



# County of Los Angeles CHIEF EXECUTIVE OFFICE

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Chief Executive Officer

June 15, 2012

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

From: William T Fujioka  
Chief Executive Officer 

Board of Supervisors  
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## KATIE A. IMPLEMENTATION PLAN SEMI-ANNUAL UPDATE

On October 14, 2008, the Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare, as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system in fulfillment of the objectives identified in the Katie A. Settlement Agreement.

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

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

**Implementation Support Activities**

| DATE              | DESCRIPTION  |
|-------------------|--|
| January-June 2012 | The Departments of Children and Family Services (DCFS) and Mental Health (DMH) joint Field Response Operations Expedited Response Pilot (FRO ERP) is currently underway. This protocol ensures communication between FRO and DCFS when the FRO team responds in person to a child, but does not hospitalize the child. All efforts will be tracked and evaluated for efficacy and improved outcomes for children. The pilot's success will be measured by implementation of an automated data system, various process indicators related to number and type of responses, and Children's Social Workers (CSWs) surveys. As of February 2012, 76 percent of joint responses were in person and 92 percent of CSWs were satisfied with the protocol. |
| February 2012     | DCFS completed a sample study on newly detained children to examine who are referred and not referred to Medical Hub(s) (Hubs) for an Initial Medical Exam. The study also examined what children are seen and not seen at Hubs. The study investigated the reasons for non-referrals. As a result of the study, a corrective action plan was developed to increase utilization of the Hubs and the number of referrals to the Hubs for the Initial Medical Exam.  |
| March 2012        | The DCFS Policy Memo "Placement of Children and Youth in Group Home Care" previously issued by the Director of DCFS was amended and re-released to all staff. The Memo expanded the age requirement for not placing a child in group home care from eight years and younger to any child 12 years of age and younger. The Memo also reinforced the Department's efforts to reduce the number of children and youth in group home care.   |
| April 2012        | Enhanced Skill-Based Training (ESBT) was rolled out to 98 percent of Line Supervisors and by the beginning of May over 60 percent of CSWs were trained.  |
|                   | The Katie A. Strategic Plan Monthly Report on the Mental Health Screening Process was revised to delete duplicative information, consolidate screening compliance charts, and incorporate the Acuity Referral and Mental Health Service Activity Standards. The new format will be submitted on a tri-annual basis to the Board of Supervisors starting in August 2012.  |
|                   | On April 13 <sup>th</sup> , the Directors of DCFS and DMH issued a joint memo to DCFS and DMH staff establishing an automated process for CSWs and Supervising CSWs (SCSWs) to receive email alerts containing mental health service information for children on their caseload. This effort will assist CSWs to better coordinate care as well as advance the Core Practice Model (CPM) and teaming efforts to achieve the departments' shared goals of child safety, permanency, stability, and well-being.  |

|           |   |
|-----------|---|
| June 2012 | The Chief Executive Office will formally transition its oversight and coordination responsibilities for Katie A. to DCFS beginning June 1, 2012. Both DCFS and DMH will continue to work collaboratively to fulfill the terms of the Katie A. Settlement Agreement. |
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## **OBJECTIVE NO. 1**

### ***Mental Health Screening and Assessment***

#### **Medical Hubs**

Since the Countywide implementation of the DHS E-mHub System, DCFS has established a data tracking report through the interface with the E-mHub System on the priority population of newly detained children served at the Medical Hub(s). The DCFS E-mHub Initial Medical Examination Report is available on DCFS' internet website on a monthly basis. The Initial Medical Examination Report lists the number of children who are newly detained, per DCFS Office, for whom a Hub referral was submitted or not and whether the child was seen at the Hub.

In response to an October 2011 recommendation by the Katie A. Advisory Panel, DCFS conducted a small sample study on newly detained children who were not referred to a Medical Hub for the required Initial Medical Examination to determine the reasons for non-referral. The study focused on interviewing CSWs and/or SCSWs to better understand the reasons why newly detained children were not referred to a Hub for the Initial Medical Exam as well as staff's familiarity with the DCFS' policy on this mandate.

