County: Los Angeles **Date: October 1, 2014**

☐ May 1st Submission (September 1st through February 28th Reporting Period)

☒ October 1st Submission (March 1st through August 31st Reporting Period)

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Name and Contact Information County Mental Health Department Representative					
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If your answer below is blank or zero, please provide an explanation.

PART A: Potential Subclass Members Identified During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Next Steps/Timelines**
1	Potential Subclass Members	16,540*	
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	1,744*	
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.	25*	
4	Potential subclass members who were unknown to the MHP during the reporting period.	837*	

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If your answer below is blank or zero, please provide an explanation.

PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Timelines**
1	Subclass Members	8,644*	
2	Receiving Intensive Care Coordination (ICC).	2,307	
3	Receiving Intensive Home Based Services (IHBS).	2,194	
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. *Do not include youth already counted in 2 or 3 above.*	407	
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC). *Do not include youth already counted in 2, 3, or 4*	290	
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).	4,623	
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	837*	
8	Declined to receive ICC or IHBS.	Unknown	

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If your answer below is blank or zero, please provide an explanation.

PART C: Projected Services			
Item #	**Service**	**Projected number of subclass members to be receiving services by August 31st**	**Strategy/Timeline Description** Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (a)	ICC	2,266	We provided the projected number of subclass members to be receiving services by February 28, 2015, not the above date of August 31st. 1. Training and coaching to CFT process and Core Practice Model to FSP and Group Homes. 2. Service Area learning labs related to ICC and IHBS 3. Ongoing Technical assistance to ICC and IHBS providers.
1 (b)	IHBS	2,266	1. Training and coaching to CFT process and Core Practice Model to FSP and Group Homes. 2. Service Area learning labs related to ICC and IHBS 3. Ongoing Technical assistance to ICC and IHBS providers.

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	Yes	No
County Contracting Process	Yes	No

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.

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If your answer below is blank or zero, please provide an explanation.

Hiring: Hiring of additional line staff proceeds; hiring sufficient coaches with training, background and credibility is an area of local DMH and DCFS focus.

Training: Time demands for training and coaching line staff are balanced against ongoing time and priorities challenges of doing direct practice work.

Service Availability: Service Availability is a barrier and challenge in certain parts of the County and is an area of focus for DMH/DCFS.

County Contracting Process: Given the size and scope of the County and the size of contract procurement needs, County requirements require extra time for implementation.

County: LOS ANGELES **Reporting Period: March 1, 2014 – August 31, 2014** **Date Completed: October 31, 2014**

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the state is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county's child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Agency Leadership *Leadership's experience implementing family-centered services in a collaborative setting.*	Los Angeles County Departments of Children and Family Services (DCFS) and Mental Health (DMH) have been planning and implementing Katie A. activities since the County's settlement in 2003. The Los Angeles County Katie A. Strategic Plan adopted by the Court and Los Angeles County Board of Supervisors in 2008 represents an articulated and detailed set of strategies for collaborating across systems to support family-centered practices. Agency leaders share responsibility and accountability for service implementation that is expressed in jointly prepared Katie A. reports to their Board of Supervisors. DCFS and DMH have a shared vision of family-centered care exemplified in our adopted Shared Core Practice Model. Implementation of the CPM is in process. Community advisory councils are present in the service areas of each DCFS regional office or are in development, as is a DCFS Director's Community Advisory Council. DCFS and DMH Director's and high level leaders meet regularly in a number of forums to discuss issues affecting access and quality of services.	N
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	DMH and DCFS have established a joint management structure, a shared budgetary model, a shared data protocol, a joint problem solving approach to privacy, confidentiality and information sharing issues, a share quality improvement process, and a Core Practice Model to integrate service planning, delivery and tracking. DCFS and DMH collaborate in the planning, development and delivery of training across systems and to the provider community.	N
Systems Capacity *The collective strength of administrative*	The County has invested significant resources to better meet the needs of Katie A. class and subclass members, including, for example, $120M mental health service dollars targeted to the class and	N

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
structures, workforce capacity, staff skills & abilities, and operating resources.	subclass, the co-location of almost 196 DMH staff in DCFS regional offices and administrative units in both departments dedicated to support Katie A. efforts.	
Service Array *Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.*	Los Angeles County operates the largest Wraparound program in the world and currently services approximately 2,200 children/youth each day. The County also has a treatment foster care program that includes ITFC and MTFC services as well as a large array of Evidence Based Practices, including significant capacity in Trauma-Focused CBT and Seeking Safety. Efforts to expand ICC and IHBS services consistent with the State's Katie A. settlement agreement continue.	N
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	DMH and DCFS have a shared Core Practice Model for which training and coaching is ongoing. The Shared Core Practice Model was heavily informed by parent, youth and community participation in its development, with an emphasis on the need to reduce racial disparity and disproportionality in the child welfare system. Both DCFS and DMH have parent support programs which also serve in an advisory capacity.	Y (In process)
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	The DCFS and DMH Strategic Plans address cultural humility issues and significant training is provided in this area.	Y (In process)
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	A set of safety and permanency data elements are monitored on an ongoing basis as part of the County's exit criteria from the County case. The Departments also conduct ongoing Quality Services Reviews which analyze the quality of the practice and children and family outcomes. Additionally, DCFS monitors and tracks a number of other significant data and outcome indicators and in monthly meetings with high level leadership reviews case specific practices directly related to these indicators for the purpose of program and practice improvement.	N
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	The departments have braided significant funding sources to provide many services, including wraparound, treatment foster care and the multi-disciplinary assessment teams for newly detained children. Monthly Katie A. budget meetings are held with program and finance staff from both departments along with the Chief Executive Office to plan and monitor budgetary matters.	N

