demonstration pilot, Residentially Based Services (RBS), which pairs short-term group home interventions with Wraparound creating a continuous flow of one team following a child from the group home back into the community.

RBS just finished the first year and the performance outcomes are encouraging. The average length of time in residential care was down to seven months. DCFS will continue to monitor the progress of the pilot. DCFS is currently considering extending the RBS pilot for another year or two, which is set to expire in December 2012. This will allow time for a more thorough review and possible contract expansion to an additional eight providers.

In the coming months, DCFS will continue to monitor the utilization of RMPs and referrals to Permanency Partners Program (P3), as both are keys to accomplishing the DCFS vision for group home care in Los Angeles.

Implementation Plan 6

- In an effort to reduce the number of children in group home care, DCFS released a letter to all staff addressing the increase of children in group home care in December 2011;
- Placement of children age eight years or younger in a group home will require the approval of the Chief Deputy or Director of DCFS;
- For any group home placement packet to be generated, the signatures of the CSW, SCSW, Assistant Regional Administrator (ARA), and Regional Administrator (RA) must be obtained on the DCFS 280 confirming that a RMP occurred prior to placement or within one-week and all efforts to utilize community-based interventions were tried;
- A mandatory referral to the P3 program must be made at the time of placement;
- For any youth placed in a group home, a regular family team meeting coordinated and facilitated by the CSW or SCSW should occur on a monthly basis;

- For any child age 12 years or younger a Permanency Planning Conference (PPC) coordinated by a PPC Facilitator should occur once every 4 months;
- The County will continue to track the number of children in group home care monthly;
- The County will explore the possibility of extending and/or expanding the RBS pilot; and
- The County will continue its participation in the Katie A. State workgroups addressing the implementation of ICC, IHBS, and TFC to reduce group care and specifically will participate on the CPM Fiscal Taskforce to develop fiscal incentives for the implementation of the CPM and alternatives to group care.

Medical Hub Non Referral Sample Study Report

Introduction

The County of Los Angeles Department of Children and Family Services (DCFS) was requested by the Katie A. Panel in the Katie A. Second Panel Report of 2011 dated October 19, 2011, to address the lack of progress in the objective that 100 percent of the newly detained children will receive an initial medical examination (exam) at a Medical Hub. The Report noted that the County had several theories about why the decline in the percentages of children served may have occurred, but had not yet determined the reason for this trend. Specifically, the Panel recommended in its Report the following steps:

- The County, assuming that it can identify children who were not referred, should select a sample of recent non-referred children for follow-up. Each worker and/or supervisor with a selected case should be contacted and interviewed about the reasons for non-referral. The Panel suspects that accountability issues may be a factor, either with CSWs or foster parents; and,
- From such interviews and the results of tracking system reports, the County should develop a clear plan to increase referrals to the Hubs. Such a plan should include accountability for non-performance.

There was a positive response to these recommendations from both DCFS which has lead responsibility to ensure that newly detained children are referred to the Medical Hubs for the required exam - and the Department of Health Services (DHS) - which has lead responsibility to ensure that DCFS-referred children are served by the DHS Medical Hubs for the exam. We welcomed the opportunity to improve upon the percentages of newly detained children being referred to a Medical Hub for the required exam. The opportunity was met with extra enthusiasm since DHS had implemented its E-mHub System, a web-based patient information tracking system on DCFS children served by the Medical Hubs along with a DCFS interface in 2011 that allowed DCFS to establish a real time, reliable, internal tracking report on the newly detained children being referred to, and served by, the Medical Hubs for the exam.

Since the formal establishment of the Medical Hubs in 2006, the method of tracking implemented by DCFS and DHS of the percentage of newly detained children served by the Medical Hubs for the exam, although informative, was not considered to be reliable due to manual tracking of data.