Based on the findings from the study, a corrective action plan, including timeframes, was developed in March 2012 to ensure that the mandate of referring the newly detained children to the Medical Hubs for the Initial Medical Examination is fully complied with. The corrective action plan includes the following recommended actions:

- Revise the current DCFS "Procedural Guide, Utilization of the Medical Hubs", by June 2012. The revised policy will mandate that CSWs detaining a child will be responsible for submitting the Medical Hub Referral Form to initiate the exam;
- DCFS Child Welfare Health Services Section will attend the Regional Office general staff meetings to present on the newly revised "Utilization of Medical Hubs Procedural Guide" starting in July 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;
- The Child Welfare Health Services Section will produce a Progress Report "Tracking Newly Detained Children Referred to the Medical Hubs" on a monthly basis for the Regional Administrators/Assistant Regional Administrators (ARAs). The Report will provide the current percentage of newly detained children referred to the Medical Hubs. The goal is to promote area offices compliance with the mandate of referring newly detained children to the Medical Hubs; and

- Via the DCFS Stats initiative, there will be focused attention placed 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.

Although DCFS has very recently implemented some of the corrective actions, the percentage of newly detained children referred to a Medical Hub for the Initial Medical Examination at 81.9 percent. In addition, DCFS and DHS and the private sector Hub at Children's Hospital Los Angeles have partnered on a pilot project to outstation a DCFS CSW at all the Medical Hubs, including two CSWs to serve the 24/7 after hours LAC+USC Medical Center Scan Clinic. Beginning in early May 2012, the pilot will be implemented and the new CSWs will address key tasks that contribute to the efficiency of DCFS making referrals to the Medical Hubs, while simultaneously improving the Medical Hubs' work flow operations.

#### **Coordinated Services Action Team - Redesign**

The Coordinated Services Action Team (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.

CSAT Redesign was implemented in all 19 DCFS Regional Offices. CSAT Quality Assurance (QA) Meetings are currently being scheduled with the Regional Managers, CSAT Teams, and Program Managers to address challenges that impact the timely submission of MHSTs and referrals to DMH Specialized Foster Care (SFC). Additionally, DMH has developed a SFC Workgroup with participation from Services Area Program Heads to revise and create SFC Guidelines for participation in the CSAT process and the Psychological Testing Process.

In early 2012, CEO, DCFS, and DMH, with input received from the Board Deputies, began a process to revise the Katie A. Monthly Mental Health Screening Memo format. As a result of these discussions, the narrative report was streamlined to delete duplicative information, incorporate the acuity referral and mental health service activity standards, as well as consolidate the screening compliance charts. On April 17, 2012, the Board Deputies approved the new streamlined format for the monthly data report and agreed that the April 2012 report would be the last report issued in the old format. Going forward, the report will be submitted on a tri-annual basis: August 31, 2012; December 31, 2012; and April 30, 2013.

**Multidisciplinary Assessment Team**

In February 2012, 97 percent (514) of all eligible newly detained children Countywide, 529 were referred to the Multidisciplinary Assessment Team (MAT). From January 2011 to February 2012, there were 6,388 MAT referrals and 4,859 MAT assessments completed.

| <b>Table 1: MAT Compliance</b>             | <b>MAT Eligible</b> | <b>MAT Referred</b> | <b>Percent</b> |
|--|---------------------|---------------------|----------------|
| SPA 1                                      | 40                  | 32                  | 80%            |
| SPA 2                                      | 83                  | 82                  | 99%            |
| SPA 3                                      | 123                 | 123                 | 100%           |
| SPA 4                                      | 37                  | 37                  | 100%           |
| SPA 5                                      | 16                  | 16                  | 100%           |
| SPA 6                                      | 99                  | 94                  | 95%            |
| SPA 7                                      | 53                  | 53                  | 100%           |
| SPA 8                                      | 78                  | 77                  | 99%            |
| <i>Total number of DCFS MAT referrals:</i> | <b>529</b>          | <b>514</b>          | <b>97%</b>     |

From January 2011 through February 2012, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 45 days. The expected timeline for completion is 45 days. The percentage completed in 45 days or less was approximately 61 percent. The percent completed by the 50<sup>th</sup> day was 78 percent and over 90 percent were completed by the 60<sup>th</sup> day from detention. DCFS management has not found a way to get these assessments to the court electronically, but is working to identify staff that will download, print, and disseminate the report to court staff.

In terms of completing the MAT assessment by case disposition, DCFS MAT Coordinators report approximately 75 percent of MAT assessments are completed prior to disposition. The remaining 25 percent are delayed for numerous reasons including:

1. Variance in timelines to disposition within the court process. While DMH MAT providers have 45 days to complete the assessment, disposition can occur prior to the 45 days;
2. CSW compliance in obtaining consent/referral documents delayed some initial MAT referrals, thereby delaying the timeline to completion;
3. Benefits establishment, including verifying/troubleshooting Medi-Cal and Medi-Cal applications; and
4. Toward the end of each fiscal year, there are provider capacity issues in several SPAs, which may delay the acceptance of MAT referrals.

