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8 **UNITED STATES DISTRICT COURT**
9 **CENTRAL DISTRICT OF CALIFORNIA, EASTERN DIVISION**
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11 KATIE A., by and through her next
friend, Michael Ludin; MARY B., by
12 and through her next friend, Robert
Jacobs; JANET C., by and through her
13 next friend Dolores Johnson;
HENRY D., by and through his next
14 friend Gillian Brown; and GARY E., by
and through his next friend, Michael
15 Ludin, individually and on behalf of
other similarly situated,

16 Plaintiffs,

17 v.

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

24 Defendants.
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CASE NO. CV-02-05662 AHM (SHx)
COUNTY RESPONSE TO ORDER OF
OCTOBER 25, 2010

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1 On August 18, 2010, the Advisory Panel in this case submitted its Twelfth
2 Report to Court.

3 On October 25, 2010, the Court responded, inter alia, with the following
4 comments and questions:

5 1. The Court long has viewed the difficulty of securing adequate funding as a
6 major concern. On page 10, the Panel reports that the incidence of case rate billing
7 (which the Court does not really understand) remains a big issue. The Court looks
8 forward to receiving a report about the September Panel meeting and the Special
9 Master's efforts in working with providers.

10 2. The Court is astounded that the IBHIS information system now is
11 projected for completion in September 2013, which is more than five years after the
12 initial projection. Why? Is the delay a reflection of management ineptitude?
13 Contractor ineptitude? Budget overruns? Is the perceived value of this system no
14 longer as important for the class members and the County as previously believed?

15 3. The recurring press reports of child fatalities within certain facets of the
16 foster care system are most troubling. The portions of the Twelfth Report on Safety
17 Indicators, at p. 26, provide limited assurance. What is encompassed by the terms
18 "abuse," "neglect" and "maltreatment"? Why do the graphs on pages 27 and 28
19 appear to suggest that the incidence or percentage of mistreatment are lower for
20 children who did not receive DMH services? Is there any data demonstrating
21 whether the measures the County has succeeded in implementing pursuant to the
22 Settlement Agreement have had any impact on the incidence of such mistreatment?

23 4. To whom are these Reports sent? Which County agencies and officials?
24 The members of the Board of Supervisors? The Los Angeles Times and other
25 media who cover "local" news and issues?

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1 The County has discussed the Twelfth Report and the October 25, 2010,
2 Comments and Questions with the Advisory Panel and Plaintiffs' Counsel and
3 responds with the attached.

4 DATED: January 19, 2011

Respectfully submitted,

5 ANDREA(SHERIDAN ORDIN
6 County Counsel

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9 By

BRANDON T. NICHOLS
Principal Deputy County Counsel

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11 Attorneys for County Defendants
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1 **Response to Judge Howard A. Matz**

2 **October 25, 2010 Proceedings**

3 1. The Court long has viewed the difficulty of securing adequate funding
4 as a major concern. On page 10, the Panel reports that the incidence of case rate
5 billing (which the Court does not really understand) remains a big issue. The Court
6 looks forward to receiving a report about the September Panel meeting and the
7 Special Master's efforts in working with providers.

8 The case rate is a monthly amount paid to the providers of Wraparound
9 services to pay for those necessary costs that are not able to be reimbursed through
10 Medi-Cal. This funding comes directly from County General Funds and, as such, is
11 paid for entirely by the County; while Early Periodic, Screening, Diagnosis, and
12 Treatment ("EPSDT") dollars used to support the Wraparound program are matched
13 by Federal and State funds, with the County share being only approximately six
14 percent. There has long been a concern that Wraparound providers are over-
15 utilizing their case rate dollars since these costs are less amenable to audit risk given
16 that they are County rather than State controlled. This may result in under-claiming
17 to EPSDT and an over-reliance on County dollars.

18 The County remains committed to fully funding the Wraparound program
19 described in the Strategic Plan and continues to explore funding options to ensure
20 the sustainability of the program. For example, Department of Children and Family
21 Services ("DCFS") and Department of Mental Health ("DMH") Wraparound
22 administrations are in the process of conducting a set of program reviews of the 34
23 Wraparound agencies, including examination of claiming practices. Additionally,
24 representatives from the plaintiff's counsel, Chief Executive Office ("CEO"), DCFS,
25 DMH, Probation, Auditor-Controller and community-based mental health providers
26 have been part of a Wraparound Case Rate workgroup to examine the
27 appropriateness and amount of the Tier I Wraparound case rate. The Wraparound
28 Case Rate workgroup has developed a "Wraparound Tier I Rate Study" template to

1 determine the average cost of Wraparound services, examine the use of case rate
2 funds versus EPSDT and determine whether Medi-Cal eligible services are being
3 billed appropriately. The Wraparound template has been forwarded to all
4 Wraparound Tier I providers and the County expects to have the data analysis
5 completed by the end of December. One of the challenges the county has found in
6 terms of providers utilization of the County case rate funds as opposed to EPSDT
7 funds, is the absence of instructions or guidance from the state on the billing of
8 EPSDT so that providers consequently exercise a variety of billing and claiming
9 practices.