The following action steps, including timeframes, were presented to the Katie A. Panel at its Retreat in December 2011 and included the following:

1. Establishment of the DCFS data tracking report on the priority population of newly detained children served by the Medical Hubs (See Methodology section below for full description) - November 2011;
2. Selection of study sample, including identification of the specific DCFS Offices that will participate in the sample study- December 2011;

3. Development of a Questionnaire for use with CSWs and/or SCSWs on children not referred to a Medical Hub- December 2011;
4. Completion of the interviews with CSWs and/or SCSWs, and collection of data - January 2012;
5. Completion of sample study report-February 2012 including plan to increase referrals to the Medical Hubs with the goal that 100% of the priority population will be referred to, and served by, the Hubs; and,
6. Develop finalized report inclusive of a corrective action plan to increase referrals to the Medical Hubs including the means to address deficiencies -March 2012.

Methodology

By way of an introduction to the Methodology Section, information was extracted from the DCFS E-mHub Initial Medical Examination Report (Report) since this report was used to identify the children who were detained in July 2011 and who did not receive an Initial Medical Exam anytime during the four-month duration between July-October 2011. The sample selected used a stratified random sampling methodology. The total sample population equaled 60, which consisted of 30 cases respectively from large and small DCFS offices. (Note: Large and small offices were categorized based on the number of monthly detentions). The following are the highlights of the sampling process, which was completed in December 2011:

1. There were no cases from the Asian Pacific/American Indian, El Monte, Family First Unit, or Santa Clarita offices;
2. A median split (median = 23 cases) separated the large from the small offices; i.e. large offices had more than 23 newly detained cases from the month of July 2011 and small offices had less than 23 cases; and,
3. Thirty (30) cases were randomly selected from each group using random number generator functions in MS Excel.

The Report was created to assist DCFS offices in tracking children who are newly detained by the Department, and who are required to be referred to, and served by, a Medical Hub, for the exam within 30 days of placement in out-of-home care. The Report includes information on a monthly basis on the number of newly detained children, the number of the children referred to a Medical Hub, and cross-references those who have yet to be referred. Currently, there are seven Medical Hubs, including Childrens Hospital Los Angeles (CHLA), the private sector Hub. (Note that children served by CHLA will be integrated into the Report at a later time). Further, there is the availability to drill down and obtain details at the individual DCFS office and unit level on the status of the referral to the Hub that includes the following: unable to schedule appointments, no show appointments, cancelled by caregivers, Hub declined referral, incomplete and unable to process referral.

Survey Instrument and Data Collection:

A survey instrument was developed in December 2011 (refer to Attachment

I.) The development of the instrument was a joint effort between the DCFS Child Welfare Health Services Section and the DCFS Research and Evaluation Section, with review and comment from other interested DCFS internal and external stakeholders. The primary aim of the questionnaire was to determine the reason(s) for the non referral to the Medical Hub for the exam as well as staff's familiarity

with the DCFS policy mandating that newly detained children be referred to the Medical Hub for an exam. In addition, other questions were included for the purpose of collecting information that might reveal barriers to meeting the goal that all newly detained children are to be referred and served by the Medical Hubs for the initial exam. Specifically, the questions addressed the child's out-of-home placement type at the time of removal from the home of the parent or primary caregiver; verification if the child had been referred to a Medical Hub for the exam; and, if the questions revealed the child had been referred, the date of the referral was captured.

Once the Survey instrument was finalized, a web-based tool was established for user-friendly data collection and analysis of the Survey results.

As a precursor to the implementation of the Survey, in December 2011, an e-mail was sent on behalf of the DCFS Medical Director to the DCFS Deputy Directors and Regional Administrators, informing them of the Study including the background and purpose, the timeline and the plan to contact CSWs (based on the randomly selected sample) to conduct phone interviews during January 2012. It was important to notify the regions so SCSWs and CSWs had knowledge of the effort and felt comfortable in responding to the Survey interviews.