From October 2011 through March 2012, DMH MAT Coordinators submitted a total of 21 MAT QA Checklists and 23 MAT CSW Interview Guides. Overall, 88 percent of the QA Checklist's eight domain ratings were positive and 96 percent of the MAT CSW Interview Guides seven domain ratings were positive. Areas rated positive on the MAT QA included efforts to engage families, caregivers, relatives, and community partners in the MAT process, the identification of the child's underlying needs, and the recognition of child trauma. Some areas that rated positive on the MAT CSW Interview Guide included the usefulness of the SOF report facilitating plan development for the family, the resourcefulness of the MAT assessors, and the improved communication between the CSW and the MAT assessor. Areas that presented as challenging included the quality of teaming amongst the Child and Family Team, the utilization of the families' formal and informal support systems, and building upon the child and family's strengths during the SOF meetings. DMH continues to provide trainings to further assist MAT providers with improving the quality of their SOF reports.

Lastly, in February 2012, 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: a Medi-Cal documentation subgroup; a SOF meeting improvement subgroup; and a subgroup focused on improving the identification of underlying needs.

### **D-rate**

As of February 28, 2012, a total of 1,280 children placed in out-of-home care received the D-rate. In a recent study conducted by DMH, as of January 31, 2011, 89 percent of children who received a D-rate were receiving mental health services and about one-third of those children were receiving intensive mental health services. Most of the intensive mental health services were delivered through Wraparound. During the interval between January 2011 and February 2012, approximately 111 children stopped receiving a D-rate, which is consistent with an overall downward trend in the population of children receiving a D-rate. Although all D-rate children have experienced significant functional impairment and mental health diagnoses, some youngsters who are recovering from their mental health issues and have not had their annual reassessment for the D-rate will no longer need to receive mental health services. Some youngsters refuse to consent to participate in mental health services altogether. DCFS and DMH continue to work to ensure that more D-rate children with significant mental health needs are enrolled in intensive home-based mental health services.

The D-rate Redesign Workgroup, composed of DCFS and DMH staff and representatives from children's advocacy organizations, has been meeting regularly to plan a redesign of the entire D-rate program in an effort to better align D-rate to the current DCFS/DMH continuum of care. Although changes made to the existing D-rate program must be submitted to and approved by the State, the Workgroup has reached consensus on several foundational principals. The following is a summary of these ideas:

- D-rate should be a tiered system of care and reimbursement in order to more accurately reflect the range of severity of symptoms/behaviors and expertise demanded of caregivers;

- The criteria for D-rate should be established by the child's extraordinary mental health needs and determined by the demands placed upon the caregiver to meet those needs based on the Child and Family Team members' knowledge of the child, as well as by clinical assessments;
- The decision to qualify the child for a D-rate, determine the necessary mental health services, and other activities needed that the caregiver must provide in order to receive a specified tier of D-rate, shall be determined by consensus within a Child and Family Team with input from the child's therapist, CSW, D-rate evaluator, caregiver, and other members of the team. The team will consider clinical assessments done within a year, other pertinent clinical documents available; and
- Re-assessment of the D-rate, the child's needs for mental health services, and other activities, should occur as frequently as needed to support the child and caregiver rather than on an annual or semi-annual basis. Children with the most profound needs should be reassessed more frequently.

### **Team Decision-Making/Resource Management Process**

For the period of September 1, 2011 – February 29, 2012, the Department completed 7,472 Team Decision-Making (TDM) meetings. This was a nine percent decrease from the previous period reported (March – August 2011). The decrease was primarily due to DCFS having three TDM facilitator items vacant, which resulted in a decrease in TDMs completed. During the last quarter of 2011 (September – December 2011), there were a total of 606 Resource Management Process (RMP) TDMs held (225 on youth entering a group home, 167 on youth being replaced from one group home to another, and 214 on youth exiting group home placement).

In March 2012, a significant effort was undertaken to further reduce the number of young children in group care. The DCFS Director amended the "Placement of Children and Youth in Group Home Care Memo" previously sent to all staff in December 2011. The amended memo raises the age requirement from age eight and younger to 12 years of age and younger. Placement of children age 12 and under will require the approval of the Chief Deputy, or Director, prior to placement in a group home setting. The memo highlights the following points:

- All placement options and intensive community-based services are to be explored, prior to placing a child age 12 years and under in a group home;
- Approval by the Regional Administrator, Office of the Medical Director, and the Resource Management Division leadership is also required; and
- Children age 12 and under will still require a Permanency Planning Conference to occur every four months. The purpose of the conference is for the team to discuss the child's current status, make recommendations on moving the child to a lower level of care, and transition back into the community.