10 2. The Court is astounded that the IBHIS information system now is
11 projected for completion in September 2013, which is more than five years after the
12 initial projection. Why? Is the delay a reflection of management ineptitude?
13 Contractor ineptitude? Budget overruns? Is the perceived value of this system no
14 longer as important for the class members and the County as previously believed?

15 The County initiated the Request For Proposal ("RFP") process to select a
16 vendor to develop the Integrated Behavioral Health Information System ("IBHIS")
17 in 2008. After the receipt of the RFP proposals, the State of California issued new
18 rules that significantly impacted the claiming process. Therefore, the RFP had to be
19 cancelled and a new RFP process was initiated and is near the end of the
20 procurement process. Once a vendor is selected, full implementation is expected to
21 take approximately two years.

22 Due to unexpected delays with the IBHIS, the Panel's Eighth Report to Court
23 in April 2008 explained that IBHIS would be delayed and subsequently revised that
24 estimate again in the Panel's Tenth Report to Court in July 2009. Since July 2009,
25 the Panel reports to Court have consistently indicated that IBHIS is scheduled to be
26 completed in 2013. In the interim, DMH developed a Katie A. Cognos Cube which
27 has enabled DMH and DCFS to share client information, therefore, no longer
28 requiring the use of the IBHIS system for this purpose. While the IBHIS system

1 will improve the County's ability to capture clinical information related to those
2 children who receive mental health services, the Cognos Cube does provide an
3 ability to track service levels and associated costs of mental health services for
4 Katie A. class members.

5 3. The recurring press reports of child fatalities within certain facets of
6 the foster care system are most troubling. The portions of the Twelfth Report on
7 Safety Indicators, at p. 26, provide limited assurance. What is encompassed by the
8 terms "abuse", "neglect" and "maltreatment"? Why do the graphs on pages 27
9 and 28 appear to suggest that the incidence or percentage of mistreatment are lower
10 for children who did not receive DMH services? Is there any data demonstrating
11 whether measures the County has succeeded in implementing pursuant to the
12 Settlement Agreement have had any impact on the incidence of such maltreatment?

13 The terms "abuse", "neglect", and "maltreatment" are defined according to
14 the Penal Code Section 11164-11174.3, Child Abuse and Neglect Report Act
15 ("CANRA"), which generally refers to the non-accidental physical harm, injury or
16 endangerment, sexual assault or exploitation, and/or general or severe neglect of
17 children.

18 The intent of Safety Indicator #1 is "Of those children who initially remained
19 home in the fiscal year (FY), how many did not experience any new (first
20 occurrence of re-abuse) substantiated referrals during the case open period, up to 12
21 months?" The data shows almost a 4 percent increase in safety from FY 02-03 to
22 FY 08-09 with those children who receive DMH services. It is important to note
23 that Katie A. class members, those children receiving DMH services, present with
24 the most chronic and severe mental health symptoms, which often result in
25 increased levels of stress for caregivers, therefore increasing their susceptibility to
26 additional instances of maltreatment and/or abuse in comparison to their
27 counterparts – non-class members. Therefore, the performance of the Katie A. class
28 is expected to always lag behind non-class members, but the features of the Strategic

1 Plan are designed to provide for increased safety for both populations, and in fact,
2 the data is already beginning to demonstrate this.

3 In addition, the County has also made significant progress in the area of
4 Permanency. For example, the Permanency Indicator #1 – Median Length of Stay
5 in foster care has experienced a 38 percent decrease (247 days) in the days for
6 children in long term care since FY 2002-2003. Also, the Permanency Indicator #2
7 – Reunification within 12 months has increased from approximately 15 percent in
8 FY 2002-2003 to approximately 37 percent in FY 2008-2009, illustrating DCFS’
9 success in reunifying all children under its supervision quickly. Lastly, as to the
10 Permanency Indicator #5c –Children in foster care – 24 months or more and have
11 not experienced a move to a third or greater placement, the County has made
12 significant progress as 45.2 percent of class members in 2002-2003 have not
13 experienced more than two moves compared with 58.8 percent of children in
14 2007-2008. This indicator also illustrates the remarkable difference between class
15 members and non-class members, as 82.6 percent (2007-2008) of non-class
16 members did not experience a move to a third or greater placement. Due to their
17 persistent mental health issues, class members often have greater difficulty
18 obtaining and sustaining placements.