In an effort to comply with the State's request to provide Potential Subclass Member information (Enclosure 1, Part A), the County of Los Angeles Departments of Children and Family Services and Mental Health provided answers to this section to the best of our ability. In some instances, the County of Los Angeles does not have access to specific data requested in the State report; and therefore, cannot follow the State's methodology. However, through DCFS' and DMH's continual collaboration, we attempted to provide an approximation for each item requested with an explanation of the rationale used to gather these numbers. In an abundance of caution, the figures offered in this section are over-inclusive and indicate a larger potential need for services than the County expects is actually present.

Enclosure 1, Part A

1. DCFS and DMH compile weekly data match sets to share information on only mutually shared clients. These weekly data sets only include information on shared clients. Because the Departments do not have access to detailed information on children that they are not serving, we attempted to answer the questions by using solely numbers shared between Departments.
   The figure reflected was compiled by adding:
   a. Matched children/youth (open DCFS case and received mental health services) that were EPSDT eligible during the requested time period of March 1, 2014 – August 31, 2014) which is *15,703*
   b. Children/youth in Wraparound, a specialty care rate home, psychiatric hospital, RCL 10 or above, 24-hour mental health facility or experienced three or more placements in a 24-month period but did not receive mental health services. This number is 837.

   Our total from the figures above of 16,540 (15,703+837) is reflected in Item #1 Page 2
2. In order to attempt to answer this question, the Departments took research that was conducted by the University of Southern California, in 2013, on the Mental Health Screening Tool (MHST). This research stated that approximately 80% of children in the Child Welfare System that test positive on the MHST go on to receive a Mental Health Diagnosis. Since the departments are not capturing the children that do not meet medical necessity that received a mental health assessment, we used the remaining 20%, in the study, as a guide to calculate the children that did not meet medical necessity. Reflecting back to the numbers used in answer 1, we took the number that are *known* to have received a mental health assessment which is the 8,719 (DMH's class no subclass member count) and multiplied it by 20%. 8,719 x 20%=1,744
3. DCFS releases a Tri-Annual Report on a quarterly basis. Looking at DCFS' final Tri-Annual Report for fiscal year 2012-2013, it is calculated that approximately 3% of the children have Mental Health assessments that are pending. These children include those that are AWOL, parents refused to sign consent, the child refuses, and/or if the child is abducted. We took the number reflected in answer 1 of children/youth in Wraparound, a specialty care rate home, psychiatric

hospital, RCL 10 or above, 24-hour mental health facility or experienced three or more placements in a 24-month period but did not receive mental health services (837) and multiplied by 3%. 837 x 3%=25

4. This answer reflects the DCFS' unmatched subclass count during the specified timeframe of 837.

The County of Los Angeles Departments of Children and Family Services and Mental Health have answered Enclosure 1 Part B and have provided a rationale for the sections mentioned below.

Enclosure 1 Part B

1. The figure provided was calculated using the States methodology with one caveat.
    a. The DCFS' unmatched subclass number (837) was accounted for in this answer because in order to later answer Item #7, we must account for the clients not receiving SMHS (children unknown to DMH). If the County provides only its confirmed subclass members, as asked in the original methodology, we would not be able to answer Item #7.
    b. In addition, we included children/youth that received 3 or more placements within 24 months whether or not the move was due to behavioral reasons. At this time, we do not have a mechanism to capture placement disruptions due to behavioral reasons.
    c. Since the initial release of the Integrated Behavioral Health Information System earlier this year, DMH information technology staff had to pull the similar data from this new system and integrate it with the existing Integrated System data. However, due to the significantly different data structure, the effort to merge the data has not been a simple effort and required support from the vendor as well as other key IT staff. This effort was further hindered with numerous power and server infrastructure issues arising during the summer month which led to repeated system shutdowns and server recoveries. Recently, a version of the combined data sources have been made available for the IT staff to leverage, which should help to resolve these issues. Furthermore, plans are in place to move the database servers to another more stable location.
7. The number provided in this number is the DCFS' reported figure of DCFS unmatched subclass members. However, these children may include children who are:
    a. Receiving SMHS from private insurance such as Kaiser Permanente, Blue Cross, etc. and
    b. Receiving SMHS services outside of the County of Los Angeles. DMH does not have access to data of the clients listed above.