**OBJECTIVE NO. 2**  
***Mental Health Service Delivery***

**Specialized Foster Care**

DMH has co-located mental health staff in each of the 18 DCFS Regional Offices. In total, there are 178 DMH staff members working in these offices. Their primary responsibility is to serve as the point of contact for DCFS CSWs regarding mental health matters. They receive a large number of referrals from DCFS for those children and youth who have screened positive on the Child Welfare MHST. Approximately, 64 percent of these screenings result in a referral to the co-located DMH staff who then make a determination regarding the acuity of the service need (acute, urgent, or routine). Less than one percent of the referrals are in acute need of mental health services and these referrals are seen the same day of referral, often being referred to the DMH Psychiatric Mobile Response Team. Approximately, two to three percent of the referrals are regarded as in need of an urgent mental health response and these cases are provided with a face-to-face contact in no more than three calendar days, though most are seen within a day of referral. Children who are identified as having routine needs for mental health services are linked within 30 calendar days.

In addition to these CSAT referrals, DMH co-located staff also participate in a variety of team meetings, including TDMs and RMPs, and has been instrumental in teaming regarding the County's efforts to reduce the population of young children in congregate care. These co-located mental health staff also provide consultation, as needed, to DCFS CSWs and coordination for Service Area MAT and Wraparound activities. In addition, they work closely with Service Area contracted mental health providers to ensure timely and appropriate service provision.

DMH has also seen steady improvements in the mental health service penetration rate within the DCFS population. Currently, almost 65 percent of the active DCFS caseload is either receiving mental health services, at present, or have received mental health services during the life of their open DCFS case.

In an effort to improve the coordination of care, DMH is now providing mental health information through an automated process to DCFS CSWs on all of their cases that are receiving mental health treatment. This information includes the name of the provider, the name and contact telephone number for the mental health staff providing treatment, the most recent service date, and a history of mental health services received during the past two years.

DMH has also convened a workgroup to examine how best to improve the intensity of mental health services for DCFS-involved children consistent with the Intensive Care Coordination and Intensive Home-Based Service arrays proposed in the Katie A. State Case Settlement Agreement. The Department is currently seeking to conduct a Countywide pilot effort using these service approaches to improve service delivery to DCFS-involved children who are being released from the hospital, or urgent care center, or who are at risk of overstay at the DCFS Emergency Response Command Post.

**Wraparound**

As of April 20, 2012, 1,184 Tier I and 1,584 Tier II slots were filled, which 66 percent of the targeted 4,200 slot rollout. Tier I enrollments have increased due to the increase in the Adoption Assistance Program utilization, the ongoing efforts to focus on community-based services instead of group homes, and the implementation of the Residentially-Based Services program.

The Wraparound administration completed the community input phase of the redesign process in preparation for the new contract release in 2014. Five workgroups were created to address different focal areas: Fiscal; Contracts; Program; Practice; and Quality Improvement/Assurance. The primary objective of these workgroups is to make the Wraparound Program more efficient and incorporate lessons learned, new advances in the field, and receive feedback from consumers and community stakeholders. The Fiscal Workgroup completed their objectives and the development of a Statement of Work for the new contract is underway.

**Treatment Foster Care**

Treatment Foster Care (TFC) provides a cost-effective individualized treatment alternative to children and youth whose needs (psychosocial and/or behavioral) cannot be met in their current home setting. Due to the severity of needs, these youth would be at risk for more restrictive placement settings in the absence of a TFC home. TFC provides an Intensive Home Based Service where children learn and practice appropriate behavioral and social skills in a supportive, home environment, generally, in their own community and close to their own family and school. The target population for TFC includes emotionally and/or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. TFC provides an alternative to group home care for these children by providing intensive in-home therapeutic and behavioral management services in a foster home with a limit on the number of other foster youth in the home. It was additionally determined that this program presents the County with a significant annual fiscal savings of approximately \$1.8 million in Fiscal Year (FY) 2010-11, as a result of meeting youth needs in community settings when compared to congregate care services.