Three managers from the Child Welfare Health Services Section implemented the Survey through the following steps:

1. The CSW who served the child at the time s/he was detained in out of home care was contacted by phone. By way of an introduction, the manager provided the reason for the phone call, along with her name, allowing the CSW to ask any questions or provide any comments;
2. If the CSW who was contacted responded that s/he was not able to access information on the child to sufficiently respond to the Survey, the manager proceeded to contact the CSW who was identified as currently serving the child and provided similar information under #1. (Note: If the CSW who was assigned to the child at the time s/he was detained was from the Emergency Response Command Post (ERCP), the manager bypassed the ERCP CSW and contacted the currently assigned CSW due to the difficulty in accessing the ERCP CSW to complete the Survey;
3. Each Survey was completed at the time of the call with the CSW. (Note: If the CSW responded to the manager that it was not a convenient time to complete the Survey, then arrangements were made between the manager and CSW to complete the Survey at a more convenient time for the CSW.); and,
4. The responses from each CSW to the Survey questions were recorded by the managers on a hard copy of the Survey instrument at the time of the phone interview with the CSW. Afterward, the manager recorded the results onto the web-based Survey instrument.

The Survey interviews were completed in January 2012. Similarly, data entry was completed in January 2012.

Survey Findings

Attachment II presents the findings of the Survey.

Among the 60 selected cases, 10 cases were eliminated from the analysis as they were not newly detained cases. Thus, there was a final survey response population of 50.

Of the 50 newly detained children, although initially identified as non-referred, 16 (32.0%) were subsequently identified as referred to the Medical Hub for the exam and 34 (68.0%) were not. The following is the breakdown of reasons for children not being referred:

- 10 (29.4%) of the 34 children were referred to the caregiver's own health care provider;
- 5 (14.7%) children were hospitalized;
- 3 (8.8%) children's Court petitions were dismissed;
- 2 (5.9%) children were placed outside of Los Angeles County;
- 2 (5.9%) children were released to their parent;
- 2 (5.9%) were referred to a hospital;
- 1 (2.9%) child was AWOL and became a Welfare and Institutions Code (WIC) 602, which is under the supervision of Probation Department;
- 1 (2.9%) child's case plan was Voluntary Family Reunification; and,
- 1 (2.9%) child was referred for a forensic evaluation and not for an initial medical exam.

In addition, the respondents did not provide a reason for seven (20.6%) of the children not being referred to a Medical Hub.

The response to the question on familiarity with the DCFS Procedural Guide, Utilization of Medical Hub (which mandates that newly detained children receive an exam at a Medical Hub), was 44 (88%) of the 50 CSWs surveyed were familiar with the policy and six were not.

The child's placement showed the following distribution: Of the 12 children, who were placed in relative homes, three (25.0%) were referred to the Medical Hub. Of the 20 children who were placed in foster family homes, nine (45.0%) were referred to the Medical Hub. Of the 12 children placed in Foster Family Agency certified homes, two (16.7%) were referred to the Medical Hub. In addition, among the four children who were placed in group homes, two (50.0%) were referred to the Medical Hub. Further, one child was placed in an adoptive home, while another was temporarily placed in a hospital and his/her out-of-home placement was yet to be determined at the time. Neither child was referred to a Medical Hub.

Discussion

In reviewing the reported reasons why children were not referred to a Medical Hub for the required exam, the reasons could be categorized as valid (i.e., the reason that the child was not referred was appropriate), or non-valid (i.e., the reason was not appropriate, such that it is not aligned with DCFS policy.)

The reasons that were considered valid for not referring a child were as follows:

- Child was hospitalized;
- Child's Court petition was dismissed at Court;
- Child was placed in out of home care outside of Los Angeles County;

- Child was released to their parent;
- Child was AWOL and became a WIC 602, under the supervision of Probation Department); and,
- Child's case plan was Voluntary Family Reunification.

Conversely, the non-valid reasons for not referring a child to a Medical Hub were as follows:

- Child's caregiver used his/her own health care provider;
- Child was referred to a hospital; and,
- Child only referred for a forensic, but not for an initial medical exam.