19 It is worth noting that the Department has succeeded in keeping the vast
20 majority of children it serves safe and protected from current and future incidences
21 of child abuse and neglect. And, the reported deaths must be understood in the
22 context that Los Angeles County’s DCFS receives approximately 173,000 hotline
23 calls each year and has the third largest caseload in the nation (over 32,000
24 children). The Department has 18 regional offices, a budget of \$1.8 billion, and
25 7,323 positions. Nevertheless, the County believes that even one child death is one
26 too many, so efforts are being made to improve performance, to keep children safe,
27 and to mitigate the occurrences of child death. Specifically, in addition to the
28 strategies outlined in the County's Katie A. Strategic Plan, over the last year the

1 Department has reviewed and strengthened its safety practices in the areas of
2 electronic safety alerts for high risk referrals as well as open cases, policy and
3 procedures, and the use of performance metrics to manage caseloads and enhance
4 safety procedures.

5 Last, the County has discussed this issue with the Panel and Plaintiffs' counsel
6 and the Panel has provided the following to give additional context to this issue:

7 The Panel has followed the attention given child deaths
8 involving children previously known to DCFS and while
9 this issue has not been the primary focus of Panel work,
10 we agree that child safety is the most important objective
11 for all children served by the Department. The County is
12 responding to the Court's questions in regard to the
13 Panel's Twelfth Report, including those related to child
14 safety issues. In that regard, the Panel would like to share
15 its observations about the current environment in DCFS
16 and the relationship of Katie A. objectives to child safety
17 needs.

18 Many systems have experienced public scrutiny following
19 publicized child deaths and the attention DCFS has gotten
20 in the past year has been among the most intense within
21 the Panel's experience. Such attention can help mobilize a
22 more effective response, especially if it goes beyond
23 anecdotes and explores trends deeply and thoughtfully.
24 Without question, the concerns expressed by the media
25 and County leadership have resulted in an intensive focus
26 on child safety practice by the CEO's office and within
27 DCFS, which continues.

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1 The focus on the child tragedies also has other unintended
2 effects. Abuse and neglect allegations increase due to
3 heightened public awareness and reporting and workload
4 expands due to a general reluctance by staff to screen out
5 reports that otherwise would not have been considered as
6 meeting the standard for a valid allegation. Morale has
7 suffered as details about cases are publically reported,
8 causing caseworkers to feel as if the entire DCFS
9 workforce is seen as deserving criticism. Resources from
10 other program areas have been redeployed to address the
11 investigative backlog. Fortunately, the Panel has not seen
12 a significant impact on Katie A. implementation as a result
13 of these brief redeployments.

14 The new DCFS Director will inherit all of these
15 challenges, which will need attention for system
16 improvement efforts to be sustained. The Panel believes
17 that a strength of DCFS that can be useful in improving its
18 child protection response is the strategy for Katie A.
19 implementation. The expansion of the use of child and
20 family teams made up of family members and
21 professionals will strengthen planning and decision
22 making by employing more expertise in addressing risk
23 and needs in individual cases. There is heightened
24 attention to assessment, often a vulnerability in child
25 protection practice. Training and coaching are being
26 developed to sharpen and broaden the assessment process.
27 And the Katie A. focus on the creation of home based
28 services resulting from thorough assessment and team

1 planning should be more responsive to child safety,
2 permanency and well-being needs. The Panel urges the
3 County to intensify its Katie A. implementation efforts
4 even as other strategies target child protection specifically.
5 The Panel will continue to review the child safety data
6 indicators, which comprise one component of the exit
7 criteria from the Katie A. Lawsuit. We will be providing
8 more information on the exit criteria in the next report to
9 Court.

10 4. To whom are these Reports sent? Which County agencies and
11 officials? The members of the Board of Supervisors? The Los Angeles Times and
12 other media who cover "local" news and issues?

13 The Katie A. Panel Reports are shared with DCFS, DMH, CEO, County
14 Counsel and the Los Angeles County Board of Supervisors. They are not routinely
15 provided to the media or news agencies but are publicly available on the County
16 DCFS' dedicated Katie A. website at <http://dcfs.co.la.ca.us/katieA/index.html>.
17 A schedule of all Katie A. related reports can also be provided upon request.

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DECLARATION OF SERVICE
Case No. CV-02-05662 AHM (SHx)

STATE OF CALIFORNIA, County of Los Angeles:

Daisy Torres states: I am employed in the County of Los Angeles, State of California, over the age of eighteen years and not a party to the within action. My business address is 648 Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles, California 90012-2713.

That on January 18, 2011, I served the attached,

COUNTY RESPONSE TO ORDER OF OCTOBER 25, 2010

upon Interested Party(ies) by placing the original a true copy thereof enclosed in a sealed envelope addressed as follows as stated on the attached mailing list:

(BY MAIL) by sealing and placing the envelope for collection and mailing on the date and at the place shown above following our ordinary business practices. I am readily familiar with this office's practice of collection and processing correspondence for mailing. Under that practice the correspondence would be deposited with the United States Postal Service that same day with postage thereon fully prepaid.

I declare that I am employed in the offices of a member of this court at whose direction the service was made.

Executed on January 18, 2011, at Los Angeles, California.

Daisy Torres



**Type or Print Name of Declarant
and, for personal service by a
Messenger Service, include the
name of the Messenger Service**

Signature

SERVICE LIST

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