| <b>Table 2: TFC Placement and Capacity (as of April 30, 2012)</b> |                               |                        |                                 |                       |
|---|-------------------------------|------------------------|---------------------------------|-----------------------|
|   | <b>No. of Placed Children</b> | <b>Certified Homes</b> | <b>Certified Home Vacancies</b> | <b>Inactive Homes</b> |
| <b>Intensive Treatment Foster Care (ITFC)</b>                     |                               |                        |                                 |                       |
|   | 54                            | 62                     | 1                               | 7                     |
| <b>Multidimensional Treatment Foster Care (MTFC)</b>              |                               |                        |                                 |                       |
|   | 17                            | 36                     | 9                               | 10                    |
| <b>Grand Total</b>  | <b>71</b>                     | <b>98</b>              | <b>10</b>                       | <b>17</b>             |

As of April 30, 2012, there were 71 youth in TFC homes. Since the inception of the program, a total of 185 youth have entered TFC and received services. Of these 185 youth, 115 have transitioned out of the program: 54.7 percent (63 of 115) graduated to a lower-level of care (i.e., home of parent, legal guardian, relative, and/or foster home); while the remainder (44.3 percent) required a higher-level of care to meet their needs. The success of TFC is also evidenced by those 71 youth who currently remain stable in their TFC homes. These youth are supported by a unique team dedicated to the provision of their needs and are now successfully moving towards permanency and pro-social stability. Since the last report in December 2011, TFC has had 38 new placements and 24 youth transitioned out of the program. Of those 24 youth who transitioned out of the TFC program during this period, 63 percent (15 of 24) of youth graduated to a lower-level of care while the remainder (38 percent) required a higher-level of care to meet their needs.

TFC has been working to develop strategies to broaden the continuum of care and improve the quality of services provided to youth with intensive needs. In addition, the program has been working to increase the number of youth enrolled to reach a target goal of 300 youth. In June 2011, a workgroup was established to increase the delivery of services to DCFS-involved youth in D-rate homes. The workgroup was comprised of managers and supervisors from CEO, DCFS, and DMH. A draft pilot proposal was developed incorporating the best practices from both TFC and Wraparound philosophies and entails close collaboration and creativity among the DCFS and DMH staffs, along with the Foster Family Agencies (FFAs) currently providing both TFC and Wraparound services to youth in D-rate homes. The objectives of this pilot are to support the development of an intensive tier within the current D-rate system and to develop a pool of professional, D-rate caregivers with more specialized training, as well as enriched support from Wraparound teams. Though this pilot is exploratory, one goal is to identify program innovations within both TFC and Wraparound that yield positive outcomes and enhance the quality of services. DCFS and DMH met with the selected FFAs in April to discuss the pilot proposal, elicit feedback, and develop a plan for implementation.

At the recommendation of the Katie A. Advisory Panel, DMH and DCFS TFC staffs have instituted a quality review process that focuses on the services delivered to TFC youths, as well as overall program management. The TFC quality review protocol draws upon many aspects of the Quality Service Review (QSR) protocol in overall philosophy and design. The reviews will be on-going and cases will be randomly chosen from youths who have transitioned out of TFC.

The completed reviews have identified specific areas for program improvement, such as adequate screening of mental health acuity prior to entry, skilled assessment of underlying needs at intake, more finely honed strategies for effective foster parent support, and increased awareness of nationally-recognized therapeutic foster care standards of practice and training. DMH and DCFS TFC program staffs have already responded to these reviews by developing a tiered-acuity rating for all referred youth, focusing on effective foster parent support strategies through a pilot with D-rate foster parents, and with efforts to bring Intensive Treatment Foster Care (ITFC) experts to Los Angeles for consultation and training. One of the identified barriers to program growth has been the limited number of appropriate caregivers to provide safe placements for our youth to receive necessary treatment services. As a result, TFC has been dedicating more resources to targeted recruitment activities.

Beginning in December 2011, TFC administration began partnering with DCFS' Permanency and Recruitment Unit (PRU) to help bolster foster parent recruitment activities. This partnership has yielded several deliverables that have led to an increased pool of potential TFC foster parents. These deliverables included placing TFC inserts and postings in Los Angeles County paystubs; a copy of the TFC flyer has been inserted into Foster Care warrants and AAP checks; and posted on the DCFS website and Facebook page. PRU has also started screening their 888 call line for potential TFC caregivers and forwarding these names to TFC Administration, which in turn is distributed among the 12 active FFAs. To date, the program has received a total of 657 names from the call screenings. Other activities are still in process, including TFC brochures and an advertisement on the internet and radio.