In reviewing the reasons for not referring a child to a Medical Hub, 14 (41.2%) were associated with valid reasons and 13 (38.2%) were associated with non- valid reasons. It is noteworthy that, again, there were seven (20.6%) responses where no reason was identified for the child not being referred to a Medical Hub. One consideration for this lack of a clear reason is that there appears to be uncertainty among CSWs which CSW has responsibility for submitting the referral to the Medical Hub. For example, should it be the Emergency Response (ER) CSW who completes the child abuse and neglect investigation and may promote the referral to a case or the Continuing Services (CS) CSW who receives the new case from the ER CSW and services the child through a case plan of Family Maintenance or Reunification. To add to the uncertainty, the current DCFS policy on use of the Medical Hubs for the required exam is silent on whether the ER CSW or CS CSW has the responsibility for referring the child to a Medical Hub for the exam. In addition, it was recognized in completing the Survey instrument with the CSWs that the role of the ERCP CSW in referring the child to the Medical Hub was vague and open to various interpretations. This is an area in which DCFS can strengthen its policy.

In terms of familiarity with the DCFS policy on the mandate to refer newly detained children to a Medical Hub, the majority of CSWs responded that they were aware of the policy. However, since some responses identified a lack of familiarity, DCFS should implement actions to ensure that there is broad familiarity with the policy both by ER and CS CSWs and their respective supervisors.

It can be noted that most recently, in February 2012, DCFS implemented a For Your Information (FYI) bulletin entitled, "Requesting a Court Order for the Initial Medical Exam." Requested by DCFS Counsel for the purpose of addressing a client's protection rights, the Bulletin instructed CSWs to request in the Detention Court report that the Juvenile Dependency Court order the child to be referred to a Medical Hub for the initial medical exam, along with other Hub services. It is anticipated that the implementation by the CSW of the request to the Court and the subsequent minute order from the Court will have a benefit of directly reminding CSWs of the policy mandate for the child to be referred to a Medical Hub for the exam. When it was released the Bulletin implemented interim policy and the plan is to integrate the Bulletin's directive into DCFS' formal Procedural Guide, Utilization in the Medical Hubs, in the near future.

Recommendations

Based on the Survey Findings, the following are the recommended actions (i.e., corrective action plan) that will be initiated in March 2012:

5. DCFS will revise its Procedural Guide, Utilization of the Medical Hubs, targeted for May 31, 2012. The revised policy will indicate that the CSW who detains the child(ren) will be responsible for submitting the Medical Hub Referral Form. The policy will also include the information outlined in the FYI titled, "Requesting Court order for Initial Medical Exam" which was released on 2/15/2012. The FYI notifies staff of the requirement to include a recommendation in the Detention Report for the court to order medical services at a Medical Hub;
6. DCFS will attend the Regional Office general staff meetings to present on the newly revised Utilization of Medical Hubs Procedural Guide starting June 2012. In addition, DCFS will continue its training on the required use of the Medical Hubs at the Core Training Academy for newly hired CSWs;
7. On a monthly basis, to hold DCFS regional offices accountable, the Child Welfare Health Services Section will implement for the Regional Administrators/Assistant Regional Administrators, a Progress Report titled, "Tracking Newly Detained Children Referred to the Medical Hubs" that will provide the current percentage of newly detained children referred to the Medical Hubs. In addition, a reminder of the mandate to refer all newly detained children to a Medical Hub will be included along with an attachment of the DCFS E-mHub Initial Medical Examination Report. DCFS will share this information with DHS Administration and the Hub MDs as a step to inform and engage stakeholders in our efforts; and,
8. Via the DCFS Stats initiative there will be focused attention on increasing the percentage of newly detained children referred to the Medical Hubs for the Initial Medical Exam. DCFS Stats provides a departmental data dashboard that maintains an inventory of measures related to Safety, Permanence and Well-Being. Implementing Medical Hub referral data on DCFS Stats will promote continuous attention to, and review of, progress towards 100% of the newly detained children being referred to the Medical Hub for the required exam.

DCFS looks forward to implementing the recommendations with the goal that 100% of the newly detained children are referred to a Medical Hub for the required exam.