On February 17, 2012, DCFS, DMH, and 12 FFAs hosted an ITFC Foster Parent Training, Recognition, and Recruitment event. The goal of this event was to recognize ITFC foster parents who demonstrated exceptional abilities to meet the needs of youth with more intense needs. In addition, the County offered training aimed at helping foster parents increase their abilities to understand the underlying needs of the youth that they serve by helping them to look beyond their diagnoses, understand the role of trauma, and develop effective strategies to help stabilize youth demonstrating behavioral concerns and how to respond appropriately. Finally, each foster parent was encouraged to invite individuals who were interested in becoming TFC caregivers so that they could learn more about the program and the individual FFAs. Overall the event was a success, with a total number of 50 foster parent attendees, 22 of who were new recruits. Promotional ink pens, bags, and information packets were distributed to the attendees.

TFC administrative staff currently participates in two State workgroups regarding a variety of issues surrounding TFC practice, management, implementation, and sustainability. The two primary groups are the statewide ITFC/MTFC Workgroup and the Katie A. Settlement Implementation Workgroup, which are attended by Los Angeles County executive leadership. The ITFC/MTFC Workgroup has been exploring best practices in managing, funding and sustaining TFC in the state of California. In addition to identifying Statewide systemic points of interest with TFC implementation, this workgroup helped to inform a formal rate increase proposal from the California Alliance of Child and Family Services. Most recently, this group completed a comprehensive assessment of ITFC core components to distinguish those activities that were allowable EPSDT services from those that were solely Care and Supervision activities. The goal of this TFC assessment of activities serves to support efforts by the Katie A. Settlement Implementation Workgroup to develop of a comprehensive TFC Medicaid billing manual that would support consistent statewide billing practices.

**OBJECTIVE NO. 3**  
***Funding of Services/Legislative Activities***

Currently, the FY 2012-13 Katie A. budget depicts approximately \$19.3 million in net County cost savings. The savings are primarily due to vacant Wraparound slots.

Leadership staff from DCFS and DMH continues to participate on the Katie A. State Settlement Implementation Workgroup to operationalize the key objectives of the settlement agreement. It is anticipated that a draft Documentation Billing Manual will be released in August 2012, that will provide guidance on billing issues for care and supervision that fall under Title IV-E, as well as mental health services that should be captured under EPSDT. A draft Core Practice Model Guide is also slated to be released in August which will outline values, goals and principles that promote working with families and service care providers as a team.

The Special Master Report on Progress Toward Completion of the Katie A. Implementation Plan was submitted to the Court in February 2012. The final comprehensive Katie A. Implementation Plan, along with the Special Master recommendations, is scheduled to be filed with the Court in June 2012.

**OBJECTIVE NO. 4**  
***Training***

Over the last six months, the County has been training both DCFS and DMH staffs on the Core Practice Model (CPM) and slowly building internal capacity to coaching in area offices. Highlights include:

**DCFS Training**

- DCFS has continued to provide Enhanced Skill-Based Training (ESBT) to staff. This is the Katie A. Advisory Panel approved training that will help staff utilize enhanced strength-based engagement, assessment, and teaming skills as they work with families.
- As of April 27, 2012, 97.6 percent of all line SCSWs has received ESBT training, and by May 30, 2013, it is projected that 60 percent of the 2,195 line CSWs will have been trained.
- Monthly, coaching groups continue in the vast majority of DCFS offices for DCFS SCSWs and ARAs. The Katie A. Advisory Panel recommended the Compton Office as a pilot, or Prototype office, for the implementation of in-depth coaching and for the development of a skilled pool of coaches on a more intensive level.
- Activities include coaches accompanying supervisors in the field for home calls, shadowing individual supervisors in conducting group case conferencing, and modeling of team formation and facilitation.

- The Prototype is building the skills of external coaches who will in turn build the skills of lead coaches and supervisors in the Compton office and the contract providers. In time, lead coaches and supervisors in Compton will increasingly coach their staff independently and the external coaches will move on to other offices. This strategy will be repeated until all supervisors in child welfare and mental health are coaching their staff on the Core Practice Model.
- On March 7, 2012, the Katie A. Advisory Panel Members observed eight live coaching sessions with families in Compton. At the end of the day, the Panel Members reported to the County being impressed with the quality, effectiveness, and progress of the coaching efforts in Compton.

### **DMH Training**

- DMH continues to offer training on the shared CPM for specialized programs within the department. In April 2012, the department began to train the Emergency Outreach Bureau (EOB) on the CPM. The goal is to train 180 clinical and administrative EOB staff by June 2012. The EOB staff is responsible to render crisis intervention and stabilization services to children/youth experiencing acute and/or urgent mental health needs.
- DMH is also in the process of contracting with Children's Institute, Inc. (CII) for Integrating Child Welfare Trauma Training into the CPM for the coaching roll-out.
- In addition, DMH continues to offer trainings to Specialized Foster Care, MAT and Wraparound providers in the key practice areas of: crisis management; diagnostic assessment and treatment for 0-5; brain development; needs-strengths assessments and teaming.

### **Integration of Coaching Efforts**

- On January 17 and 18, 2012, a combination of 13 DMH, DCFS, and LATC coaches and administrators traveled to Utah to observe their staff in child and family team meetings, coaching interactions, and to learn in general about how they successfully implemented their 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 Los Angeles County moves forward with its coaching efforts.
- On February 16, 2012, coaching began in the Compton office with six units, along with selected DMH co-located staff, and 15 contracted providers. Coaches from DMH, DCFS, and LATC are in Compton three days per week to model effective engagement, teaming, and assessment approaches with supervisors and workers. The coaching activities include coaches accompanying supervisors in the field for home calls, shadowing individual supervisors in conducting group case conference, modeling of team formation, and facilitation.

- The 18 external coaches are scheduled to coach DCFS supervisors and DMH contract providers for six months. It is expected that supervisors will enhance their skills, cultivate new skills with the intention to transfer these skills onto their workers.
- DMH and DCFS are working in collaboration with the IUC to finalize and provide an evaluation of the coaches and the supervisors. The evaluation for the Compton coaching prototype office will begin in June 2012.
- Coaches meet with Compton leadership and supervisors twice a month to provide a feedback loop for everyone to discuss coaching and ways that the Prototype can be tweaked to ensure that we are meeting the needs of staff and families.
- The Countywide planning and identification of coaches has begun. CPM Coaching is scheduled to roll-out in May 2013 to the DCFS Pomona office and, subsequently, to the Torrance and Wateridge offices.
- A Coaching Oversight Committee meets monthly to plan, coordinate and problem solve issues related to coaching in the County. The Committee is comprised of representatives from the DCFS Child Welfare Mental Health Division, DMH administration, contracted Los Angeles Training Consortium administrators, and DCFS and DMH line coaches.

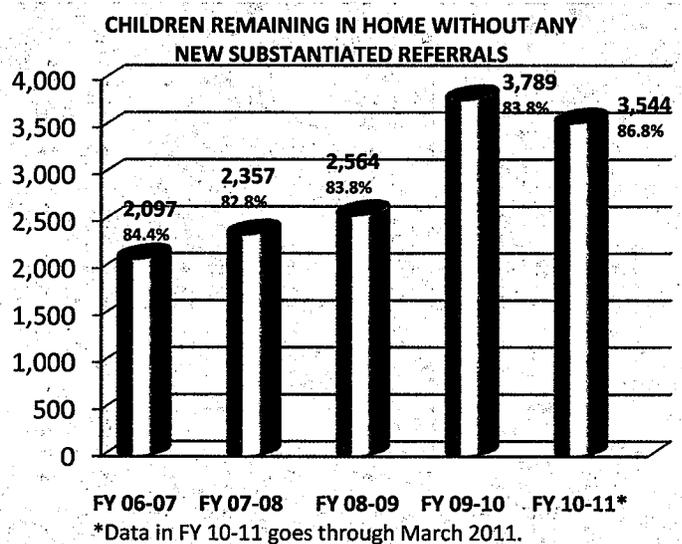
#### **OBJECTIVE NO. 5** ***Caseload Reduction***

The DCFS total out-of-home caseload has been reduced from 15,390 (September 2011) to 15,230 (March 2012). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, the Department is allowed to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

The individual CSW generic caseload average in March 2012 was 26.97, which is a very slight increase of .18 children per social worker since April 2011 (26.79). The Emergency Response caseloads depict a decrease (.56) in number of referrals from April 2011 (17.51) to March 2012 (16.95).

Under the leadership of Philip Browning, DCFS Director (Director), three phases of data analysis are planned for approximately 300 separate zip codes that cover the entire Los Angeles County catchment area. The Director consulted with other jurisdictions and advocacy groups for a model of equitable caseload distribution; however, none is available. This may be the first time that an analysis to determine caseload equity in the child welfare field has ever been conducted in the nation. The Director assigned DCFS Business Information Services Division to develop an "equity analysis" to enable the Department to balance caseloads. This effort will enable DCFS to assign staff equitably across regional offices and have a positive effect on reducing caseloads.

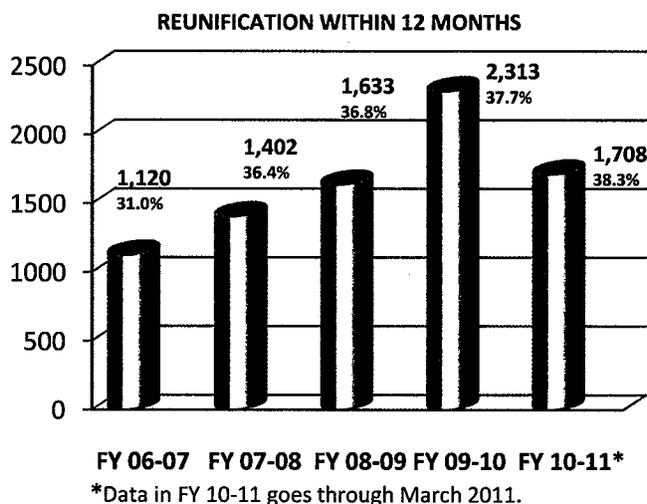
**OBJECTIVE NO. 6**  
**Data and Tracking of Indicators**



**Safety Indicator 1:**

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

*The percentage of children remaining in home without any new substantiated referrals appears to be remaining fairly steady and slightly increased to 86.8 percent in FY 2010-11*



**Permanency Indicator 1:**

*Reunification within 12 months for children receiving mental health services.*

*Despite a decrease (605) in the overall number of children that were reunified since FY 2009-10, the percentage of children reunified is remaining steady at approximately 38.3 percent in FY 2010-11.*

**OBJECTIVE NO. 7**  
***Exit Criteria and Formal Monitoring Plan***

**Quality Service Review**

The Quality Service Review (QSR) provides an in-depth, case-based review of the front-line DCFS and system partners practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services. To date, 188 cases have been randomly selected for review. An average of 10 children, youth, caregivers, family members, service providers and other professionals, per case, have been interviewed and the baseline results demonstrate consistent themes and patterns across the 16 DCFS regional offices reviewed: Belvedere; Santa Fe Springs; Compton; Vermont Corridor; Wateridge; Lancaster; Palmdale; Pomona; Glendora; El Monte; Pasadena; San Fernando Valley; West San Fernando Valley – Santa Clarita; Metro North and West Los Angeles.

On average, 89 percent of the cases across the offices have scored acceptably on the *Child and Family Status* Indicators, while roughly 43 percent of the cases scored favorably on the *Practice (System Performance) Indicators*.

Based upon the reviews conducted thus far, the following practice lessons have been identified: (a) engaging families and giving voice and choice to children, parents, and caregivers in decision-making enhances understanding and participation, leading to better outcomes; (b) strength-based identification of needs helps gain understanding of underlying needs and treatment of trauma required for true and lasting change to occur; (c) improved long-term view provides a clearly articulated vision and guides all the work toward safe closure; and (d) better teamwork improves the functioning of the total support system around the family to unite, communicate, and coordinate actions toward the case plan goals and following case closure. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

The remaining two offices of the first QSR Cycle will be reviewed during the 2012 calendar year in the following order: Torrance (May 14th); and South County (August 20th). Concurrently, a Specialized QSR, requested by the Katie A. Advisory Panel, is being conducted on a sample of 20 Tier II Wraparound cases between the months of April through July 2012.

**SUMMARY HIGHLIGHTS**

| DATE      | DESCRIPTION   |
|-----------|---|
| Ongoing   | CPM, ESBT, coaching and QSR training continues to roll out to both DCFS and DMH staff and mental health service providers to improve practice.  |
| Ongoing   | DMH and DCFS continue to enhance the implementation and coordination of the high-needs service delivery spectrum of TFC, Wraparound and D-rate. |
| June 2012 | CEO will transition oversight and coordination responsibility for Katie A. to DCFS.   |

This is the final Katie A. Implementation Plan Semi-Annual Report the CEO will prepare to the Board. The departments will continue to provide briefings to the Board Deputies through the Children and Families' Well-Being Cluster, and will provide memos to the Board on topical areas of interest as requested.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Lesley Blacher at (213) 974-4603, or via e-mail at [lblacher@ceo.lacounty.gov](mailto:lblacher@ceo.lacounty.gov).

WTF:BC  
LB:lb:km

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